Introduction to Human Services: An Equity Lens 2e

Introduction to Human Services: An Equity Lens 2e

ELIZABETH B. PEARCE AND MARTHA OCHOA LEYVA

OPEN OREGON EDUCATIONAL RESOURCES

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Message to Students

Dear Students,

This book is significant in several ways. It is the very first openly licensed text specifically for the human services profession. Second, it benefitted both from original writing but also the steadily developing openly licensed world of academic works. As an interdisciplinary field, we were able to draw on multiple existing openly licensed works.

What do you recall about March 2020? Sudden lockdowns impacted all of us, causing many of us to lose employment and our everyday routines. Human services majors, in particular, were not only increasingly caring for family members but also for children who were unable to attend school or child care. Students still attended college but with fewer emotional, mental, and financial resources.

I made a pretty rash decision in the summer of 2020. I started adapting an openly licensed resource for social work from Ferris State University into an openly licensed text for human services majors. It was pretty rough—a few new chapters, along with rapidly updated information and repaired broken links. But it was enough to save those students $180 at a time of diminishing resources, and for that, we were all grateful.

The opportunity to create a more comprehensive text arose when Open Oregon Educational Resources offered me the chance to work with professional editors, additional authors, an equity consultant, and a project manager in 2022. While the urgency of the pandemic has faded, the call for breaking down the barriers to knowledge is no less important. What you are reading now is the result of the efforts of many who believe in the importance of making knowledge access equitable; making it "free" is just the beginning.

This book is an overview of an extremely broad profession. You will explore the many settings and jobs that will be open to you in the human services field. You will learn about working with specific populations and settings, such as working with children, families, older adults, people with disabilities, people with substance use disorders, military members, and in criminal justice and healthcare settings.

This text includes two critical concepts that affect all of us. Mental health and the related practices of self-care are touched on in several chapters, but there is also a chapter devoted specifically to mental health care and settings, as well as mental health disorders.

In addition, this text contains an approach to the history of social services that does not appear in any human services text, commercial or openly licensed. The inclusion of this work is possible because of the scholarly and openly licensed work by Kelichi Wright, MEd, LCPC, LPC; Kortney A. Carr, LCSW, LSCSW; and Becci A. Akin, PhD, all associated with the School of Social Welfare at the University of Kansas.

Specifically, it discusses the ways that trauma imposed on Native and Black populations in the United States has contributed directly to the creation of the human services and social work profession. The trauma of enslaving Black people and stealing land from Native Americans and the disruption of family relationships in both groups contributes to the disproportionate need for social services and continued discrimination against both groups today. Students of human services and professionals in the field must understand the past in order to practice ethically in today's world.

As the text has evolved, students have been actively involved in giving feedback and ideas about additions and improvements to the text. Please join in by offering your ideas and input.

–Elizabeth B. Pearce

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About this Book

Accessibility Statement

This book was created in good faith to ensure that it will meet accessibility standards wherever possible, and to highlight areas where we know there is work to do. It is our hope that by being transparent in this way, we can begin the process of making sure accessibility is top of mind for all authors, adopters, students and contributors of all kinds on open textbook projects.

If you encounter an accessibility issue, please let your instructor know right away.

Equity Lens

The Open Oregon Educational Resources Targeted Pathways Project seeks to dismantle structures of power and oppression entrenched in barriers to course material access. We provide tools and resources to make diversity, equity, and inclusion (DEI) primary considerations when faculty choose, adapt, and create course materials. In promoting DEI, our project is committed to:

1. Ensuring diversity of representation within our team and the materials we distribute
2. Publishing materials that use accessible, clear language for our target audience
3. Sharing course materials that directly address and interrogate systems of oppression, equipping students and educators with the knowledge to do the same

Designing and piloting openly licensed, intersectional, and antiracist course materials is one starting point among many when addressing inequities in higher education. Our project invites students and educators to engage with us in this work, and we value spaces where learning communities can grow and engage together.

We welcome being held accountable to this statement and will respond to feedback submitted via **our contact page**.

Course Learning Outcomes

Educators, students, and future employers all benefit when course-level learning outcomes guide our shared work. When course-level learning outcomes are public, institutions demonstrate a commitment to equitable student success through the potential for increased collaboration and inclusive course design. This project analyzed learning outcomes across the state of Oregon to identify themes and com-

monalities. Authors used this analysis as a basis for developing course outcomes that could match the curriculum of multiple institutions in Oregon while still considering their local needs and context.

Course Learning Outcomes

1. Identify the core principles, theoretical perspectives, and historical development of the human services field.
2. Articulate the centrality of social justice and multicultural equity in the practices of the human services profession.
3. Describe the characteristics and skills of helping professionals.
4. Apply reflective tools for career assessment self-awareness.
5. Apply knowledge and skills to identify the next steps in the career path, including internships and work settings.
6. Identify the complexities of human and social problems.
7. Describe services, systems, and programs that comprise human services.

Teaching and Learning Approach

The authors of this book embraced an equity-minded design for structure, scope, and sequence of chapters and chapter content. They sought to honor the needs and experiences of students who are often underserved in higher education in Oregon. Authors considered Transparency in Teaching and Learning (TILT), Universal Design for Learning (UDL), and culturally responsive teaching to design meaningful learning pathways for you. You will find rich images and multimedia in addition to written content. You will also find provocative discussion questions that align with learning outcomes and objectives.

Culturally Responsive Teaching is not something you do superficially—it is something that you have to think about deeper motivation of students and your own motivation as an educator. You have to consider culture and all the elements and intersections that come with that.

Instructors, please see the Instructor Resources section in the Back Matter for an overview of curriculum design as well as openly licensed course packs and teaching tools.

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CHAPTER

1

An Overview: Human Services

1.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 1: Human service professionals recognize and build on client and community strengths (National Organization for **Human Services** [NOHS], 2024).

This chapter provides a broad overview of the human services field, including a definition of the **profession**, the multiple disciplines that are related, and the ways a human services **degree** may be used. Next, the generalist aspect of being a human services professional is outlined, including the core theories and approaches used. One of those, the **strengths-based approach**, is reflected in the ethical standard quoted above: human services professionals recognize and build on client and community strengths.

The last part of the chapter describes the characteristics, skills, and knowledge needed to be a human services worker. As a potential professional, examine yourself in relation to these questions: How am I already strong? Where can I grow? Am I invested in characterizing the needed qualities? Overall, this chapter will give you an introduction for deciding whether this profession is one you want to explore more deeply.

LEARNING OBJECTIVES

1. Define the field of human services, including its core principles.
2. Describe the relationship between human services and related fields.
3. Describe the important intersection of theory and practice in human services.
4. Analyze the needed characteristics, skills, and knowledge of helping professionals, then assess your areas for professional growth.

KEY TERMS

This list includes important vocabulary for understanding the ideas introduced in this chapter. Look for the words in bold along with their definitions in the text.

- BIPOC: This term refers to Black, Indigenous, and People of Color
- Collaboration: The act of working with others.
- Congruence: Being "real"; actions in line with values and beliefs.
- Client: The term refers to the individual, family, groups, and communities who are the recipient of support services—in other words, whose goals, needs, and strengths constitute the primary focus of the provider in the human services field.
- Ecological systems theory: Emphasizes the complexity of the environments that each individual interacts with.
- Empathy: Being able to feel and relate to another's feelings.
- Equity: Equity involves acknowledging and addressing imbalances caused by bias or systemic structures, as we don't all start from the same place.
- Equality: This is one of the central principles of democracy. It is based on the belief that all people should have the same opportunities to be successful and have a productive, enjoyable life. Equality is rooted in fairness, since it is linked to the notion that everyone will be able to achieve based on their efforts and contributions to society instead of their status or position.
- Generalist approach: Using multiple disciplines and methods.
- Human services: A professional field focused on helping people solve their problems.
- Interdisciplinary approach: Using multiple disciplines, or knowledge branches, working together to solve problems.
- Service model: Focuses on prevention, intervention, and remediation to help people solve problems.
- Social justice: Viewpoints and efforts toward every person receiving and obtaining equal economic and social opportunities; removal of systemic barriers.
- Unconditional positive regard: The belief that everyone has worth and deserves our consideration.

- Intersectionality: A perspective that recognizes that individuals are impacted differently based on characteristics such as social class, race, ethnicity, gender, sexuality, ability, and age, and that it is important to look at the intersections of these identities.
- Inclusion: The active, intentional, and ongoing engagement with diversity. Inclusion is seen as a universal human right. The aim of inclusion is to embrace all people regardless of race, gender, or disability, or a medical or other need. It is about giving equal access and opportunities and getting rid of discrimination and intolerance. It affects all aspects of public life.

Land and Labor Acknowledgement

It is essential to recognize that Portland, Oregon today is a community of diverse Native peoples who continue to live and work here. As such, we must acknowledge and honor all Indigenous communities—past, present, and future. Their ongoing and vibrant presence is not something to be taken lightly.

It is also vital to acknowledge the systemic policies of genocide, relocation, and assimilation that have impacted many Indigenous families to this day. As settlers and guests on these lands, we must respect the work of Indigenous leaders and families and pledge to make ongoing efforts to recognize their knowledge, creativity, and resilience and the complexity of what this word means.

We must approach this with a sense of urgency and a commitment to change. We cannot simply pay lip service to these issues; we must take action to ensure that Indigenous communities are given the respect and recognition they deserve.

We respectfully acknowledge and take ownership of the traumatic history of forced labor of Black Americans who have advanced our country. We would like to recognize the remarkable contributions of Black Americans who have played a critical role in advancing our country despite facing tremendous adversity. We will be forever indebted to the enslaved and exploited African Americans who were established in our U.S. infrastructure and economy, advanced civil rights, and continue to influence popular **culture**. It is our solemn responsibility to continuously recognize the historical horror of the transatlantic trafficking of their people, chattel slavery, Jim Crow, and current systemic oppression and injustices placed on Black Americans and to work towards a better future for all actively. We are grateful for the sacrifices made by their ancestors, who have paved the way for us to be where we are today.

We must consider how the education system as a whole has not been a place of safety, support, and reformation for all students and educators especially in higher education. For many BIPOC and other marginalized educators they have had to carve and push into spaces that were not created for them or the students in the classroom or communities. Their histories are still being told are not real or appropriate to share with all students. When in reality their history is our history and has been whitewashed to make some people in power comfortable.

Our knowledge has been stolen and renamed under a more digestible image or told that it does not come from "credible sources" however the people who are choosing the criteria of those sources come from one perspective not allowing **intersectionality** to come into play which allows bias to be the only lens to be used. Challenge and debate is central to education and that is what you will be asked to do everyday over the week not only over the time of this course but over your life. Challenge the notion of what is established as how we have always done things.

I invite you to visit the following websites to learn more, explore or get involved.

The **Sogorea Te' Land Trust** is an urban Indigenous women-led land trust based in the San Francisco Bay Area that facilitates the return of Indigenous land to Indigenous people.

LANDBACK is a movement that has existed for generations with the purpose to get Indigenous Lands back into Indigenous hands.

The **Native Land Digital Map** allows you to go beyond learning about the indigenous land where you are now, but all over the world.

Beyond Land Acknowledgement asks organizations to move past words of land acknowledgments into concrete steps, including a call to action for those audience members who are reading the land acknowledgment and not just asking for free labor from Indigenous people with no tangible steps for action.

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1.2 What Is Human Services?

Some people may be unfamiliar with **human services** as a **profession**. **Human services** is a broad interdisciplinary field that aims to meet people's needs, prevent and remedy problems, and improve their quality of life. It promotes accessibility, accountability, and coordination among professionals and agencies in service delivery. Human services help people achieve stability, including basic needs like food and shelter, counseling, and substance abuse treatment. It is a crucial component of society's social **welfare** system, centering **equity** (figure 1.1). Human services professionals rely on the following areas to meet the needs of their clients:

- an interdisciplinary knowledge base that includes **prevention**, **intervention**, and **remediation**;
- a commitment to the delivery of essential services and working with other agencies to improve people's overall quality of life; and
- a focus on equity and **social justice** to optimize the potential of individuals and groups (Kincaid, 2009).



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Figure 1.1. Human services is a field that emphasizes collaboration, social justice, and serving others.

The broad definition of this discipline means that many jobs and careers fit under the umbrella of human services. People motivated to help others find themselves together in this field even though they work in a wide range of settings, including schools, medical offices and hospitals, private nonprofit agencies, and governmental services.

For example, people who work in human services perform functions that help people resolve life's problems, such as **housing insecurity** and homelessness, unemployment, food insecurity, addictions, custody, or the social and emotional sides of loss, tragedy, and illness. They provide services helping people with adoptions, fostering children, parenting, mental health challenges,

dealing with grief and loss, and other life transitions.

Interdisciplinary and Collaborative Approach

Human services is grounded in the context of human development and human organizational behavior, or how people behave in groups. Human services requires a uniquely **interdisciplinary approach**, meaning multiple disciplines contribute to the profession.

This broad understanding comes from multiple fields, such as but not limited to:

- human development and family sciences
- psychology
- sociology
- early childhood development and education
- public health and nutrition
- communications
- criminal justice
- **restorative justice**
- community organizing or grassroots movements
- for-profit organizations
- nonprofit organizations
- public agencies

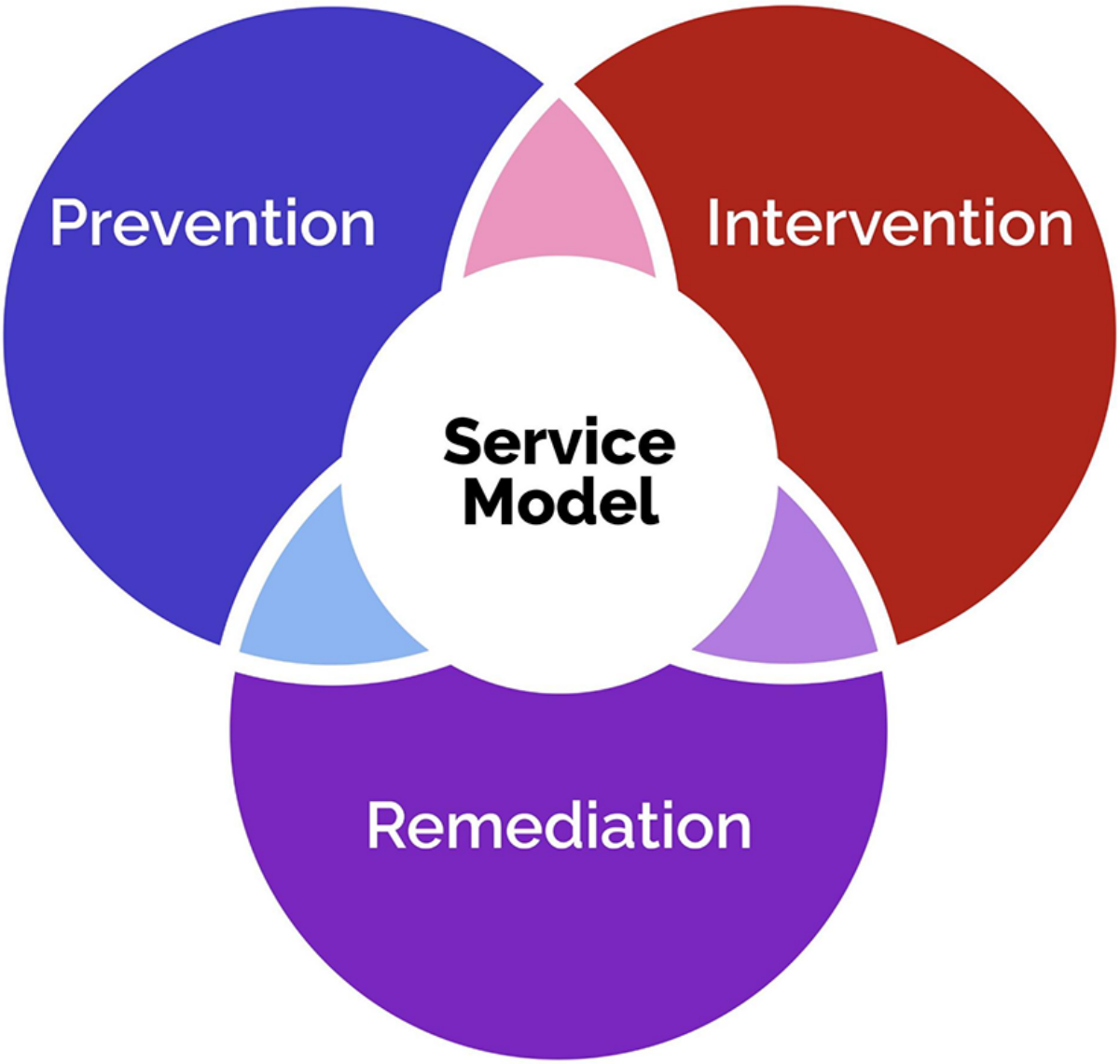
While the professionals in human services may have a specialized focus in one of these areas, they will also have enough broad-based knowledge and experience to draw on when needed for work in a wide variety of environments.

Collaboration is an essential part of human services and means that many agencies and services must work together to best serve individuals, families, and groups. Just like the image in figure 1.1, the human services professional must piece together a solution that serves the entire person. Professionals work to make the delivery of services as smooth and complete as possible. Planning; communicating; focusing on others' experiences, needs, and strengths; and being other-centered are important to delivering human services. There are times when a human service professional may need to step aside or refer a client to another service that can more fully support the client in their goals.

Being knowledgeable about other services and being intentional about asking questions when one doesn't know the answers are highly valued skills in human services. The combination of collaboration, communication, and knowledge can lead to smoother service delivery, which in itself benefits others. All of these factors contribute to helping people use human services to achieve the best quality of life possible.

The Human Services **service model** focuses on preventing problems, intervening in problems, and remediating problems. As you learn more, consider which mode you might prefer most.

Human services professionals' primary work is helping people solve their life problems across three stages: preventing problems, intervening in problems, and remediating problems, as shown in figure 1.2.



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Figure 1.2. The service model includes three stages for helping people: prevention, intervention, and remediation.

The human services field includes professionals who specialize in only one aspect of the service model. As you read this text, consider your career from the lens of **prevention, intervention, and remediation**. Where do you want to focus?

- **Prevention:** Professionals may work in education, public health, or policy planning. It also includes helping individuals prevent the recurrence of problems through planning, budgeting, problem-solving, or counseling support.
- **Intervention**: Professionals involved in **intervention** help people solve problems as they occur. When working in intervention, professionals can provide intervention at the policy and programmatic levels, and when professionals work in program design and creation

at programmatic levels to support creating programs that provide the framework for prevention and remediation services. Professionals may work at the policy level to design and create needed services, or they may work individually to assist people in accessing services and stabilizing their lives.

- **Remediation**: Professionals in the area of remediation work with programs and policies that involve chronic problems, such as addiction and criminal behavior. To help people **rehabilitate** themselves, human services workers use a **strengths-based approach,** which involves using the strengths of individuals, families, and communities to solve problems.

Equity, Equality, Social Justice, and Inclusion

The human services field is grounded in the principles of equality, social justice, and inclusion. Our ethical duties require us to incorporate these values into our work and decision-making processes in prevention, intervention, and remediation. Chapter 3 and Chapter 4 will delve deeper into how these lenses are employed in our field. Understanding these concepts early on is essential, as they will shape our discussions of human services. Ethical Standard 10 of the National Organization for Human Services mandates that professionals provide services without discrimination or preference to any group, especially those historically oppressed.

However, these words can seem hollow without concrete examples. In upcoming chapters, we will explore how equity, equality, social justice, and inclusion manifest in the three modes of service delivery. Establishing clear definitions of these terms will provide a framework for our future discussions.

Equity involves acknowledging and addressing imbalances caused by bias or systemic structures, as we don't all start from the same place.

Equality is one of the central principles of democracy. It is based on the belief that all people should have the same opportunities to be successful and have a productive, enjoyable life. Equality is rooted in fairness, since it is linked to the notion that everyone will be able to achieve based on their efforts and contributions to society instead of their status or position.

Inclusion is the active, intentional, and ongoing engagement with diversity. Inclusion is seen as a universal human right. It aims to embrace all people regardless of **race**, **gender**, or **disability**, as well as medical or other needs. It is about giving equal access and opportunities and eliminating discrimination and intolerance. It affects all aspects of public life.

Social Justice is the explicit effort toward every person receiving and obtaining equal economic and social opportunities while removing systemic barriers.

As we progress in these chapters, remember that our intersecting identities will be crucial in shaping our approach toward equity, inclusion, and social justice. It's important to acknowledge that our intentions may not always align perfectly with the impact we have, but we must take ownership of our actions and strive to improve our skills in this regard. We can positively impact and create a more just and equitable society with confidence and a willingness to learn.

Human Services and Related Fields

An associate's **degree** in human services can lead to bachelor's, master's, and doctoral degrees in multiple fields, including human services, social work, counseling, public health, psychology, or sociology. More discussion of degrees, licenses, and careers will appear in Chapter 9. Collabora-

tion across disciplines is common, as visualized in figure 1.3, and multidisciplinary teams are often required to support clients with high needs.



Figure 1.3. Collaboration amongst multidisciplinary agencies and individuals can feel disjointed, but it is important to work together toward the best quality of life for clients.

The Distinction between Human Services and Social Work

Human services is a relatively new profession, having emerged from social welfare work in the 1950s and 1960s. Social work became a more prominent field in the same era, and these two fields are intertwined. Social work and human services focus on helping people both individually and in groups, and they emphasize social justice, which is the view that everyone deserves economic, political, and social rights and opportunities that lead to equal outcomes.

One key distinction between human services and social work is that social work has a specific licensing and credentialing system, and human services does not. Psychology, public health, education, and sociology are other fields related to human services. If you are considering human services as a career, you may want to look into these other fields as well.

Professionals from both fields may work side by side in settings such as addiction treatment centers, incarceration programs, government agencies, and nonprofit agencies. Both professions can work with individuals, groups, and communities to perform advocacy work, community organizing, and even policy work. However, access to certain levels of clients and scopes of practice require

certain degrees and training programs. Depending on these requirements, you would need to consider either the human service field or look into social work as an option. However, an associate-level move to the bachelors, masters, or doctoral level of education is not always necessary to do the work that you want to do.

Sociology and Psychology

Human services and social work are both applied fields with a focus on working with people, while psychology and sociology are more focused on theoretical understandings of social problems. Both are important foundations for the applied fields, but psychology and sociology dive deeper into science, research, and theory than do human services. Psychology is focused on the study of the individual human mind, the way it functions, and how it affects behavior. Sociology focuses more on studying society's structure, development, and functioning.

The study of social problems, which is fundamental to human services, comes from the field of sociology. Sociologists research, teach, study, and analyze organizational and societal behavior, including social problems and how they affect people and society.

Psychology is another field that has specific credentials associated with higher-level degrees. Students who wish to become psychologists typically think about earning a doctoral degree, during which they might treat patients in a clinical setting or conduct diagnosis and assessments in settings such as schools or prisons. Others will earn a doctorate to perform scientific research related to the brain and behavior.

Students sometimes ask about becoming a counselor or a mental health therapist. These are also roles certified and licensed by states and other jurisdictions. It is important to look at the certification requirements in the state where you reside or plan to reside. Examples of these roles include Licensed Marriage Family Therapist (LMFT) and Licensed Professional Counselor (LPC). These roles almost always require a master's degree and sometimes a doctoral degree. An undergraduate degree in human services, psychology, social work, or a related field prepares students for these advanced degrees.

Criminal Legal System

The criminal legal system is another broad field that encompasses all aspects of the systems related to law enforcement, including social processes such as laws, policies, and the practices of the court systems. Related jobs include police officers, lawyers, parole and probation officers, CASA (court-appointed special advocates), case managers, and correctional officers. Some working in the helping professions may also be placed within the criminal legal system, such as social workers, counselors, behavioral aides, and addiction counselors. These helpers may be embedded within a jail or prison, but they might specifically work with people in other parts of the justice system too.

People interested in the remediation aspect of criminal legal work are often inspired by the grounding principles of human services. Students of human services who have also studied the criminal legal system may head toward careers in parole, probation, or other helping roles within a correctional facility.

Public Health, Education, and Early Childhood Education

Public health, education, and early childhood education are considered helping careers and are application based, just like human services. People with human services and public health degrees

might end up working side by side with one another in organizations that are focused on people's health, but there will likely be more specialized jobs in that same organization that require a public health degree. An increased focus on public health issues during the COVID-19 pandemic has resulted in the overlap of multiple

Students who want to work with children of varying ages may be interested in the education or early childhood education fields. There is certainly an overlap with the human services field, because there are many families with children who seek help from human services professionals. A primary difference between teaching children and serving families with children is that a teacher is responsible for designing and implementing a curriculum for a group of children and typically spends eight hours per day with those students. The human services professional is more likely to work with children when their parents are present and for shorter periods of time.

For example, someone with a human services degree might be a family support specialist for Head Start or another early childhood education program. Teachers in public schools must be certified by the states they live in; and states vary whether this certification is completed at the bachelor's or the master's degree level. This applies to K-12 teaching consistently and, in some states, to early childhood teaching.

Another lesser-known career path that has become much more popular in the last few years has been that of home visitors. Home visiting itself has been an informal practice in many cultures around the world and includes lactation support, nutritional guidance for babies and parents, parenting advice, attachment questions, and much more.

Versions of home visiting programs started about forty years ago with nurses in formal settings, but that required a higher level of education that excluded home service providers. This has changed and expanded in recent years to include a whole new set of excellent professionals in programs such as Early Head Start and even programs explicitly working with BIPOC teen parents. These professionals have extensive training in family support systems and child support needs.

Professional Associations and Licensing

Human services, social work, psychology, sociology, public health, education, and early childhood education are similar in that they are all fields involved with helping or studying individuals and society. In addition, they are all professions.

Professional fields are defined by their requirement of long-term education and training. Some have licensure systems as well as requiring an undergraduate or graduate degree. In addition, professions are distinguished by having a professional association and a code of **ethics** that members use in their work.

Learn more about resources that are critical to human services workers who want to stay up-to-date on research, effective strategies, and the problems facing the people we serve by exploring the following links:

- **The National Organization for Human Services [Website]**
- **The Ethical Standards for Human Services Professionals [Website]**
- **Journal of Human Services [Website]**
- **NOHS Virtual Knowledge Series [Website]**



Figure 1.4. The National Organization for Human Services provides formal opportunities to engage with colleagues in human services.

Earning a degree, participating in a professional organization, and taking advantage of **internship** opportunities are all significant steps in preparing for the future. As you progress through future chapters, you can better understand the ethical **standards** and principles that guide human service providers. Additionally, you will learn about the various types of credentials and qualifications available to individuals in this field, as well as potential career paths and opportunities for licensure. By delving into these topics, you will be better equipped to navigate the complex human services landscape and make informed decisions about your professional development.

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1.3 Theories, Practices, and Concepts Central to Human Services

The introduction to this section is based on the work of Aika Fricke while she was a candidate for her MSW at Ferris State University (figure 1.5).



Figure 1.5. Aikia Fricke at her graduation in 2006.

Aika Fricke has worked for Community Mental Health for Central Michigan since 2008 as a clubhouse advocate, case manager, and most recently as an employment specialist. She is a full-time mother to "four lovely children and a full-time wife to a wonderful and very supportive husband, as without his tremendous support furthering my education would not have been possible."

Human services professionals take a **generalist approach**, which means they use their broad knowledge across many disciplines and methods to solve problems. An advantage of the generalist approach is the awareness of theories, foundational concepts, and practices of multiple fields and practitioners that promote well-being. A generalist approach introduces students to the application of addressing social problems at the individual (micro), group (mezzo), and community (macro) levels while following ethical principles and critical thinking (Inderbitzen, 2014). Generalist human services workers in a helping **profession** use a wide range of **prevention**, **intervention**, and **remediation** methods when working with families, groups, individuals, and communities to promote human and social well-being (Johnson & Yanca, 2010).

Being a generalist practitioner prepares you to enter nearly any profession within the human services and social work fields, depending on your population of interest (Inderbitzen, 2014). You may develop a specialty within the generalist approach during your education, internships, or professional life. For example, the program director for people experiencing homelessness would apply their generalist knowledge to a specific population: those who have **housing insecurity** or are houseless. A medical social worker would apply their broad knowledge to a specific group of people hospitalized at a cancer center.

Why Theories and Research Matter

Have you ever wondered, "Why is my three-year-old so inquisitive?" or "Why are some fifth graders rejected by their classmates?" or "Why do some people become addicted to alcohol and others do not?" Theories can help explain these and other occurrences. Theories offer possible explanations about how we develop, why we change over time, and what kinds of influences impact development.

A theory guides and helps us interpret research findings as well. It provides the researcher with a blueprint or model to help piece together various studies. Think of theories as guidelines, much like directions that come with an appliance or something that requires assembly. The instructions can help you piece together smaller parts more easily than you would using only trial and error. There are many theories of development. In this book, we have chosen to draw on many theories, several of which are summarized in this chapter.

Ecological Systems Theory

Ecological systems theory is an interdisciplinary study of complex systems that focuses on the dynamics and interactions of people in their environments (Kirst-Ashman & Hull, 2015). Professionals use this theory to identify, define, and address problems within social systems.

Ecological systems thinking helps us understand the relationships between individuals, families, and organizations within our society. It is used to identify how a system functions and how the negative impacts can affect a person, family, organization, or society as a whole. The same information can be used to identify strengths and to cause a positive impact within that system (Flamand, 2017).

The **ecological systems theory** was developed in the late 1970s by Urie Bronfenbrenner. It draws on systems theory and an environmental approach known as person-in-environment. This approach asserts that individuals are influenced by their surroundings. However, some critics argue that the model places too much emphasis on the biological and cognitive aspects of human development and that it should include more on the socioemotional element of human development.

The ecological systems theory emphasizes the complexity of the environments and systems that each individual interacts with. In helping professions, professionals support clients and community members in identifying what is working well and what is negatively impacting them within multiple systems and environments (figure 1.6).

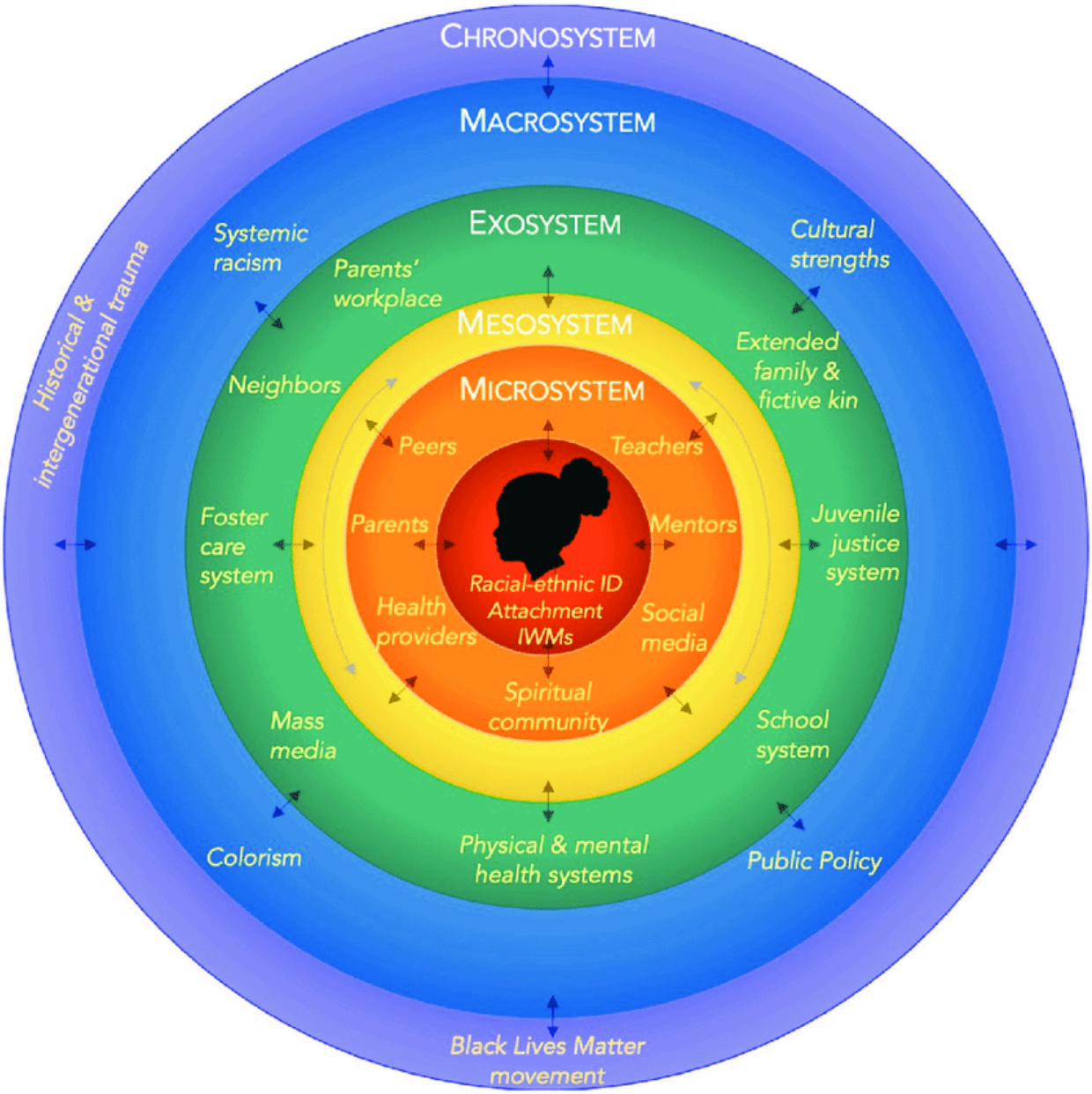


Figure 1.6. Ecological systems theory shows how the individual is influenced by different systems, from the microsystem to the chronosystem. Image description available. **Image description.**

To illustrate this theory and the following theory, we will use this vignette about "Marlene."

STORIES FROM HUMAN SERVICE WORK: MARLENE

Marlene has been working with the school social worker because she has been crying during class for multiple days during the past few weeks. After talking for a few minutes, Marlene describes having a recent fallout with her social group, which is mostly made up of her Black friends. As a child of a multiracial family–a Black mother and Korean father–she reports having difficulty authentically relating to any group and being stereotyped as exotic. Marlene says her parents are supportive and talk to her often about her mental health, though she has more conflict with her step-siblings. She says she feels more overwhelmed than ever and needs help knowing what to do next.

Microsystem

The ecological systems theory is typically illustrated with six concentric circles that represent the individual, environments, and interactions (figure 1.6). The **microsystem** is the smallest system, focusing on the relationship between a person and their direct environment, typically the places and people that the person sees every day. Often, this includes parents and school for a child or partner, or work and school for an adult.

STORIES FROM HUMAN SERVICE WORK: MARLENE

Marlene's family is one of the primary sources of both support and anxiety for her. Her parents were concerned in her middle school years when she had trouble making friends, but they were very encouraged when she found a close group of friends in high school. A teacher she is close with saw the argument Marlene had with her friends and suggested she talk with a social worker to help her feel better.

Mesosystem

The mesosystem, which lies between the micro and exo systems, represents how those people and places interact and cooperate. If they work together well, it can positively affect the individual. For example, if a student also has a job, is the employer willing to work around the school schedule? If a child attends a childcare program, do the teacher and the parent communicate clearly? The mesosystem is important because it is about the relationships and the interactions among important environments.

STORIES FROM HUMAN SERVICE WORK: MARLENE

The family moved to this city about three years ago. Previously, Marlene's family lived in Arizona, along with her extended family. Marlene talks about having more connections with her community in Arizona, including a spiritual community and a local community of musicians. When they moved, Marlene lost these connections, as did her family. Although her parents make more money than they did in their previous city, they are away from home a lot more and have less time to spend with Marlene.

Exosystem

The exosystem includes the people and places that an individual interacts with regularly but not daily, such as a place of worship, club, lesson, or social group.

STORIES FROM HUMAN SERVICE WORK: MARLENE

Marlene was also recently injured while on a trip with the marching band, in which she plays the trumpet. Because the trip was in a different state's hospital network, her parent's medical insurance did not cover her care. The bill was over $10,000, placing additional financial strain on the family. Marlene's new school is also predominantly White students, and she sometimes suspects teachers are harder on her than other students. Marlene's relationship with her extended family is maintained via video chat, except for their annual trip for a family reunion in Arizona every summer.

Macrosystem

The macrosystem identifies the larger values and attitudes of the **culture** and varies by location and interest.

STORIES FROM HUMAN SERVICE WORK: MARLENE

Marlene's struggle with racial identity is mirrored in our larger culture's struggle with its racialized history and present inequities. The discrimination that Marlene faces is a product of his-

torical oppression. Similarly, her family's struggle with health insurance and financial precarity is common in our culture, though more common among minoritized racial and ethnic groups.

Chronosystem

The chronosystem describes time as a system that affects individuals. Large events and trends—such as the dramatic increase in college costs and debt, the COVID-19 pandemic, and the frequency of record-setting wildfires on the West Coast of the United States—are all examples of events in the chronosystem that affect individuals and families in the first part of the twenty-first century.

STORIES FROM HUMAN SERVICE WORK: MARLENE

Many adolescents have reported increases in depression and anxiety during the COVID-19 pandemic. It's possible that Marlene has been affected or that her family may have had trouble adapting to the crisis. It is important to consider large socio-cultural events and their effects on individuals. The chronosystem helps us understand how Marlene's struggles with racial identity development are impacted by present-day events and compare them with previous generations' struggles. Although Marlene's chronosystem enables her to keep in contact with extended family in her previous city, her identity also makes her online life more vulnerable to abuse and harassment.

Evidence-Based Practice

Evidence-based practice (EBP) is not simply "doing what the literature says." It is a process that human service workers engage in with their clients. The bedrock of EBP is a proper assessment of the client or client system (such as a family or social group). Once we have a solid understanding of what the issue is, we can evaluate the literature to determine whether there are any solutions others have found to be effective. If this sounds familiar, that's because it's the same approach a doctor, physical therapist, or other health professional would use. Evidence-based practice prevents workers from using quack interventions that are not based in science.

Drisko and Grady (2015) define EBP as being composed of "four equally weighted parts: 1) client needs and current situation, (2) the best relevant research evidence, (3) client values and preferences, and (4) the clinician's expertise" (p. 275). A human service worker uses their skills in engagement and assessment to talk with clients, identify their issues, and collaboratively decide on evidence-based approaches to the client's goals.



Figure 1.7. Evidence-based practice is a process that joins scientific evidence, clinical expertise, client values, and the agency or organizational context in which one is practicing.

EBP is situated within an agency context. As depicted in figure 1.7, evidence-based practice is also impacted by the resources available to the clinician at their human service agency—the "clinical context" in the diagram. Some agencies specialize in one type of treatment that they perform for all clients (e.g., 12-step addiction recovery, kidney dialysis), while others may use multiple EBPs or work on teams that develop new EBPs not yet in the literature.

Social science allows workers to test their ideas about how to help people using the scientific method. Publishing those results allows others to build knowledge within a scientific community. Historically, the scientific community has excluded people from the Global South, indigenous communities, women, people with disabilities, and other oppressed groups. This biases the scientific literature towards people who speak and write English, access scientific articles via well-funded university libraries, and purchase the laboratory, software, and other resources needed to produce new scientific discoveries.

Because social science in part tries to establish truths applicable to all humans, problems arise when researchers make general statements about all people based on studies that almost always use participants from Western, educated, industrialized, rich, and democratic (WEIRD) countries. These studies incorrectly classify participants as "standard subjects" and exclude researchers and participants from less developed countries (Henreich et al., 2010). Arnett (2008) found that 70 percent of the people studied in prominent psychology journals were from the United States alone, and a 2020 reanalysis found that 89 percent of the world's population is not represented by the cultures studied in psychology journals (Thalmayer et al., 2020).

Even when diverse samples are assessed by social scientists, across history and today, scientists extract data and publish it without regard for the long-term impact on communities or respect for the traditional knowledge practices of Indigenous people (Smith, 2021). Another limitation in the scientific literature is that EBP studies often isolate a single diagnosis or issue. A study investigating treatments for major depressive disorder (MDD) may be less helpful if you are helping someone from a different culture than yourself who also has MDD, autism, and a physical **disability**.

The scientific literature does not contain the One True Answer to a problem, and human service workers must use their critical thinking skills to link data and practice. You should stay abreast of new research when working with clients and implementing evidence-based practices. At the same time, pay attention to practices used by BIPOC communities over centuries of use, such as meditation. Whether or not these practices have been researched and have produced formal evidence, the long-time use of these methods is itself another kind of evidence. Make sure to engage with sources of evidence beyond science, such as what your clients and communities center on when making decisions.

Strengths-Based Approach

The **strengths-based approach**, also known as the strengths perspective, emphasizes that every person, group, family, and community has strengths, and every community or environment is full of resources (Johnson & Yanca, 2010). Often attributed to Bertha Reynolds, a mid-twentieth-century social worker, and Dennis Saleebey, a late-twentieth-century scholar, the approach has a foundation in the work of Black scholars and social workers. W. E. B. Du Bois wrote about the strength of Black people in adapting to and surviving in hostile conditions. In the early twentieth century, Black social workers such as Birdye Henrietta Haynes, Elizabeth Ross Haynes, and others focused less on pathologizing Black people and

more on the strengths and resilience strategies found within families and communities (Wright et al., 2021).

When using the strengths approach, not only is the human services professional or social worker helping the client to identify their personal strengths, but the worker is also helping the client identify local resources to help the client's needs. There are many things to keep in mind, as figure 1.8 illustrates. This approach focuses on the strengths and resources the client already has rather than on building new ones.



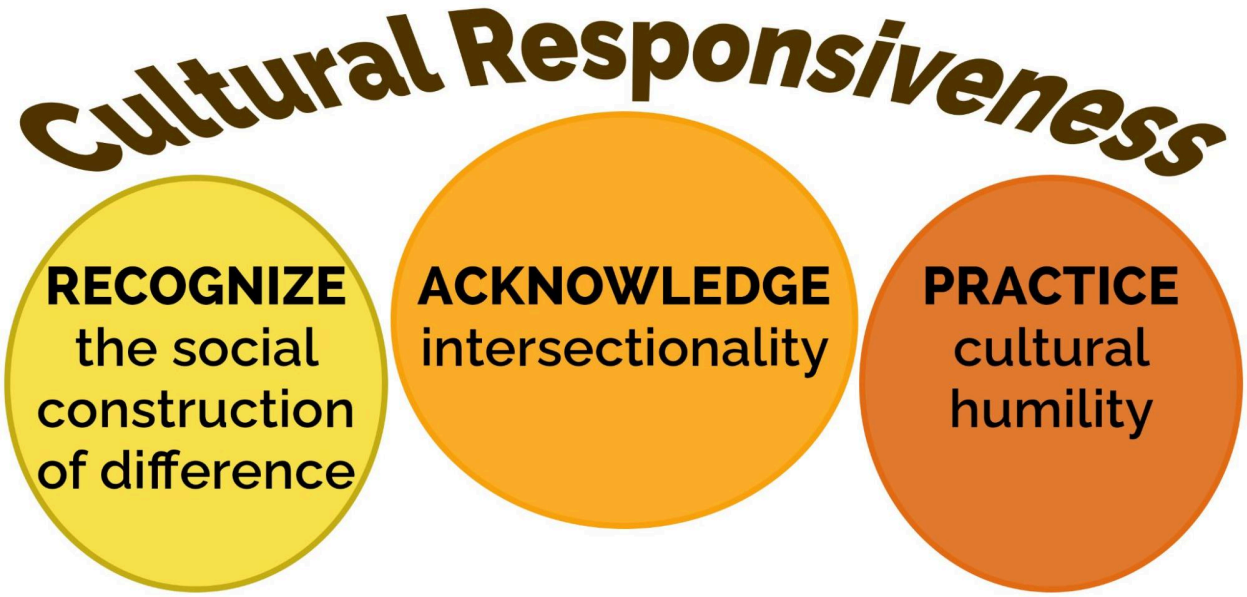
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Figure 1.8. A strengths-based approach emphasizes the resources, resilience, and strengths within the individual and their community. Image description available. **Image description.**

Cultural Responsiveness

Cultural responsiveness, also known as a culturally responsive approach, involves being aware that each individual you meet has their own set of beliefs, values, routines, and rituals that contribute to their culture.

Cultural responsiveness means being aware of cultural factors and appropriately responding to them, as described in figure 1.9. As a human services professional, learning about cultures is a part of your job. You can learn about culture specifically from that culture's members but do not expect people from marginalized groups to do all the work of teaching you. Read, listen, and watch media sources created by, rather than for, members of a culture. Culturally responsive human services workers include culture as part of their assessments. They tailor their interventions to consider the client's culture and the effects of oppressive systems.



Designed by Elizabeth Pearce & Michaela Willi Hooper, Open Oregon Educational Resources, CC BY 4.0.

Figure 1.9. Cultural responsiveness includes understanding the social construction of difference, which is described below, intersectionality, and attending to what others tell us about their experiences–i.e., cultural humility.

People are the experts in their own lives. To be truly client-centered, professionals must remember what a person's values are and their preferences for the outcome of their life situation. It can be tempting to think that, as a professional, one knows what is best, but each individual's values, traditions, and culture must be respected. This includes working to understand our own culture, what that looks like, and the impact it has on the people and the world around us. How do your intersectional identities impact those around you, and what weight do each of your identities carry in the world around you? Cultural responsiveness is something that evolves with you over your career as you understand more about yourself and the context around you.

Understanding intersectional identities will impact how you respond culturally. We are not experts in people's lives and may not know every detail of our client's lives, but we bring expertise

and skills. With our unique identities, diverse experiences, and ongoing commitment to cultural responsiveness and humility, we provide a solid foundation for supporting our clients on their journey toward growth and healing. We must grow confident in our ability to positively impact our clients' lives and help them achieve their goals.

Human services professionals must explore our cultural humility and identity work as a lifelong process. If we come from systems that have historically held more power, such as White cisgender men, it is especially important to challenge ourselves on the systems of power that we benefit from and reflect on our unconscious biases. Reflections about unconscious bias should happen in classrooms, during work meetings, while building treatment plans, in ethical decision-making, during the supervision of individuals and groups, and over our lifetime.

Depending on our intersecting identities, the depth and breadth of these experiences will look different. We need to center **race**, as this factor is central to the systems of power and privilege we have access to—not only as human services professionals but as humans. It is essential to ask ourselves questions such as, "When was the last time I had to prove my **gender**?" or "She does not look like she could be your mom; she looks Mexican, and you don't." "No, but where are you really from?" I am guessing many of you have not had to prove your mother was your mother by showing them a family picture off your wall just so police would believe you and let you and your mother walk into your apartment at the age of 7 years old just because she had a deep beautiful olive tone, eyes the color of toasted hazelnuts and dark jet black ringlet curls. You had peach-colored skin that Huitzilopochtli kissed from playing too long outside, untamed braids light brown with hints of red, and eyes the same shade of green from the grass you had just been playing in. Reflection is a critical practice that we must continue to grow as providers.

Where Theory and Practice Meet

All of these approaches may be used in a variety of settings. Thinking about where you might apply these perspectives in your daily life can be helpful. Human services are often described as being applied at the macro, mezzo, or micro levels (figure 1.10).

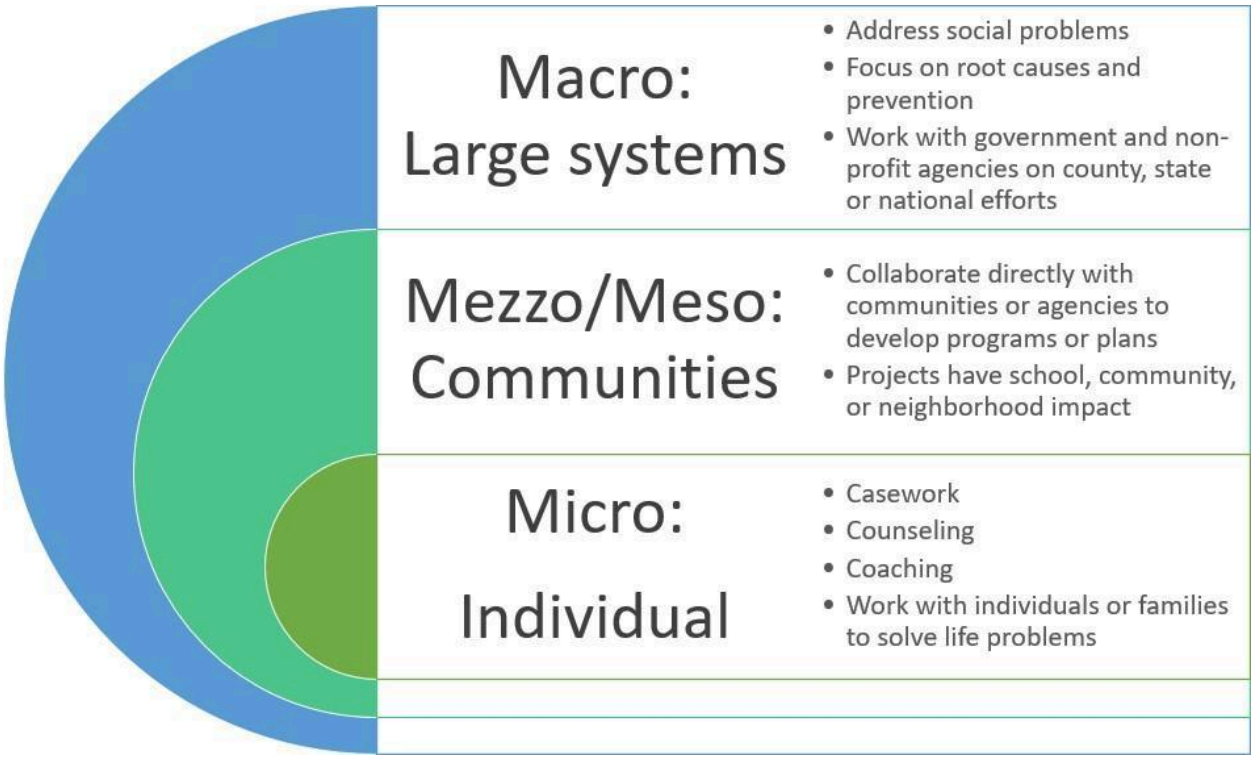


Figure 1.10. The broad human services profession allows practitioners to move among the micro, mezzo, and macro levels. Image description available. **Image description.**

Micro Level

Micro-level practice happens directly with an individual client or family. In most instances, this is considered to be a case management and therapy service. Micro-level work involves meeting with individuals, families, or small groups to help identify and manage emotional, social, financial, or mental challenges. This may include helping individuals find appropriate housing, health care, and social services. Micro-level practice may even include helping members of the military and families cope with military life and circumstances, helping with school-related resources, or working with clients around substance use, **houselessness**, or food insecurity.

The focus of micro-level practice is to help individuals, families, and small groups by providing one-on-one support and building skills to help manage challenges (Johnson & Yanca, 2010). Many professionals begin at the micro level to understand the inequalities, disadvantages, systemic oppression, and advocacy needed for vulnerable populations.

Mezzo (Meso) Level

Mezzo (meso) level practice involves developing and implementing plans with communities such as neighborhoods, places of worship, and schools. Professionals interact directly with people and agencies with the same passion, interest, location, or challenge. The big difference between micro- and mezzo-level social work is that instead of engaging in individual counseling and support, mezzo practitioners help groups of people. Human service professionals might help establish a free food pantry within a local place of worship, health clinics to provide services for the uninsured, or community budgeting and financial programs for low-income families.

While working at the mezzo level, professionals should be aware of the system oppression that affects individuals, families, and communities. For example, in a community that has high levels of contamination in its air and water, it may not be enough to advocate for additional healthcare resources. It may be equally valuable to advocate for the source of pollution to be clearly identified and pressured to make changes.

Macro Level

Macro-level practice is similar to mezzo practice in that both tend to address social problems. The macro practice is on a larger and less direct scale, and it often uses a preventative approach. The responsibilities on a macro level typically involve finding the root cause, the why, and the effects of citywide, state, and/or national social problems. Awareness of systems of privilege and oppression is foundational to this work.

Professionals are responsible for creating and implementing human service programs to address large-scale social problems. Macro-level social workers often advocate for state and federal governments to change policies to serve vulnerable populations better (Kirst-Ashman & Hull, 2015). They may be employed at nonprofit organizations, public defense law firms, government departments, and human rights organizations. While macro-level human services or social workers typically do not provide therapy or other assistance, such as case management, to clients, they may interact directly with the individuals while conducting interviews if they are researching the populations and social inequalities of their interest.

The human services and social work professions are broad and allow practitioners to move within the micro, mezzo, and macro levels. As you continue to read this text, consider the approaches described above as well as the level of human services work that is most appealing to you.

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Figure 1.7. "Venn-diagram-ebp" by Carla M. Allen is licensed under **CC BY ND 4.0**.

1.4 Characteristics Needed for Human Services Work

As often as lists have been created, so have the list of characteristics that make the "perfect" candidate for **human services** provider. This book will attempt to do the same, while acknowledging that no one list will satisfy everyone or cover every need. Still, these characteristics are broad enough to cover the needs of many areas in the field and can fit the different micro, mezzo, and macro levels.

These skills can be used for therapeutic, preventative, and even systemic work, and they can look different for individuals depending on intersecting identities. The idea of looking for perfection is an idea of White supremacy that we as a human service field need to help break as it sets unrealistic expectations. We need to allow flexibility in what human service workers can look like based on the context and communities we are working in.

Empathy

Empathy is often described as putting yourself in somebody else's shoes. While this description is helpful, empathy in helping is more intentional than this saying implies. Professional **empathy** is being able to look at the client's issue or situation from the client's point of view. You are attempting to see the world through the other person's lens, but it does not mean that you can then know exactly how the client is feeling. It does not mean that you agree with this point of view or that you have had a similar experience to the client.

In fact, if you have had a similar experience, it may be tempting to say, "I had the same thing happen." Remember that even if you have been in the same position, this does not mean you both see the situation the same way. Empathy shows that, as another human, you are trying to understand how the client views their experiences and situation. This involves maintaining a judgment-free approach to your work.

For example, let's think about a human services student interning as an intake worker at a diversion facility for recipients of DUI infractions. The student may hear many versions of "I only had two drinks," "I wasn't impaired at all," or "Everybody I know drives home after parties. I think they singled me out unfairly." The student may not agree with these statements, but can the student understand how the client may view the situation? Developing your ability to view the situation from the client's point of view is critical to working effectively.

Another way of looking at empathy is to consider these four elements:

1. **Perspective Taking:** When you share or take on the perspective of another person, you must also be able to recognize someone else's perspective as truth.
2. **Being Nonjudgmental:** When you judge another person's situation, you discount their experience. To take on the perspective of another person, you must put away your own thoughts, assumptions, and biases.
3. **Recognizing Emotions**: Recognizing someone else's emotions or understanding their feelings requires you to be in touch with your own feelings and to put yourself aside to focus on the person in distress.
4. **Communicating Understanding**: You should be able to express your understanding of the other person's feelings and ask them to tell you more (Wiseman, 1996).

Being compassionate with clients involves using empathy rather than sympathy—two behaviors that can be confused. While empathy requires seeing things from another's perspective, sympathy involves seeing things from your own perspective. Empathy helps build connections between people, whereas sympathy puts one person (the one expressing sympathy) apart the other person, creating disconnection.

ACTIVITY: EMPATHY

Dr. Brené Brown is known for her work related to empathy, shame, and sympathy. In this three-minute video, she gives examples that distinguish empathy from sympathy.



This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=KZBTYViDPlQ**

Figure 1.11. Brené Brown on Empathy vs Sympathy [Streaming Video] Transcript.

After watching the video, answer the following questions:

1. What are the differences between empathy and sympathy?
2. How does empathy fuel connection?
3. What does it mean to "silver line" something?

Congruence and Unconditional Positive Regard

Congruence (also known as genuineness) has to do with how a helper presents themselves. It is vital that the client feels that the worker is being real with them rather than just playing a role. As fellow humans, we intuitively understand this. Think of a time when you were asking someone for help. Your gut tells you when someone is being "fake" or doesn't care about the situation. When congruence is being considered, we must also be flexible when thinking about neurodivergent clients and providers who have different cultural needs. Not all clients process emotions both internally and externally the same way, and this alone should give us a moment of pause. What preconceived notions do you have? What are some things that need to be unlearned about what emotional responses look like? How did you learn to show specific emotional reactions?

Just as we are sensitive to insincerity, our clients can pick that up in a human services worker. The solution is to find the balance between your everyday life and your working life. It doesn't mean telling your every life story to a client, but it does mean being comfortable in your role of helper. This involves the development of boundaries that allow you to be your true self in your working relationships but maintain a constraint between your personal and professional life. We will discuss self-disclosure in more detail later in this book. When we consider congruence, two things of note are social expectations of how someone "should" express or feel during a particular situation and differences in cultural considerations.

These will affect how a provider or client may experience or present themselves in an experience. Some ways social expectations lenses are impacted could be because of neurodivergence, developmental **trauma**, or even language barriers; the reasons are endless. The key to aligning your intentions with your expression is to have a genuine relationship and connection with the client. Clients sometimes say, "You are paid to care," which brings us to **unconditional positive regard** for those client-provider relationships.

Unconditional positive regard means that everyone has worth and deserves our consideration simply by the fact that they are human. We come to each client and each relationship with a sense of respect and warmth regardless of the client's past or current attitudes or behaviors. By meeting the client on this level ground, you are inviting the client to work with you as an equal partner in creating solutions. As with empathy, this requires the suspension of judgment of our clients. The term unconditional positive regard was coined in 1956 by clinical psychologist Carl Rogers expanding on the work of Stanley Standal in 1954.

ACTIVITY: SELF-ASSESS YOUR STRENGTHS AND CHALLENGES

Each person who enters the human services field brings their own set of strengths and challenges. This activity asks you to think about the strengths you already have and about the areas you might want to improve.

On a piece of paper, draw a circle and divide it into three sections. Label the sections "Characteristics," "Skills," and "Knowledge," as shown in figure 1.12.

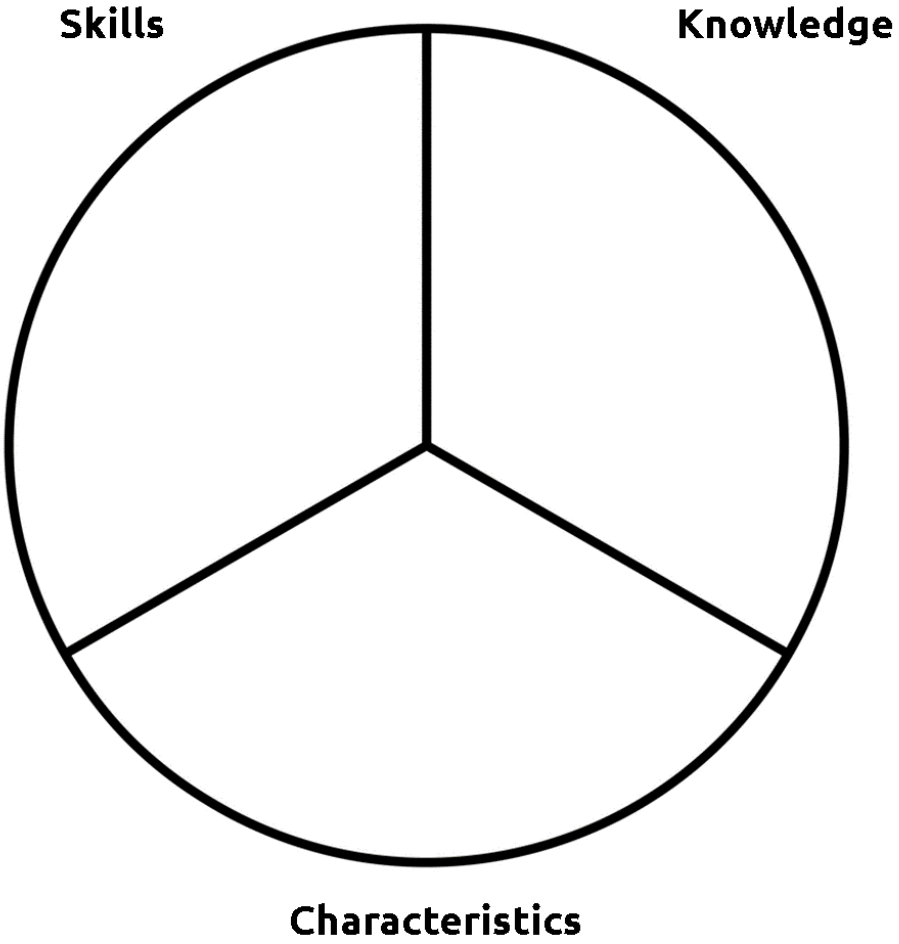


Figure 1.12. Each section of your circle will represent either skills, characteristics, or knowledge.

Review the following list of skills, characteristics, and knowledge, and write those you feel confident about in the matching section of the circle. Now, outside each section, write some of the attributes that you would like to strengthen.

Characteristics

- Patience
- Flexibility
- Curiosity
- Understanding of Self
- Community Care
- Attunement
- Humility
- Empathy

Skills

- Communication Skills (Oral, Written, Artistic, Listening)
- Documentation Skills (Objective Observations, Assessments, Qualitative Data Gathering, Quantitative Data Gathering)
- Ability to Ask for Help (Self Reflection, Group Reflection)
- Cultural Humility and Navigation
- Critical Thinking

Knowledge

- Awareness of **Equity**, Inclusion, Justice, and Diversity
- Understanding of Lifespan Development
- Theories of Effective Helping
- Knowledge Specific to You and Your Role
- **Intersectionality**
- **Restorative Justice**
- Ethical Code of your **Profession**

For example, you may feel very confident in your ability to empathize with others but know that you can be impatient. You would write "empathy" in the "Characteristics" section of the circle and "patience" on the outside of the circle. You can include other areas of strengths and challenges that you feel are important. For example, you might write "bilingual in Russian" in the section on knowledge, or "understanding of ADA laws" outside that section.

Each of us will have a unique circle that reflects where we are in our journey. It is important to realize that we all have areas where we are strong but that we all also have areas for growth. If you are able, compare and contrast your charts with a classmate or two. It can be interesting to see the wide variety of backgrounds that are present.

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Figure 1.11. "Empathy versus Sympathy" activity by Elizabeth B. Pearce is licensed under CC BY 4.0.

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Figure 1.12 "Knowledge, Skills, and Characteristics" by Yvonne M. Smith LCSW is licensed under CC BY 4.0.

1.5 Key Takeaways and Discussion Questions

This section includes key takeaways and discussion questions to help you retain and apply the ideas from this chapter. Use this section to help you prepare for class.

KEY TAKEAWAYS

- The **human services** field draws on multiple disciplines to create a knowledge base for professionals to use while helping people solve life's problems.
- Human services workers use multiple foundational theories and practices to inform their work. Central to all of them is respect for the client's strengths, experiences, environments, and **culture**.
- Being a human services worker requires a combination of characteristics, skills, and knowledge. Assessing oneself for strengths, weaknesses, and areas of growth is critical to becoming a professional.

DISCUSSION QUESTIONS

- If you were not going to study human services, which of the related fields most appeals to you, and why?
- What strengths do you bring to the field? How do you feel these will help you work with people?
- What are some of your challenges? How will you work on these areas?

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CHAPTER

2

Historical Context and Contemporary Focus

2.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 34: Human service professionals maintain awareness of their own cultural and diverse backgrounds, beliefs, values, and biases. They recognize the potential impact of these factors on their relationships with others and commit to delivering culturally competent services to all clients (NOHS, 2024).

Understanding your identity and background is critical to being able to help others, whether their experiences are similar to or quite different from your own. As **human services** professionals, we must also understand how historical actions, laws, and practices impact us today. In this chapter, we examine the ways in which human services work is related to settler and colonization practices and laws in the United States. Keep your own identity in mind as you read.

What has been taught as social work and human services history has focused on White activists and social service providers as the leaders of this field, when in fact Indigenous and Black people have implemented helping practices within their own communities for far longer than the fields of social work and human services have existed.

This chapter describes practices developed within Indigenous and Black communities as well as the early leaders who formalized human services and social work practices in White-dominated **culture**. Then we will look at the current practices and focuses of human services. Finally,

we will examine how cultural humility and decolonization are intertwined.

The Contributions of Scholars from the University of Kansas School of Social Welfare

The first two sections in this chapter—"Understanding the Historical Context of Human Services in the United States" and "Integrating and Honoring BIPOC Contributions"—draw heavily on the work of three scholars: Kelechi Wright, MEd, LCPC, LPC; Kortney A. Carr, LCSW, LSCSW; and Becci A. Akin, PhD, all associated with the School of Social **Welfare** at the University of Kansas. Their seminal work, adapted here for length and clarity, **"The Whitewashing of Social Work History: How Dismantling Racism in Social Work Education Begins With an Equitable History of the Profession" [Website]** appeared in the openly licensed **Advances in Social Work [Website]** peer-reviewed journal in 2021.

LEARNING OBJECTIVES

1. Describe the historical context of and what it means to "Whitewash" the human services field.
2. Explain what it means to decenter the history and current practices of White providers of human services and expand to BIPOC history and diverse providers.
3. Describe cultural humility, the social construction of difference, and **intersectionality**.
4. Identify the dimensions of diversity and how each relates to the human services **profession**.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Ageism: The stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) toward others or oneself based on age.
- Culture: Shared meanings and shared experiences by members in a group that are passed down over time with each generation.
- Decolonize: An ongoing process that supports the decentering of Eurocentric ways of learning and understanding the world. The most essential part of decolonization is continual reflection. Education systems should be willing to reflect on curriculum, power dynamics, their structuring, and any action undertaken on behalf of their students.
- Ethnicity: Social identity based on one's culture of origin, ancestry, or affiliation with a cultural group.
- First language: The language an individual learns in early childhood

- Gender: The socially constructed perceptions of what it means to be male, female, nonbinary, or something in between, the way you present to society.
- Intersectionality: Inequalities produced by simultaneous and intertwined social identities and how that influences the life course of an individual or group.
- Origin: The geographical location where a person was born and spent at least their early years.
- Race: Socially created and poorly defined categorization of people into groups on the basis of actual or perceived physical characteristics that have been used to oppress some groups.
- Religion: Shared systems of beliefs and values, symbols, feelings, actions, experiences, and a source of community unity.
- Sex: A biological descriptor involving chromosomes as well as primary and secondary reproductive organs.
- Sexuality: A person's emotional, romantic, erotic, physical, and spiritual attractions toward another in relation to their own sex or gender. Sexuality exists on a continuum or multiple continuums.
- Spirituality: Connection to something larger than yourself (a higher power), a quest for meaning, and a commitment to live each day in a sacred manner.
- Whitewashing: Focusing on the accomplishments of White people and groups while excluding BIPOC strengths and accomplishments.
- White savior complex: An ideology in which a White person acts upon from a position of superiority to rescue a BIPOC community or person.
- White fragility: a concept that explains how and why White people are sensitive, uncomfortable, or defensive when confronting information about racial inequality, White dominance, and injustice.
- Voluntouring: a short trip that combines volunteer work with tourism.

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2.2 Understanding the Historical Context of Human Services in the United States

To understand the history of **human services** and social work in the United States, it is important to place it in the context of the settlement and colonization of the states from the 1500s into the twentieth century. Many textbooks focus on the innovations of early White activists and social service providers without acknowledging the White supremacist practices that harmed Indigenous and Black individuals and families. Focusing on the accomplishments of White people and groups, and

excluding BIPOC strengths and accomplishments, is known as "**whitewashing**."

As the dominant racial-ethnic group, White European Americans enforced laws and practices that harmed Black and Indigenous families. At the same time, they maintained the power position of being the only ones to solve these family problems, which had been created through White dominance. Specifically, they used aggressive tactics to dislocate Native American communities and to remove children from their homes to be sent to boarding schools, all of which disrupted family ties. The intentional enslavement of Black people from Africa and the ways in which Black families were separated (married and partnered couples broken up, children removed from their biological families) caused great harm to family and community relationships. Once we acknowledge these actions, the responses of White activists can be seen in a different light. Perhaps they would not have been needed at all, or certainly not as much.

As you read this chapter, you may confront some uncomfortable or painful feelings. If you are a member of a group that was affected negatively by White dominant actions, it may be a relief to see those actions acknowledged as a contributing factor to the need for the human services and social work fields. Or it may add to pain and **trauma** that you and your ancestors have experienced. If you are a White person, it may be tempting to deny the past and its effects on the present. You may experience what is called "White fragility," a concept that explains how and why White people are sensitive, uncomfortable, or defensive when confronting information about racial inequality, White dominance, and injustice (DiAngelo, 2018). You may be someone who relates to multiple ethnicities, racial identities, and conflicting feelings. With any feelings that you experience, you are not alone. Pay attention to your feelings and reflect on your responses, but keep reading.

This chapter will include White leaders who influenced the formalization of social services, and it will focus on the ways that Black, Indigenous, and people of color actually innovated and created caring practices and services that heavily influenced human services in the past and today. By examining cultural practices, this chapter attempts to resist and repair the damages caused by White supremacist ideology.

Why History Matters

History is used as a teaching tool to help shape the future. If what we learn from the historical record is not accurate, it will create a false narrative and reinforce harmful stereotypes.

Creating a more just future is embedded in the human services **profession**'s belief system, and an inaccurate view of the past distorts efforts to do so. Human services, like other academic disciplines, depends on history to train and equip students. It also readily uses history to inform theories, philosophies, and ideologies that shape the discipline and the next generations of human services professionals, social workers, mental health counselors, and other professions that help people solve life's problems.

New students seeking to work in helping professions are learning a specific history that reinforces stereotypes: that BIPOC are the weak and inferior receivers of help, while Whites are the innovators and distributors of help and care. It is true that the majority of the people in helping professions such as social work are White (Council on Social Work Education, 2020). However, failing to tell the stories of leaders who were persons of color creates an inaccurate view of history and reinforces White supremacist ideologies. These BIPOC historical leaders largely remain unnamed and have been barred access to professional recognition for their contributions to social **welfare**.

Working to **decolonize** is an ongoing process that supports the decentering of Eurocentric ways of learning and understanding the world. The most essential part of decolonization is continual reflection. Education systems should be willing to reflect on curriculum, power dynamics, their structuring, and any action undertaken on behalf of their students. In addition, decolonization includes pointing out the strengths and accomplishments of marginalized communities that have been documented in the same ways that White accomplishments have been. It also requires giving credit to those BIPOC human service providers who have not received the recognition they deserve.

Failing to tell the full narratives around how people of color have helped themselves and led as helping professionals within their own communities is a disservice to a complete and honest understanding of social welfare history. This led to a historical pattern where Whites were often the "wounders," after which a profession, like social work, was praised for creating a response that represented the "healers." Consider how some White providers can slip into a White savior complex when they don't examine the reason for supporting communities of color.

Remember that the **White savior complex** refers to an ideology that a White person acts from a position of superiority to rescue a BIPOC community or person. To truly understand the history of the profession, we must also acknowledge how White supremacy and racism affect Black, Indigenous, and people of color in family and community life. The White savior complex dynamic can be clearly seen in missionary work or "voluntouring," which is a short trip that combines volunteer work with tourism. What is not considered when doing this type of work is how this will take paid work from locals in the area. Before taking such a tour, ask yourself: Could the money spent on the tour be donated to a local organization to benefit local infrastructure for longtime support rather than allowing an NGO to run all support systems in the region? Do I have the knowledge, skill set, and experience for the job at the level that this community needs for the work to be sustainable long-term?

All of these questions, as well as continued self-reflection and examination of privilege and power, can help us understand history and the need to decolorize the way we have learned it. These factors together influence how we function in human services as providers. Wanting to support communities in need is not wrong in itself; however, how did these communities get to this state? Am I the best person, or is my organization the best to do this work? How do privilege and power play a role in my decisions? These are not black-and-white choices; context always matters.

Origins of the Profession Intertwined with Racism

People have been providing social welfare to one another far longer than the profession has officially existed. Even social work, which has existed longer than human services and which shares similar foundations, has a debatable **origin**. It is often identified as having started in the mid- to late 1800s (Austin, 1983). During this time, the United States continued to enslave Black people and embraced the concept of manifest destiny, the belief that expansion of the United States throughout the West was determined by God. These efforts destroyed Native American communities and families. While there is some interpretation and analysis involved when discussing the origin of human services, the timing is deeply connected to a time when White supremacist racist actions were institutionalized.

Professional tradition has held that social welfare work sprang from frameworks and principles that spanned Europe, the United States, and the Middle East (Dulmus, 2012). It is difficult to date

determine whether these principles or practices existed in other regions of the world, such as Asia, Central America, South America, or Africa. Although communal societies have long held the family or village responsible for the care of vulnerable persons, many Indigenous peoples passed down history orally and did not record their history in the same manner as Europeans did.

The Crowned White Founders of Social Welfare

Note: This section has an Activation Warning.

From the murder of Native peoples and the stealing of their land to legalized slavery and the Jim Crow era, BIPOC people have continued to be subjected to institutional racism for centuries while the White founders of the social work discipline were emerging. Jane Addams (1860–1935) has been described as a sociologist, philanthropist, labor reformist, advocate for juvenile justice, women's suffrage proponent, and settlement activist (Harris, 2011). Addams is noted for having a long list of accolades that credit her with many accomplishments, including Yale University's first honorary **degree** awarded to a woman and being the first woman to receive the Nobel Peace Prize (Alonso, 2004). She is recognized in textbooks as one of the earliest influences on the creation of the juvenile justice system and as assisting in the earliest conceptualizations of the **child welfare** system. She has been crowned by the social work profession as the "mother of social work" (Joslin, 2004).

By current understanding, Addams was born into White privilege and benefitted from the concept of "the great White hope," a slogan from the early 1900s expressing the idea that one **race** is superior to others. This phenomenon glorifies the White hero who "selflessly" comes to aid the ethnically different marginalized community (Pimpare, 2010). Such efforts are seen as sacrificial, as many White women like Addams fulfilled duties and responsibilities as wives and mothers, and did not work outside of the home (Brownlee, 1979). By serving the needy, Addams appeared to be "selflessly" deviating from her privileged position.

To recognize and challenge this whitewashing of the history of human services, the discipline must consider whether these criteria are still valid in determining who is deemed a founding member of social services and who is not. Addams was not alone in her quest for social welfare for the oppressed. Many BIPOC sacrificed so that future generations would experience social justices that they were denied during their own lifetimes. A host of Black activists, such as Edgar Daniel Nixon and A. Philip Randolph, who are both now recognized for their avid social activism, did jail time and suffered many hardships for advocacy work during the same period that Addams was gaining attention for her activism (Baldwin & Woodson, 1992; Kersten, 2007). Yet few BIPOC were awarded prizes. In the next section, we will discuss BIPOC social welfare communities and leaders whose efforts have been hidden or downplayed in the past.

Black Social Welfare Forerunners

Three examples of Black early social welfare leaders are W. E. B. Du Bois, Eugene Kinckle Jones, and Ida B. Wells. Du Bois (1868–1963) lived during the same era as Addams. Du Bois, pictured in Figure 2.1, was the first African American to receive a doctorate from Harvard University (Morris, 2015). Interestingly, his work parallels that of the two founding women of social work. His work mirrored macro-focused social work. In fact, his research and work were so prolific that some scholars label him a sociologist (Green & Wortham, 2015).



Figure 2.1. A portrait of W. E. B. Du Bois by James E. Purdy.

One scholar suggests that Du Bois is the rightful yet forgotten heir to the title of "father of social work" (Morris, 2015). Du Bois fervently wrote to advocate for the advancement of people of color. He poignantly spoke and organized civil actions petitioning for structural change in institutions. Despite the overlap of Du Bois's ideas and actions with social work, he is almost never mentioned as a founder of social work.

Du Bois, like Addams, did not have an opportunity to study social work because the discipline was not yet established as an academic or vocational category during their university careers. Yet his labor to study for the purpose of social activism and reform seems equal to Addams's efforts. Du Bois fought for **social justice** amid Jim Crow laws, legal lynching practices (Morris, 2015), and legally supported institutional racism. Due to widely held racist views and structures, Du Bois did not receive a Nobel Peace Prize for his work at the time, just as many BIPOC activists have not received credit for their accomplishments over the years due to these structures.

A second example of a Black social work pioneer is Eugene Kinckle Jones (1885–1954), a leader in the National League on Urban Conditions Among Negroes, now renamed the National Urban League (NUL). This organization has historically advocated against racial discrimination (Fenderson, 2010). Jones is well known for his focus on advocating for better health, housing, and economic conditions. He worked for the inclusion of Black employees in labor unions, organized civil rights activism against businesses that were legally able to deny jobs to Black people, and advocated for school reform to incorporate more opportunities for people of color. Jones was elected to the leadership of the National Conference of Social Work (NCSW) in 1925, and he was the first Black person on the executive board of the NCSW (Armfield, 2011; Armfield & Carlton-LaNey, 2001).

A third example of a Black social welfare leader is Ida B. Wells (1862–1931), who set the foundation for the modern-day civil rights movement. Much of her activism occurred via her work as a journalist and speaker. She was well known for her anti-lynching activism, including building awareness internationally, as she worked for social justice. She advocated for African-American equality, especially that of women (Dickerson, 2018). She was one of the founders of the National Association for the Advancement of Colored People (NAACP) in 1909 with W. E. B. Du Bois and others.

Modern-Day BIPOC Leaders and Scholars

Some scholars are seeking to uncover the work of people of color's contributions to social welfare. One scholar, Dr. Crystal Coles, uses older documents to examine common activities and characteristics of people from the southern region of the United States (Coles et al., 2018). She highlights the unique role of research inquiry in exploring marginalized peoples' influences on social work. She studies primarily the impact African American women have had on social work in specified regions of the South. Finding many Black women in roles that we now would call "community educators" and "civil rights advocates" with Dr. Hohl did more extensive research on 121 women.

Similar methods are used to examine the revolutionary lives of 121 Black women who led in many social welfare-involved vocational roles, though they were legally barred from doing so because of the color of their skin. Another scholar, Dr. Elizabeth Anne Hohl, posthumously assigned, for these women, social roles and vocational titles that many were denied legal rights to claim because of their **ethnicity** and/or **gender** identity. These women, each of them born in the 1800s, were deemed to have embodied roles such as: "community educators," "civil rights advocates," "abolitionists," "community leaders," or "philanthropists" (Hohl, 2010). When looking deeper into the lives of these individuals and the types of activities in which they engaged, many of them could be called a social worker, human services worker, or social welfare advocate.

One notable challenge with finding and naming solitary leaders among BIPOC is that many BIPOC communities valued and practiced co-sharing of roles. Focusing on an individual's influence is more of a White **culture** characteristic; the celebration of Addams's work is one example (Okun & Jones, 2000). An example of the more collective BIPOC approach is found in the work of Coles and her colleagues. They reference the work of a hundred-year **collaboration** of women of color to create and sustain a health system in Virginia. These women, who were operating in the majority culture's societal opposition and legal barriers, were able to create a social welfare structure within the health sector that continued to endure for centuries.

Another example of a modern-day BIPOC scholar is Hilary Weaver, member of the Lakota Nation, whose work on Indigenous peoples uncovers many untold stories of advocacy and social welfare efforts. In one piece of her work, Weaver (2020) described the four-decade story of two Indigenous women, the Conley sisters, who led a successful collective struggle to protect a Wyandotte Nation burial ground in Kansas City. In this same chapter, Weaver described Laura Cornelius Kellogg, an Oneida activist who founded the Society of American Indians and fought for economic self-determination, education, and land recovery at great personal cost. The retelling of these stories of Indigenous advocacy and leadership further demonstrates how White filtering of history has omitted many BIPOC contributions to social welfare-involved work.

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Figure 2.1. "W. E. B. DuBois." by James E. Purdy, 1907, gelatin silver print, from the National Portrait Gallery is licensed under Creative Commons–Public Domain License.

2.3 Integrating and Honoring BIPOC Contributions

In addition to individual scholars, many **human services**, social work, and advocacy organizations have worked to bring increased recognition to the roles of BIPOC in recent decades. For example, the National Association of Black Social Workers (NABSW) created the Academy for African-Centered Social Work. This organization emphasizes that the work of people of African ancestry has been excluded from social **welfare** history and from mainstream social work pedagogy and curricula.

Marginalization of past and present BIPOC social workers seriously minimizes their potential contributions to inform and strengthen current policy and practices.The NABSW has challenged the discipline to diversify curricula. They assert that failing to intentionally diversify educational materials leaves students to assume the main contributions to the discipline are White, which overtly and covertly reinforces White supremacy (Bent-Goodley et al., 2017).

The Role of Education

One approach to holding up the contributions of BIPOC lies in education. Currently, social welfare-involved work is not taught with an understanding of the ways that White supremacy is interwoven in its history. It seems that few social work education programs have exposed and dismantled the concept of the "great White hope," yet this work needs to be done. Not only does there need to be a revision of who the discipline bestows the honor to as founders, but there also needs to be a greater understanding of ensuring that what is defined as social work or human services works. There needs to be a revision of what educational **standards** are and the Eurocentric lens used to measure them, as this continues to perpetuate White Supremacy (Wright et al., 2021).

For example, Jane Addams supported the eugenics movement and its scientific racism, which grew during the early twentieth century. It promoted the propagation of "wellborn" people and the **prevention** of childbearing among those who were determined to be defective mentally, morally, or physically (Kennedy, 2008).

Historical analysis of social welfare work's White forerunners must also address the fact that Black activists and social services leaders of the Progressive Era were sidelined (McCutcheon, 2019). It is possible to see those identified as "founders" for what they were: individuals who sought to make change in one area of injustice while perpetuating injustice in another area. Maybe the answer is not to make them "angels" or "demons" but to live in the tension of their realities and what they prioritized. It requires telling their stories in the history books in light of such frictions.

It also calls for a radical review of who should be embraced as a founder of a discipline that is committed to **equity** and that "include[s] respecting the dignity and welfare of all people," as stated in the Preamble of the National Organization for Human Services (NOHS) and the "inherent dignity and worth of all persons," a principle embedded in the National Association of Social Workers (NASW) Code of **Ethics** (NOHS, 2019; NASW, 2021).

Understanding and Dismantling White Supremacy

To dismantle White supremacy, we will focus on three aspects relevant to the human services **profession**'s understanding of history. First, White supremacy focuses on the written word. In the White **culture**, if it is not written down, it did not happen (Okun & Jones, 2000). This mantra is learned in most helping professions. Addams and her contemporaries came from a majority culture that valued the written word, and so they richly documented their research, observations, conversations, and findings. In contrast, many BIPOC come from traditional settings where such an effort is a luxury in comparison to focusing one's energies on survival, especially in Addams's time period. Communities frequently shared knowledge in many areas, as represented by, including how to help others. These are the foundations of the human services profession.

The second highly relevant aspect of White supremacy that contributes to the marginalization of BIPOC is the belief that there is only one right way to do things (Okun & Jones, 2000). It is necessary to consider whether the identified founders of social welfare incorporated the opinions of marginalized peoples in their work, continued to perpetuate the oppression, and embodied the "one right way" of doing things.

Individualism is the third relevant characteristic of White supremacy. To single out Addams as a founder is to add to the White supremacist notion that highly prizes individualism (Okun & Jones, 2000).



Figure 2.2. E. Franklin Frazier was a leader in social work, sociology, and cultural history. Grounding human service work in Addams and not Frazier reveals a history that focuses too heavily on White women from economically advantaged backgrounds. This poster was commissioned in 1943 by the U.S. Office of War Information. Image description available. **Image description.**

Individualism focuses on the advancement of one person rather than the collective whole. This contributes to an atmosphere where cooperation is less valued. Monuments for (some) racial advancements are dedicated to Abraham Lincoln and John F. Kennedy. Likewise, there is a focus on Martin Luther King Jr. as an individual leader, while it is commonplace in the Black community to think of him as synonymous with his collaborator. However, we do know that the contributions of these Black community leaders have different weight depending on how accurate of U.S. history lessons you are receiving. As human services professionals of any background, we need to embrace more than just White ways of perceiving and seek

to call attention to communal contributions to our discipline.

How Can Students Make a Difference?

As a beginning student in this profession, you're starting to understand the potential significant impact you could have in the field. Here are some roles you can play:

1. It's crucial to become aware of the **whitewashing** of the discipline. Don't accept the single story of the discipline at face value. Instead, when a story is being told, ask to consider the other perspectives that have contributed to the field.
2. Learn more about BIPOC scholars who are not well known and who have made a significant impact in the human services field and associated fields.
3. Advocate for a more diverse representation of scholars in your course materials. Consider knowledge from sources outside academic ways of knowing. Look for traditional ways of knowing, such as Native storytellers, elders from BIPOC and marginalized communities, and oral traditions. This will help expand the ways we look for and absorb information.
4. Continue questioning assumptions about what's important and valued within the discipline.
5. Diversify learning methods, teachers, and sources. What does a classroom setting look like? Who do our educators look like? Look at educator programs and recruitment, what does the student community and life look like?

Textbooks matter. A failure to accurately depict the past will slant how the future is framed. Without critical analysis, this slant will only continue to perpetuate White supremacist mindsets. Start paying attention to textbooks in all of your courses. Do you notice other places where the context of White supremacist history is ignored? Vigorous work by educators, researchers, and practitioners is needed to stop reusing the same publications and intentionally attempt to present the history of social work equitably.

Consider the authors of textbooks, including their history and bias. How often do you see yourself reflected in books and stories? Consider the publishers who own the textbook companies and their interest in the materials that are and do not include what is written in the content. How relevant is what you are reading to your practice in the field? Can you give feedback about what you are reading? How is that feedback received? You have more power in this process than you think. Use it.

The next section of this chapter focuses on skills and knowledge that can be used to work in a way that focuses on community strengths and values while emphasizing diverse voices and viewpoints.

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"Integrating and Honoring BIPOC Contributions" by Elizabeth B. Pearce is adapted from **"The Whitewashing of Social Work History: How Dismantling Racism in Social Work Education Begins With an Equitable History of the Profession"** by Kelechi C. Wright, Kortney Angela Carr, and Becci A. Akin in **Advances in Social Work, Vol. 21 No. 2/3 (2021): Summer 2021-Dismantling Racism in Social Work Education** is licensed under **CC BY 4.0**. Adaptations by Elizabeth B. Pearce: Edited for brevity; slight reorganization of content; contextualized for human services; revised reading level. Added the following content: protestant work ethic, worthy/unworthy poor, and cultural humility concepts.

Figure 2.2. "E. Franklin Frazier" by Charles Henry Alston. U.S. National Archives and Records Administration. Public domain.

2.4 Diversity and the Human Services Profession

The first two parts of this chapter focused on how an inaccurate past affects **human services** students, clients, and professionals, as well as ways to reinterpret the past to bring more truth about how communities of color impacted the field of human services. In this section, we describe some of the skills and understandings that have emerged as best practices.

To begin, let's discuss the major **dimensions of diversity,** or the aspects of social identity that all of us possess. It is one step toward creating a more just future for all of those participating in human services and social **welfare**.

Dimensions of Diversity

Respect for diversity has been established as a core value in human services. In fact, the preamble of the Ethical **Standards** of Conduct refers to diversity twice in the opening paragraphs. Appreciating diversity includes understanding dimensions of diversity and how to work within a wide range of individual and community contexts. It also includes a consideration of how to work within systems of inequality.

Human services professionals must be mindful of diverse perspectives and experiences when working with clients, consulting with peers, conducting research, and designing interventions. At the same time, they must be aware of the macro-level problems that people face and work to combat oppression and promote justice.

Although it is impossible to discuss all of the dimensions of human diversity in this section, we present some common dimensions that are also aspects of each person's social identities.

Culture

While numerous definitions for **culture** are available, key defining components include shared meanings and shared experiences by members in a group that are passed down over time with each generation. That is, cultures have shared beliefs, values, practices, definitions, and other elements that are expressed through family **socialization**, formal schooling, shared language, social roles, and norms for feeling, thinking, and acting (Cohen, 2009).

Culture in today's society refers to more than just cultural and ethnic groups. It also includes groups who are connected via **religion**, **sexuality**, geography, or other characteristics. Culture can be examined on multiple ecological levels to understand its impact. This means that culture can influence the norms and practices of individuals, families, organizations, local communities, and the broader society. For example, cultural influences can have an impact on how members function and interact with one another. Culture should be understood within a broader context of power relationships, as well as how power is used and distributed (Trickett, 2011).

Race

While physical differences often are used to define **race**, there is no consensus for this term. Typically, **race** has been defined using observable physical or biological criteria, such as skin color, hair color or texture, facial features, etc. However, biologists, anthropologists, psychologists, and other scientists have determined that these biological assumptions of race are false and have been used to harm members of marginalized groups.

Research has proven that there are no biological foundations for race and that human racial groups are more alike than different. In fact, more genetic variation exists within racial groups rather than between groups. Therefore, racial differences in areas such as academics or intelligence are not based on biological differences but are instead related to economic, historical, and social factors, such as the search for power and control via colonization (Betancourt & Lopez, 1993).

Race has been socially constructed and has different social and psychological meanings in many societies (Betancourt & Lopez, 1993). In the United States, Black, Indigenous, and people of color experience more racial prejudice and discrimination than White people. The meanings and definitions of race have also changed over time and are often driven by policies and laws. The social construction of difference in both race and **gender** is discussed more thoroughly in the next section.

Ethnicity

Ethnicity refers to one's social identity based on culture of **origin**, ancestry, or affiliation with a cultural group. Ethnicity is not the same as nationality, which is a person's status of belonging to a specific nation by birth or citizenship (e.g., an individual can be of Japanese ethnicity but British nationality because they were born in the United Kingdom). Ethnicity is defined by aspects of subjective culture such as customs, language, and social ties (Resnicow et al., 1999).

While ethnic groups are combined into broad categories, or umbrella groups, for research or demographic purposes in the United States, there are actually many more specifically defined ethnicities that do not appear on documents. For example, there may be a check box for "Latine," but people who are in this umbrella group are more likely to identify with a specific country, region, or nationality. Latine may refer to persons of Mexican, Puerto Rican, Cuban, Spanish, Dominican, or many other ancestries. Asian Americans have roots from more than twenty countries in Asia, with the six largest Asian ethnic subgroups in the United States being Chinese, Asian Indians, Filipinos, Vietnamese, Koreans, and Japanese, as indicated in figure 2.3.

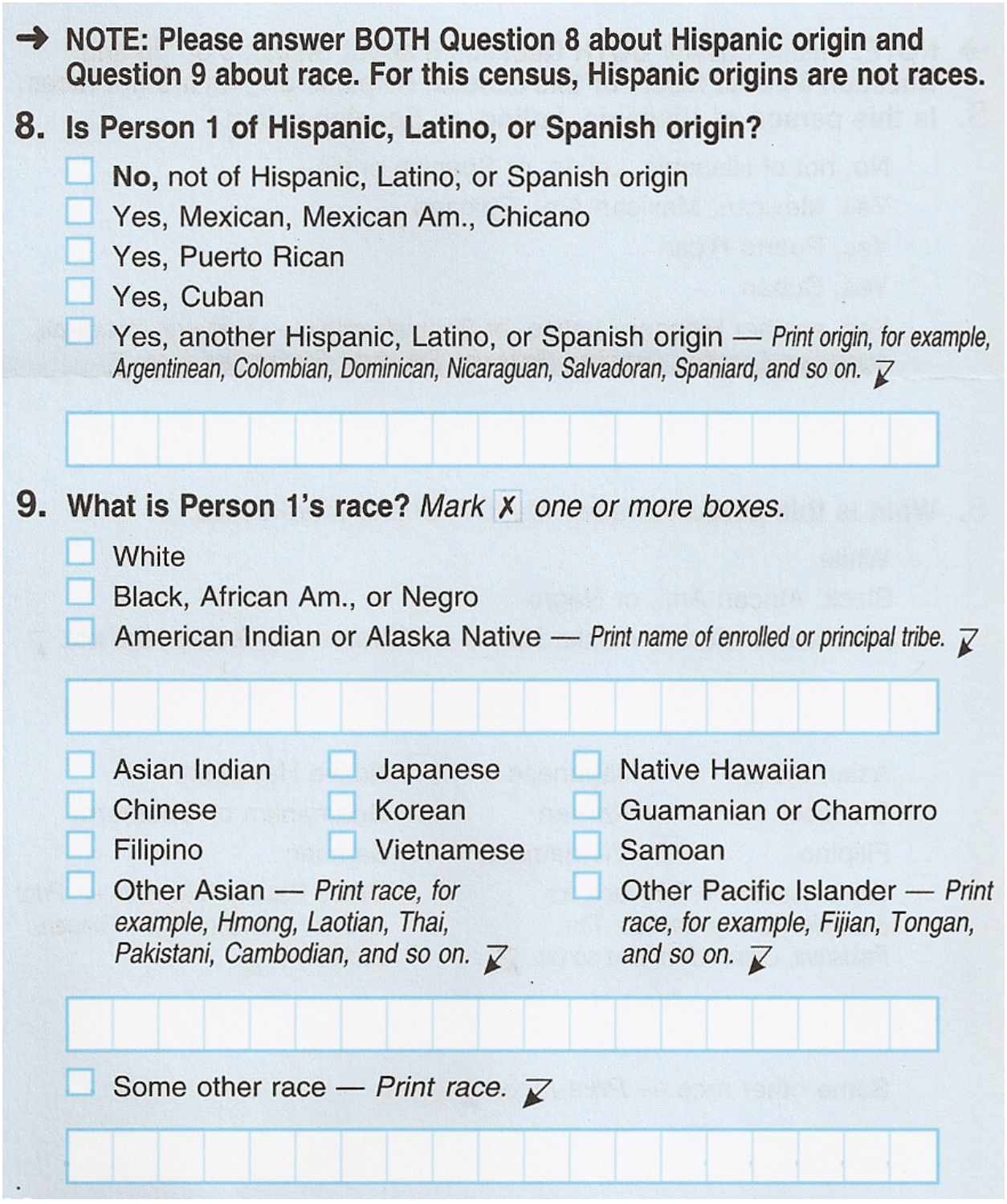


Figure 2.3. U.S. Census forms demonstrate how the government defines race and ethnicity. Image description available. **Image description.**

Origin and First Language

Origin refers to the geographical location where a person was born and spent at least their early years. This includes regions of the United States as well as other countries. A person's origin will impact the cultural norms that influence them during their early childhood development, or perhaps longer. In addition, it impacts their **first language**.

First language refers to the language learned in early childhood. This language may be learned in the home, in a childcare setting, and in greater society. Even within the United States, there are regional differences in the English language, as well as the possibility that a language other than English is spoken in the home. Consider that the United States does not have an official language, not even English (USAGov, n.d.). Given this fact, English might not be a person's first language, even if it is heard and seen around a lot.

Origin and first language are closely tied to culture and ethnicity, but there are differentiations as well. For example, a Filipino person may have grown up in the Philippines, but they could have been born in the mainland United States or in Hawaii. In the Philippines, where the official languages are English and Filipino, there are 183 living languages, many of which are indigenous. A person growing up there might speak one or more of these languages. A Filipino person growing up on the mainland of the United States would likely learn English, but they may also use a Filipino language at home. A Filipino person growing up in Hawaii might be exposed to English, Hawaiian (although the indigenous language of the islands was banned in 1898 when Hawaii became a territory of the United States, there are still remnants), and a Filipino language. Because the Hawaiian language and the Filipino language are from the same language family, there may be crossover. As this example shows, great diversity exists even among people who share a similar origin or first language.

Consider how language evolves within a single language. If your first language is Spanish but your family is from Mexico, you may understand the Spanish spoken in Argentina to an extent. However, the accent, the words specific to that country, and the context from the specific culture make an impact on how the language is spoken and understood by its speakers and those who are supporting those communities.

Gender and Sex

Gender refers to the socially constructed perceptions of what it means to be male, female, or nonbinary in the way you present to society. In the past it was more common to see gender in a binary way, either male or female, but increasingly gender is seen more on a continuum.

Gender is different from **sex**, which is a biological descriptor involving chromosomes as well as internal and external reproductive organs. Sex is also less binary than we might expect. A small percentage of people are known to be born as "intersex," meaning that they have primary and secondary sexual characteristics that are both biologically male and biologically female. However, even that is not as simple as xx xy, as sex is assigned at birth. Factors that are biological in nature change over time and are not stable as many believe. So endocrinologists and geneticists could not say definitively what is male, female, neither, or anything in between from a biological perspective due to this changing nature.

As a socially constructed concept, gender has magnified the perceived differences between females and males leading to limitations of attitudes, roles, and how social institutions are organized. For example, gender norms influence the jobs viewed as appropriate or inappropriate for women or men, and household or parenting

responsibilities are divided between men and women.

Gender is not just a demographic category. It also influences behavioral norms, the distribution of power and resources, access to opportunities, and other important processes (Bond, 1999). For those who live outside of these binary traditional expectations for gender, the experience can be challenging. The binary categories for sex, gender, and gender identity have received the most attention from both society and the research community, with the most attention given to gender identities most recently (e.g., gender-neutral, transgender, nonbinary, and GenderQueer) in recent years (Kosciw, Palmer, & Kull, 2015).

The attention paid to other gender identities and to changing gender identities is increasing, both academically and publicly. As a teenager, Nicole Maines, a successful actor who portrayed television's first transgender superhero in *Supergirl*, filed an anonymous lawsuit after being excluded from the school restroom because of her transgender identity. The suit resulted in a victory before the Maine Supreme Judicial Court in 2014. This was the first state court to rule that barring transgender students from the school bathroom that matches their gender identity is unlawful (Maines, 2015; Nutt, 2015).

Gender is not a new complex conversation for many communities, but in the United States it has become about laws and who has the right to determine what gender is and when children are old enough to understand how they experience it. As of the time of this writing, there are more than 400 pieces of anti-trans legislation in the United States.

Sexuality

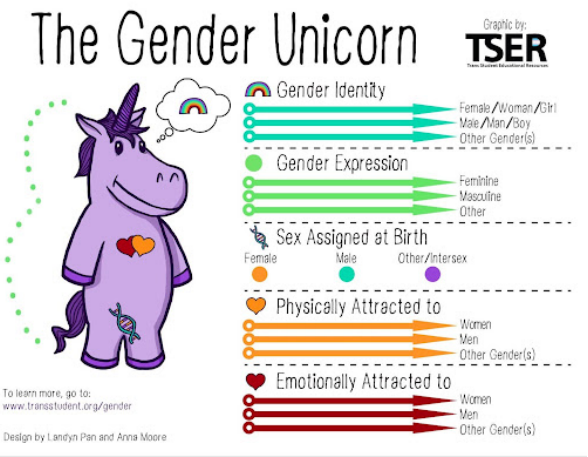


Figure 2.4. Queer and trans organizers have been making the distinction between gender identity, gender presentation/expression, sex, and attraction for decades. No one person or organization created the concept. However, similar gender mapping concepts to the unicorn seem to have originated on social media sites like Tumblr. Image description available. **Image description.**

Sexuality refers to a person's emotional, romantic, erotic, physical, and spiritual attractions toward another in relation to their own sex or gender. Sexuality exists on a continuum or on multiple continuums, and it crosses all dimensions of diversity (e.g., race, ethnicity, social class, ability, religion, etc.).

Sexuality is different from sex, gender identity, or gender expression. Over time, gay, lesbian, asexual, and bisexual identities have extended to other sexualities, such as pansexual, polysexual, and fluid. Increasingly, research is being conducted on these populations (Kosciw et al., 2015). Members of the LGBTQIA2S+ communities have been historically marginalized and oppressed, facing both legal restrictions and social stigma. One step forward was the legalization of same-sex marriage in the United States.

Not all communities have the same social constructs regarding gender and sexuality. As a provider, be careful not to assume that the sexual constructs used in your own community are the same as those of clients you will be working with.

Age

Age describes the developmental changes and transitions that come with being a child, adolescent, or adult. Power dynamics, relationships, physical and psychological health concerns, community participation, and life satisfaction vary for individual members of different age groups (Cheng & Heller, 2009).

Age stereotypes contribute to **ageism** and adultism. **Ageism** refers to the stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) toward others or oneself based on age. Stereotypes that characterize older people as slow, frail, incapable, out-of-touch, or grumpy are harmful.

Although the skills, values, and training of human services professionals can make a difference in the lives of older adults, the attitudes within our **profession** and society are barriers. Seeing both older adults and young children as capable is key to being strengths-based in your approach to working with them. However, we must be careful not to dismiss the need to learn to evolve with the times and not assume that just because "they have always been done this way," traditions, ways of practicing, and ways of thinking, including elders' views of how youth and children can involved in society and make their own decisions, must stay the same.

Youth activism and voices are also part of what we need to consider. Assuming that correct answers are only going to come from someone who is older does a disservice to children and youth whose voices come with knowledge and truth in younger bodies.

Socioeconomic Status

Socioeconomic status (SES) is a way of describing an individual's or family's status that includes three components: education, income, and employment. The education component refers to the highest level of education completed: high school, a certificate, training programs (CTE), college, or advanced degrees. Income includes not just wages, but also sources such as stocks, bonds, or real estate, as well as inherited wealth. Employment refers to the level of status that one's job or career has within society. Employment status may or may not be equivalent to level of education or salary.

Socioeconomic status is a complex combination of factors that indicates difference in power, privilege, economic opportunities, and resources. It will also relate to a person's social capital, which is the relationships and networks that each person has available to them. For example, the college professor might be more likely to be able to connect one of their children or friends to a job with a researcher, whereas the doctor might be able to connect an ill family member with a colleague who is an expert in medical specialty.

Socioeconomic status and culture shape a person's worldview. It influences how they feel, act, and fit in. It also impacts the schools they attend, the health care they have access to, and the jobs they have throughout life. The differences in norms, values, and practices between social classes can also have impacts on parenting, well-being, and health outcomes (Cohen, 2009).

Ability and Disability

Disabilities refer to visible or hidden and temporary or permanent conditions that provide barriers or challenges. They can impact individuals of every age and social group. In the past **disability** was viewed using a medical model, primarily by

explaining diagnosis and treatment models from a pathological perspective (Goodley & Lawthom, 2010). In this traditional approach, depicted in figure 2.5, individuals diagnosed with a disability are often discussed as objects of study instead of complex individuals impacted by their environment.

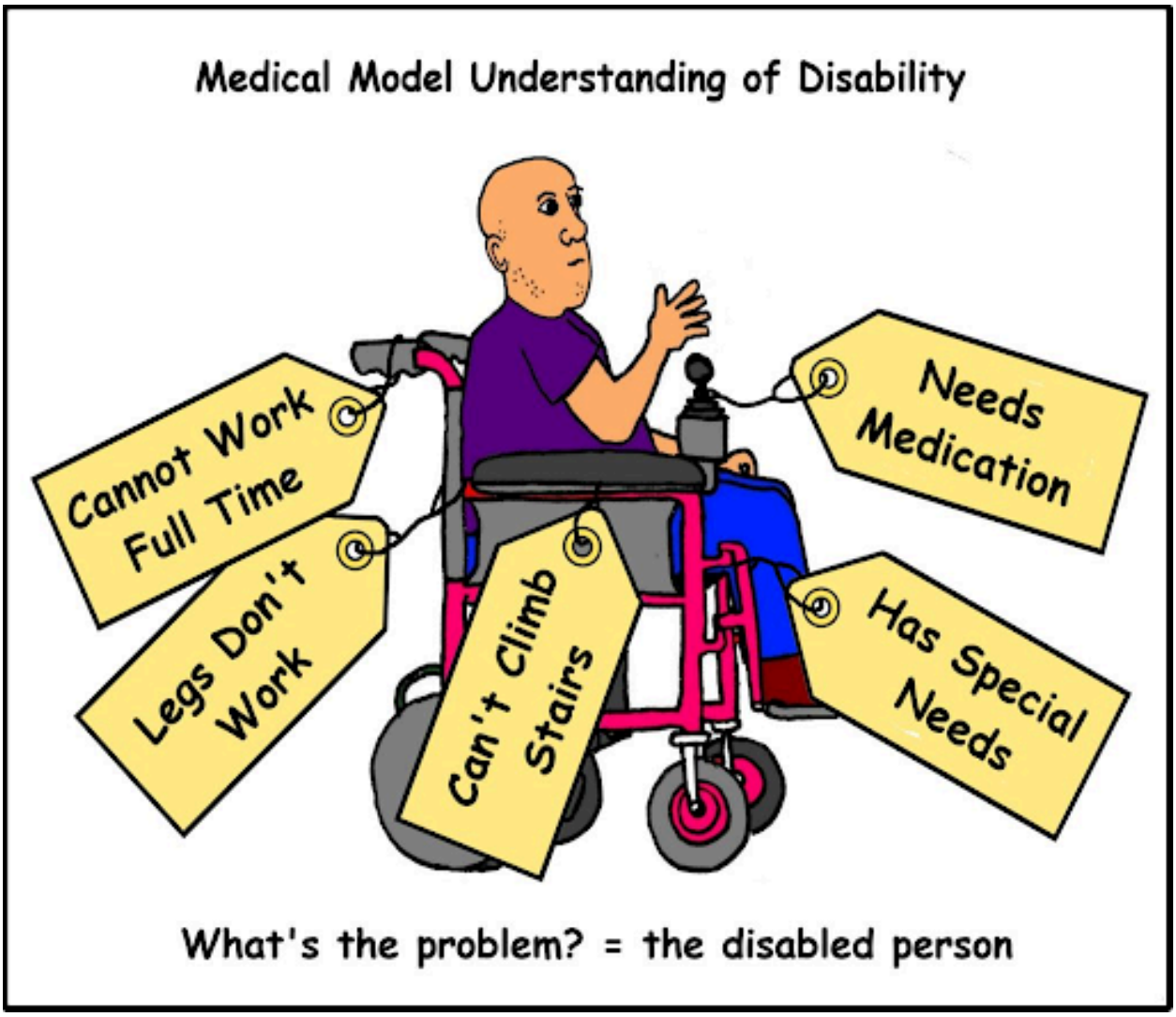


Figure 2.5. The medical model of disability views the person and their disability as the problem. Barriers to care are considered a part of the person's disabling condition. Image description available. **Image description.**

The more current social model views ability and diagnosis from a social and environmental perspective and considers multiple ecological levels. The experiences of individuals are strongly valued in this model. Community-based participatory research is a valuable way to explore experiences while empowering members of a community with varying levels of ability and disability.

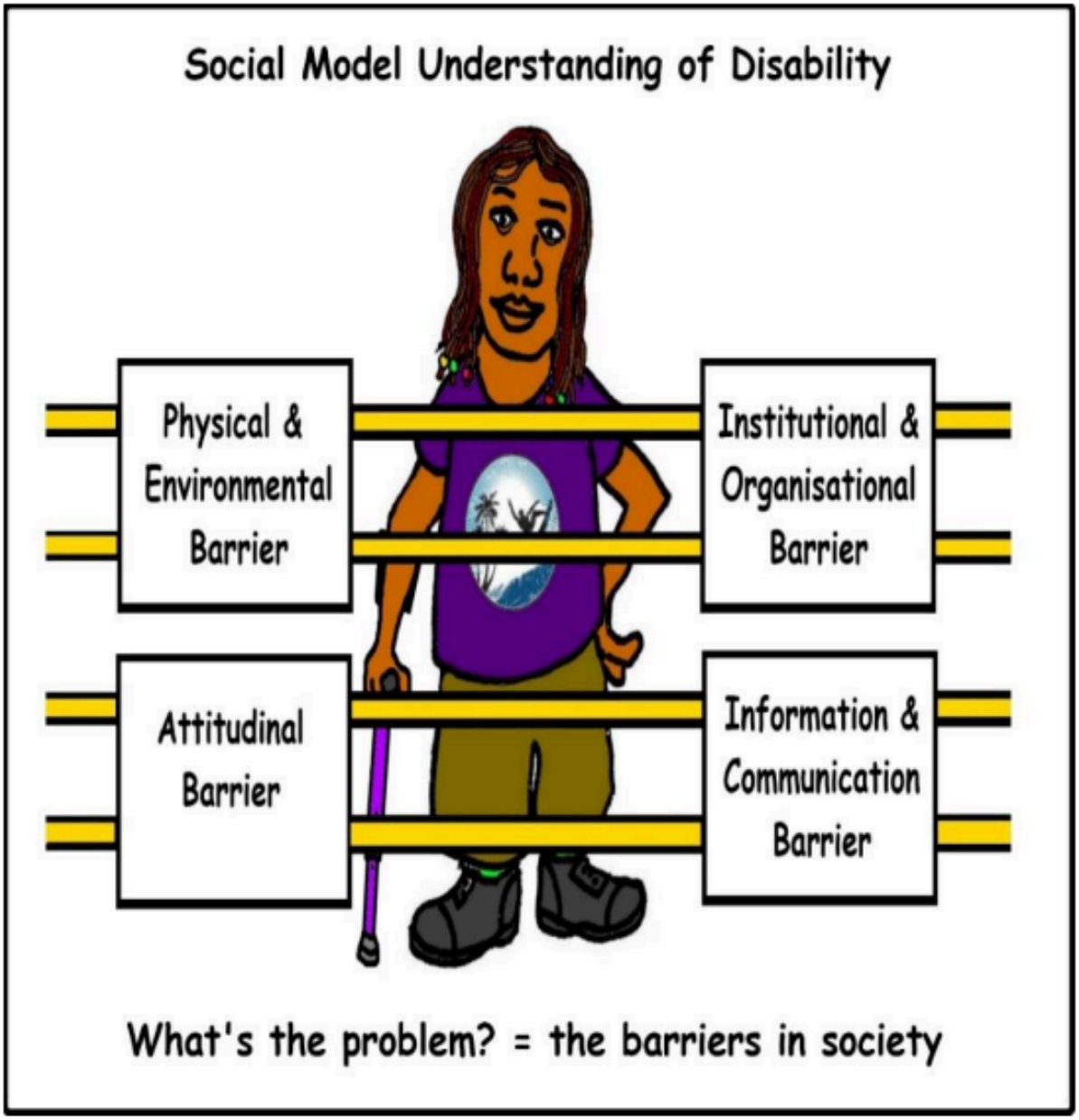


Figure 2.6. The social model of disability barriers reframes barriers to care as society's problem. All members of a society are likely to become disabled at some point, and society must account for them. Image description available. **Image description.**

Identifying who has a disability or health condition can be a challenge and can have real, tangible consequences for an affected person or group. For example, if prevalent research suggests that a particular disability or health condition is relatively rare, it is possible that few federal and state resources will be devoted to those individuals. But if the methodology for identifying individuals with that condition is flawed, then the prevalence rates will be inaccurate and potentially biased.

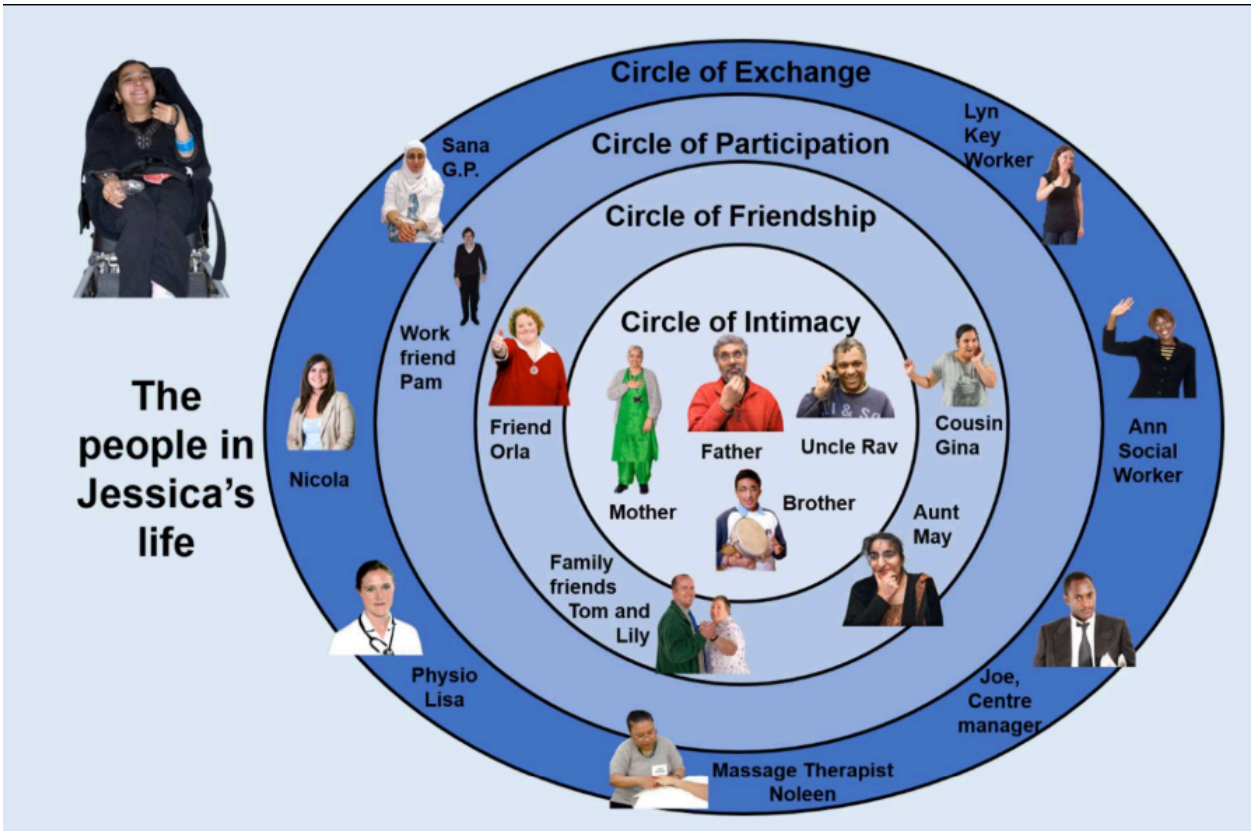


Figure 2.7. The social model of disability is about more than barriers. This figure demonstrates the circles of support necessary for everyone, including people with disabilities, to live their best life. Image description available. **Image description.**

As human service providers, we must always consider how our own communities and the communities we work with understand and have access to support. How does this all impact children and youth under the age of 18 in schools and what happens after they leave the education systems? What do transitions to life after graduation look like if students and families receive support for that to happen for them?

Religion and Spirituality

Definitions of **religion** typically include shared systems of beliefs and values, symbols, feelings, actions, experiences, and a source of community unity. Religion emphasizes beliefs and practices, relationships with the divine, and faith, all of which differentiate it from common definitions of culture. Further, religion is an important predictor for well-being, satisfaction, and other life outcomes (Tarakeshwar, Stanton, & Pargament, 2003). It involves an institutionalized system of religious attitudes, beliefs, and practices, plus the service and worship of God or the supernatural.

A differentiation between religion and **spirituality** has become more relevant recently, as many individuals consider themselves more spiritual than they are religious. Definitions of **spirituality** typically focus on a connection to something larger than yourself (a higher power), a quest for meaning, and a commitment to live each day in a sacred manner (Brady, 2020). Spirituality refers to the way individuals seek and express meaning and purpose. It is also the way people experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.

The importance of religion and spirituality to physical and emotional well-being and a strong sense of community merits the inclusion of both in research and practice (Tarakeshwar et al., 2003). **Collaboration** with religious organizations and embedding interventions into these settings may have positive impacts on individuals in the community and may also help religious organizations reach goals. However, if religious organizations exclude or condemn people based on other social characteristics (e.g. race, sexuality, or gender), then this could present a conflict for human services professionals who are committed to **equity** in service.

Privilege and the Dimensions of Diversity



Figure 2.8. Black Lives Matter is a social movement that campaigns against violence and systemic racism toward Black people.

Privilege, or the unearned advantages that individuals have based on membership in a dominant group (e.g., race, gender, social class, sexuality, ability), contributes to the systems of oppression for non-privileged individuals and groups. Privilege can come in multiple forms and individuals can have multiple privileges. In particular, White privilege, or the advantages that White people have in society, are important for psychologists to examine more extensively to understand how White people participate in systems of oppression for racial minority groups in the United States (Todd et al., 2014). As discussed earlier in this chapter, Black and Indigenous people have been actively oppressed. Activism, such as that pictured in figure 2.8, is one way that awareness has been increased.

White experiences and perspectives tend to be pervasive in curriculum, policy, pedagogy, and practices to the exclusion of work and research by people of color (Suyemoto & Fox Tree, 2006). This results in systems of privilege and oppression in society.

While the various dimensions of diversity discussed in the previous sections are a start for understanding human diversity, they do not fully describe an individual, community, or population. We, as human services professionals, must consider that these dimensions do not exist independently of each other. The following sections will explore how **social constructivism**, **intersectionality**, and the practice of cultural humility inform our understanding of the dimensions of diversity.

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Figure 2.3. "**Census 2010: Ethnicity vs. Race**" by Nathan Gibbs is licensed under **CC BY NC SA 2.0**.

Figure 2.4. "**The Gender Unicorn**" by Elan Paulson is licensed under **CC BY SA 4.0**.

Figure 2.7. "The people in Jessica's life" by HSE Ireland is shared under public domain.

Figure 2.8. "Black Lives Matter DC, March For Our Lives, Washington DC" by Lorie Shaull is licensed under CC BY-SA 2.0.

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Figure 2.5. "Medical Model Understanding of Disability" by Dave Lupton is all rights reserved.

Figure 2.6. "Social Model Understanding of Disability" by Dave Lupton is all rights reserved.

2.5 Social Construction of Difference

The dimensions of diversity can also be thought of as the various social identities we have. They can help us understand the **social construction of difference**, which is when hierarchical value is assigned to perceived differences between socially constructed ideas.

In forming our own social identities, we connect most easily to people who share the same group membership(s) that we do. According to the Social Identity Theory formulated by Henri Tajfel, we see people who are members of different groups as "others" (McLeod, 2019). Generally, we tend to be drawn to others who are more similar to ourselves, whether in appearance or in other social characteristics, such as age, ability, or **sex**. This, combined with the likelihood of overestimating the similarities and differences between groups, contributes to the social construction of difference.

Social Construction of Race

The social construction of **race** deserves special mention, since there is a broadly held public assumption that there are significant biological and genetic differences between human beings based on "race" (meaning observable physical differences such as skin color). In actuality, race is a social construct rather than a biological reality (figure 2.9).

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=CVxAlmAPHec**

Figure 2.9. What Is the Origin of Race [Streaming Video]. Transcript.

Watch this video from PBS *Origins*, entitled "The **Origin** of Race in the USA." In this brief overview, you will learn the history of how we came to socially construct the categories of race and where they leave us today.

Reflecting on what you learned, consider the following questions:

1. Where did the term Caucasian come from, and why do we still use it?
2. How has race been used in both positive and negative contexts throughout history?

3. What are some other points in history during which our understanding of race evolved?

Scientists state that while genetic diversity exists, it does not divide along the racial lines that many humans notice (Gannon, 2016). In fact, members of the human "race" (that is, all humans) share 99.9% of their genes (National Human Genome Research Institute, 2011). Ancestry and geography likely influence which genes get turned on and expressed. What complicates our understanding of race is that we have behaved for centuries as if there is a biological difference. Because there has been a longstanding discriminatory practice against people of color, there are multiple impacts today (Berger & Luckman, 1966).

The reasons for doubting the biological basis for racial categories suggest that race is more of a social category than a biological one. Another way to say this is that race is a social construct. In this view, race has no real existence other than what and how people think of it, as shown by variations in skull shape in figure 2.10.

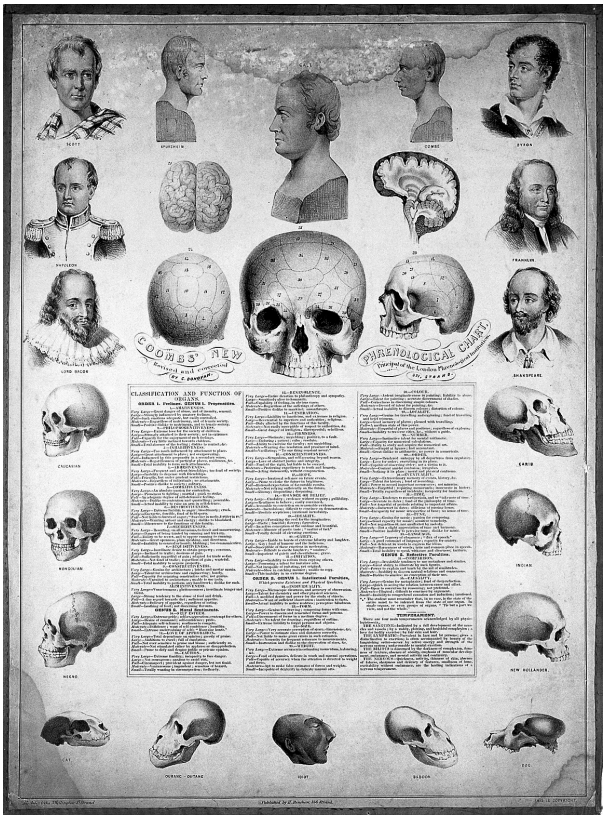


Figure 2.10. The social construction of race has evolved throughout history, always to justify the position of those in positions of privilege. Although it seems ridiculous today, the pseudoscience of phrenology supposedly measured intelligence using facial features associated with race.

This understanding of race is reflected in the problems of placing people with multiracial backgrounds into any one racial category. Would you consider former President Barack Obama to be White, Black, or multiracial? He had one Black parent and one White parent. As another example, the well-known golfer Tiger Woods was typically called an African American by the news media when he burst onto the golfing scene in the late 1990s. In fact, his ancestry is one-half Asian (divided evenly between Chinese and Thai), one-quarter White, one-eighth Native American, and only one-eighth African American (Williams-León & Nakashima, 2001).

Historical examples of attempts to place people in racial categories further underscore the social

constructionism of race. In the South during the time of slavery, the skin tone of enslaved people lightened over the years as babies were born from the union, often in the form of rape, of slave owners and other Whites with enslaved people. As it became difficult to tell who was "Black" and who was not, many court battles over people's racial identity occurred. People who were accused of having Black ancestry would go to court to prove they were White in order to avoid enslavement or other difficulties (Staples, 1998).

Litigation over race continued long past the days of slavery. In a relatively recent example, Susie Guillory Phipps sued the Louisiana Bureau of Vital Statistics in the early 1980s to change her official race to White. Phipps was descended from a slave owner and an enslaved person and thereafter had only White ancestors. Despite this fact, she was called "Black" on her birth certificate because of a state law, echoing the "one-drop rule," that designated people as Black if their ancestry was at least 1/32 Black (meaning one of their great-great-great grandparents was Black). Phipps had always thought of herself as White and was surprised after seeing a copy of her birth certificate to discover she was officially Black because she had one Black ancestor about 150 years earlier. She lost her case, and the U.S. Supreme Court later refused to review it (Omi & Winant, 2015).

Social Construction of Other Identities

Social construction of **gender** is another widely accepted concept in **human services**. The differences that we attribute to the biological designation of female, male, or intersex are predominantly constructed by our societal beliefs and not by biology. The recent broadening of gender identity and expression clearly demonstrates this concept.

Other identities are also constructed via societal agreement. **Sexuality**, ability, **religion**, **ethnicity**, age, and other identities may contain some physical parameters and certainly contain meaning to the individuals that possess them. However, critical to our study of families is the understanding that society creates and reinforces social construction of these characteristics and those constructions favor some groups, discriminate against others, and generally impact the lives of families.

Intersectionality

Articulated by legal scholar Kimberlé Crenshaw (1991), the concept of **intersectionality** identifies the ways that race, class, gender, sexuality, age, ability, and other aspects of identity are experienced simultaneously. This means that multiple inequalities affect the life course of any individual.

Notions of gender and the way a person's gender is interpreted by others are always impacted by notions of race and the way that person's race is interpreted. A person is never received as only a woman—how that person is racialized impacts how the person is received as a woman. While a White woman may experience some bias or discrimination based on gender, a woman who is Black may experience discrimination based on both race and gender. So, notions of Blackness, Brownness, and Whiteness always influence gendered experience, and there is no experience of gender that is outside of an experience of race.

In addition to race, gendered experience is also shaped by age, sexuality, class, and ability. Likewise, the experience of race is impacted by gender, age, class, sexuality, and ability.



Figure 2.11. An idea expressed by many women of color, intersectionality was defined and articulated by legal scholar Kimberlé Crenshaw.

Understanding intersectionality requires a particular way of thinking. It is different from the ways in which many people imagine identities operate. An intersectional analysis of identity is distinct from single-determinant identity models, which presume that one aspect of identity (say, gender) dictates one's access to or disenfranchisement from power.

An example of this idea is the concept of global sisterhood, which is the idea that all women across the globe share some basic common political interests, concerns, and needs. If women in different locations did share common interests, it would make sense for them to unite on the basis of gender to fight for social changes on a global scale. However, if the analysis of social problems stops at gender, we miss an opportunity to pay attention to how various cultural contexts shaped by race, religion, and access to resources may actually place some women's needs at cross-purposes to other women's needs. Therefore, this approach obscures that women in different social and geographic locations face different problems.

Although many White, middle-class women activists of the mid-twentieth century United States fought for freedom to work and legal parity with men, this was not the major problem for women of color or working-class White women, who had already been actively participating in the US labor market as domestic workers, factory workers, and enslaved laborers since early colonial settlement. Campaigns for women's equal legal rights and access to the labor market at the international level are shaped by the experiences and concerns of White American women. In contrast, women of the Global South, in particular, may have more pressing concerns: access to clean water, access to adequate health care, and safety from the physical and psychological harms of living in tyrannical, war-torn, or economically impoverished nations.

An intersectional perspective examines how identities are related in our own experiences and how the social structures of race, class, gender, sexuality, age, and ability intersect for everyone. For example, "gender" is too often used simply and erroneously to mean "White women," while "race" too often connotes "Black men." As opposed to single-determinant and additive models of identity, an intersectional approach develops a more sophisticated understanding of the world and how individuals in differently situated social groups experience differential access to both material and symbolic resources, such as privilege.

Cultural Humility and Cultural Competence

As our world becomes increasingly diverse and interconnected, understanding each others' experiences and cultures becomes crucial. Without a basic understanding of the beliefs and experiences of individuals, professionals can unintentionally contribute to prejudice and discrimination or negatively impact professional relationships and the effectiveness of services. To understand cultural experiences, it is important to consider the context of social identity, history, and individual and community experiences with prejudice and discrimination. It is also important to acknowledge that our understanding of cultural differences

evolves through an ongoing learning process (Tervalon & Murray-Garcia, 1998).

Cultural competence is generally defined as possessing the skills and knowledge of a **culture** to work with individual members of the culture effectively. This definition includes an appreciation of cultural differences and the ability to work with individuals effectively. However, the assumption that any individual can gain enough knowledge or competence to understand the experiences of members of any culture is problematic. Gaining expertise in cultural competence, as traditionally defined, seems unattainable, as it involves the need for knowledge and mastery. True cultural competence requires engaging in an ongoing process of learning about the experiences of other cultures (Tervalon & Murray-Garcia, 1998).

Cultural humility, which takes into account this ongoing process, is the current model for human services professionals. **Cultural humility** is the ability to remain open to learning about other cultures while acknowledging one's own lack of competence and recognizing power dynamics that impact the relationship. The practice of cultural humility requires continuous self-reflection, recognition of the impact of power dynamics on individuals and communities, embracing "not knowing," and a commitment to lifelong learning. This approach to diversity encourages a curious spirit and the ability to openly engage with others in the process of learning about a different culture. As a result, it is important to address power imbalances and develop meaningful relationships with community members in order to create positive change (Culturally Connected, n.d.).

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Figure 2.10. "**Phrenological chart with portraits of historical figures and illustrations of skulls exhibiting racial characteristics**" Lithograph by G. E. Madeley, authored by C. Donovan is licensed under **CC BY 4.0**.

Figure 2.11. "**Kimberlé Crenshaw**" by Heinrich-Boll-Stiftung is licensed under **CC BY SA 2.0**.

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Figure 2.9. "**What is the Origin of Race in the United States**" by **PBS Origins** is licensed under a YouTube Standard license.

2.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- In order to break the cycle of the **whitewashing** of social **welfare** history, we must each work to unlearn inaccurate history and pay attention to contributions from BIPOC communities.
- **Intersectionality**, or the ways that multiple social identities may contribute to inequalities, should be considered when working with others.
- While it is important to understand the basic definitions of the dimensions of diversity, it is even more essential to practice cultural humility and learn about each individual's lived experience.
- Accurate language will be important to consider when speaking not just about our clients but about the field as a whole. Retelling accurate history is crucial to healing and changing patterns of harm found in the systemic oppression of marginalized communities we both serve and belong to.

DISCUSSION QUESTIONS

1. Discuss the suggestions for students at the end of "Integrating and Honoring BIPOC Contributions." Which of these seem approachable? Which are challenging? How can you support one another in helping the **profession** progress in this way?
2. How are cultural humility and cultural competence different from one another?
3. What connections can you make between the social construction of difference (in **race**, **gender**, and other identities) and intersectionality?

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CHAPTER

3

Trauma and Support Practices

3.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

STANDARD 15: Human service professionals must establish processes to identify client needs and assets, actively draw attention to them, and facilitate planning and advocacy at individual, community, and societal levels to address them (NOHS, 2024).

This chapter dives into **trauma**, trauma-informed practices, and **trauma-informed care**, a set of principles that can be applied in any organization or system to improve care for clients. Trauma-informed care relates to Ethical Standard 15: professionals can identify, address, and advocate for the needs of their clients. Identifying and effectively addressing trauma is crucial to the ability of providers to meet their clients' needs. When engaging in trauma-informed practices, human service professionals also identify and call attention to their clients' assets. More broadly, people working in **human services** can and should advocate for using trauma-informed care practices in organizations within their communities so that clients' needs can more effectively be met.

This chapter also explores how working with people who have experienced trauma impacts human service professionals. Human service professionals are exposed to significant trauma during their work. Because of this, people within this **profession** need to have wellness and **self-care** practices. Just as human service professionals need to call attention to the needs of others, it's also important that they have their physical, emotional, and spiritual needs met so they can be effective at helping others.

LEARNING OBJECTIVES

1. Identify the different kinds of trauma and their impacts on people.
2. Compare trauma-informed care and trauma-informed practices.
3. Describe the origins and practical applications of **restorative justice** and restorative practice.
4. Explain the complexity of resilience.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time they appear in the chapter.

Key terms for this chapter are:

- Acute trauma: a single traumatic incident
- Attachment theory: a theory that highlights how attachment patterns are developed beginning in the earliest stages of life
- Chronic trauma: a traumatic experience repeated over a period of time
- Complex trauma: a repeated traumatic experience inflicted by a caregiver
- Intergenerational trauma: a phenomenon in which the descendants of a person who has experienced a terrifying event show adverse emotional and behavioral reactions to the event that are similar to those of the person himself or herself
- Intersectionality: a perspective that recognizes that individuals are impacted differently based on characteristics such as social class, race, ethnicity, gender, sexuality, ability, and age, and that it is important to look at the intersections of these identities.
- Restorative Justice: It is a theory of justice that focuses on mediation and agreement rather than punishment. Participants must accept responsibility for harm and make restitution to those they have harmed. Indigenous people like the Maori have used this system successfully in their communities for generations. The major component is the community circle.
- Restorative Practice: an approach that helps to strengthen relationships, builds community, and prevents conflict. This can include community circles but also other approaches to relationship building and harm repair.
- Trauma: the result of an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life-threatening. Trauma has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.
- Trauma-informed care: a collection of approaches that translate the science of the neurological and cognitive understanding of how trauma is processed in the brain into informed clinical practice for providing services that address the symptoms of trauma

- Trauma-specific practices: practices that directly treat the trauma that an individual has experienced and any co-occurring disorders that they developed as a result of this trauma
- Vicarious trauma: secondary traumatic stress, which is an occupational challenge for people working in the human services field due to their continuous exposure to victims of trauma and violence. This has also been called secondary trauma. The negative effects of this work can make providers feel as if the trauma of the people they are helping is happening to them or the people they love.
- Systemic Trauma: Beliefs, practices, and cultural norms that reinforce the oppression of marginalized communities.
- Resilience: the ability to bounce back from difficult times in life. Resilience comes from the lessons and skills we absorb as we grow up and as we face all of our difficulties, whatever they are. This includes safety nets and relationships within the community, not just with friends and family. Understanding BIPOC and other marginalized communities have a nuanced relationship with resilience so knowing
- Compassion fatigue: this has two main components: burnout and secondary traumatic stress
- Self-care: is defined as needs for overall well-being. It helps manage stress, reduce ailments, and foster positive emotions for a healthier life. Self-care can be viewed in nine domains: environment, physical, social, emotional, spiritual, personal/relationships, professional, financial, and community.

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3.2 Trauma: A Common Experience

Trauma impacts people of all ages and all walks of life. More than 60 percent of adults have experienced at least one traumatic event, and about 25 percent reported experiencing three or more traumatic events before the age of eighteen (Merrick et al., 2018). Working in the **human services profession**, you are likely to encounter many clients who have been traumatized. As a result, it's crucial to understand what trauma is and how you may directly or indirectly address it in your career.

At the same time, you are likely to hear many stories of trauma when working with clients, which can be a traumatic experience in and of itself. This is another reason that it is essential for human service workers to understand trauma and have knowledge of wellness practices to address it.

Defining Trauma

Since the 1990s, a number of different definitions of trauma have been developed by professionals and researchers. Desiring a unified concept, the Substance Abuse and Mental Health Services Administration (SAMHSA) drew on these existing

definitions to establish a framework for understanding trauma.

According to SAMHSA (2014), **trauma** is the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. Generally, there are four kinds of trauma: **acute trauma**, **chronic trauma**, **complex trauma**, and **intergenerational trauma**, as shown in figure 3.1.

Note: This table has an Activation Warning.

Kind of Trauma	Definition	Example
Acute	A single traumatic incident	A car accident or a natural disaster. It may only be a single incident, but it can have lasting effects, such as fear of being in a vehicle.
Chronic	A traumatic experience repeated over a period of time	Intimate partner violence, family violence and war. Both have lasting effects on many people, and the consequences can be hard to overcome.
Complex	A repeated traumatic experience inflicted by a caregiver	Physical abuse, sexual /violence abuse, and verbal/emotional abuse (also known as psychological abuse). Complex trauma leaves a child confused and conflicted. The person who inflicted harm was supposed to be the one protecting them and keeping them safe. When that does not happen, the child does not know who to trust.
Intergenerational	Descendants of a traumatized person react as if the trauma was experienced by them (American Psychological Association [APA], 2022)	Many groups have experienced intergenerational trauma, including descendants of Guatemalan genocide survivors, Rwandan genocide survivors, Native American boarding school survivors, and enslaved persons. Parents and grandparents pass down trauma responses in the way they model and teach relationship skills, behaviors, values, and beliefs.
Systemic	Beliefs, practices, and cultural norms that reinforce the oppression of marginalized communities	Racism, ableism, homophobia, xenophobia, White supremacy, transphobia, and misogyny are some examples.

Figure 3.1. Trauma affects each person differently, but these basic descriptions help us to understand the general trends in how people are harmed by trauma.

Events, Experiences, and Effects of Trauma

SAMHSA also developed the concept of the three E's of trauma: event(s), experience of event(s), and effect. These three Es further define the concept of trauma and its effects on individuals.

Events or circumstances include the actual fear of reaching out for help, the extreme threat of physical or psychological harm (i.e., natural disasters, violence, etc.), or severe **neglect** of a child that imperils a healthy range of factors, including the individual's cultural development (SAMHSA, 2014). These events may occur once or may be repeated over time.

The individual's experience of these events helps determine whether it is traumatic (SAMHSA, 2014b). Something traumatic for one individual may not be traumatic for another individual. For example, two soldiers may serve in a combat zone, but only one may develop post-traumatic stress disorder. Similarly, siblings may respond differently to the incarceration of a parent.

How an individual experiences the event may be linked to various factors. These factors include the individual's cultural beliefs, such as the subjugation of women and the experience of **intimate partner violence**. Another factor is the availability of social support, whether the individual is isolated or embedded in a supportive family or community structure. Finally, they also include the developmental stage of the individual. For instance, an individual may understand and experience events differently at age five, fifteen, or fifty (SAMHSA, 2014b).

The long-lasting adverse effects of the event are a critical component of trauma. These adverse effects may occur immediately or may have a delayed onset. Examples of adverse effects include an individual's inability

- to cope with everyday stresses,
- to trust and benefit from relationships,
- to manage cognitive processes, such as memory and attention,
- to regulate behavior,
- or to control the expression of emotions.

In addition to these more visible effects, there may be an altering of one's neurobiological makeup and ongoing health and well-being (SAMHSA, 2014b).

Traumatic effects may range from hypervigilance, or a constant state of arousal, to numbing or avoidance. These effects can eventually wear a person down physically, mentally, and emotionally. Trauma survivors have also highlighted the impact of these events on spiritual beliefs and the capacity to make meaning of these experiences (SAMHSA, 2014b). In the next section, we'll discuss the science behind how trauma impacts physiological and psychological processes.

Recent research and the development of new theories have helped us better understand how trauma affects individuals in the long term. These theories give us an idea about how early trauma disrupts neurodevelopment and psychological processes. At the same time, by better understanding trauma, we can work to develop better interventions to address its impact.

Attachment Theory

Children who experience trauma may develop issues with attachment. **Attachment theory**, pioneered by John Bowlby and Mary Ainsworth, highlights how attachment patterns originate from the earliest stages of life. Bowlby's work focused on the bond between the infant and the primary caregiver. He developed a model of four stages of early development attachment that children go through from birth to two years old. He believed this was a critical part of development and that attachment experiences have long-lasting impacts on children. Particularly, these early attachment experiences shape future relationship patterns.

Ainsworth expanded upon this work to develop a typology of four kinds of attachments that children have with their mothers (primary caregivers). In her research, she looked at how children between the ages of one and two responded to mothers leaving and returning. Her research describes the following attachment types shown in figure 3.2.

Attachment Type	Definition
Secure	Children are distressed when their caregivers leave and quickly become calm when their caregivers return.
Anxious – Avoidant	Children do not seem to care when their caregivers leave, despite internal distress, and do not react when their mothers return.
Anxious – Ambivalent	Children are in distress when their caregivers leave and feel ambivalent when their caregivers return, alternating between being clingy and avoidant.
Disoriented – Disorganized	Children lack any consistent pattern in response to separation and return of the caregivers.

Figure 3.2. It is believed that the attachments children form in the first years of life affect their attachments as adults.

Like Bowlby, she claimed that these attachment styles impacted future relationships outside of the family. Because of this, developing a secure attachment is integral to children's emotional, cognitive, and interpersonal development. There is some research to support these claims. Research suggests that children are more likely to develop secure attachments if parents consistently meet their needs (Lahousen et al., 2019).

So, how do these ideas about attachment relate to trauma? Early traumatic experiences can influence the extent to which children feel safe and can form secure attachments. Traumatic experiences are associated with insecure attachment styles and have a neurobiological impact on individuals, particularly during the early stages of development (Lahousen et al., 2019). Trauma impacts various brain regions, some of which encode traumatic information that may later lead to emotional or behavioral problems (Lahousen et al., 2019). These regions are involved in development, leading to behavioral problems and stress reactions later on (Lahousen et al., 2019). These issues often reflect an insecure attachment style.

Trauma-Informed Care

In treatment settings, there is a helpful distinction between treating the trauma experience and treating the symptoms of trauma (Atkins, 2014; Dass-Brailsford, 2007; Friedman et al., 2014). Although there are numerous evidence-based treatment approaches for treating the experience of trauma, not all providers are trained and qualified to treat trauma. Trauma treatment requires specialized training and supervised experience (Dartmouth Psychiatric Research Center, 2015; SAMHSA, 2014a). This has the potential to create a treatment gap between the number of trained providers in trauma care and the treatment needs of patients with trauma histories. Even though not every provider is trained to engage in trauma processing therapies, it is recommended that institutions train their professional staff in the ability to provide care that is sensitive to the unique symptoms of trauma (SAMHSA, 2014b). A structured approach that institutions can use to provide such care is known as **trauma-informed care** (SAMHSA, 2014a; Curran, 2013).

Trauma-informed care is a collection of approaches that translate the science of the neurological and cognitive understanding of how the brain processes trauma into informed clinical practice for providing services that address

trauma symptoms (SAMHSA, 2014a; Curran, 2013). It is important to note that trauma-informed care is distinct from **trauma-specific practices**.

Trauma-specific practices directly treat the trauma an individual has experienced and any co-occurring disorders that they developed due to this trauma. Trauma-specific practices include interventions such as prolonged exposure therapy, eye movement desensitization and reprocessing (EMDR), and trauma-focused cognitive behavioral therapy (Menschner & Maul, 2016). Practitioners must undergo special training to utilize these techniques, so not every organization may offer these treatments.

A trauma-informed care approach can include trauma-specific practices and incorporate key trauma principles into the **organizational culture**. This approach is not designed to treat the trauma experience (such as processing the trauma narrative), but rather to assist in managing symptoms and reducing the likelihood of retraumatization of the patient in the care experience (Najavits, 2002; SAMHSA 2014b). As such, interventions of trauma-informed care are appropriate for a range of practitioners to utilize in various clinical settings.

Assumptions of Trauma-Informed Care

Along with defining the concept of trauma, SAMHSA's approach to trauma-informed care includes four assumptions and six key principles. There are four R's that highlight the key assumptions of the trauma-informed care framework: realization, recognition, response, and resistance to retraumatization.

A program, organization, or system that is trauma-informed

- realizes the widespread impact of trauma and understands potential paths for recovery,
- recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system,
- and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist retraumatization (SAMHSA, 2014b).



Figure 3.3. Trauma-informed agencies REALIZE the widespread impact of trauma and understand potential paths for healing, RECOGNIZE the signs and symptoms of trauma in clients, staff, and others involved with the system, RESPOND by fully integrating knowledge about trauma into policies, procedures, practices, and settings; and actively RESIST RETRAUMATIZATION.

By realizing trauma, people's experiences and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances. Their experiences and behavior may be related to past circumstances, such as a client dealing with prior **child abuse**. They may currently be experiencing trauma, such as a client experiencing intimate partner violence. Finally, clients' experiences and behavior can be related to the emotional distress that results from hearing about the firsthand experiences of another, such as the **vicarious trauma** experienced by a human services professional.

There is an understanding that trauma plays a role in mental and substance use disorders. **Prevention**, treatment, and recovery settings should systematically address trauma (SAMHSA, 2014b). Trauma is not only present in the behavioral health sector. It also plays a significant role in education, child **welfare**, criminal justice, health care, and other community organizations addressing social problems. Trauma is as much of a barrier to effective outcomes in these systems as it is in mental health and substance use disorder treatment.

When engaged in trauma-informed care, people in the organization or system can also recognize the signs of trauma, including how these may present differently in various settings or populations (SAMHSA, 2014b). People in the organization use screening and assessment tools to help identify trauma. Additionally, organizations should provide training for staff members so that they can identify trauma responses.

The program, organization, or system responds by applying the principles of a trauma-informed approach to all areas of functioning. The program, organization, or system integrates an understanding that the experience of traumatic events impacts all people involved, whether directly or indirectly (SAMHSA, 2014b). Staff in every part of the organization change their language, behaviors, and policies to consider the experiences of trauma among children and adult users of the services and staff providing the services.

Organizations accomplish these changes through staff training, a budget that supports this ongoing training, and leadership that realizes the role of trauma in the lives of their staff and the people they serve. The organization has practitioners trained in evidence-based trauma practices. The organization's policies—such as mission statements, staff handbooks, and manuals—promote a **culture** based on beliefs about resilience, recovery, and healing from trauma. The organization is committed to providing a physically and psychologically safe environment. Leadership ensures that staff work in an environment that promotes trust, fairness, and transparency. The program's, organization's, or system's response involves a universal-precautions approach in which one expects the presence of trauma in the lives of individuals being served, thereby ensuring not to replicate it (SAMHSA, 2014b).

A trauma-informed approach seeks to resist the retraumatization of clients and staff (SAMHSA, 2014b). In a trauma-informed environment, staff recognize practices that strip clients of agency or make them feel trapped—both of which they may find retraumatizing. At the same time, trauma-informed organizations ensure they are not retraumatizing staff by creating a high-stress environment without proper support.

Key Principles of Trauma-Informed Care

In addition to these four assumptions, there are six key principles of a trauma-informed approach: safety; trustworthiness and transparency; peer support; **collaboration** and mutuality; empowerment, voice, and choice; and cultural, historical, and **gender** issues.

1. **Safety** refers to staff and clients throughout the organization feeling secure physically and psychologically. The physical setting and interpersonal interactions at the organization should promote safety. Staff at the organization should not assume what their clients need to feel safe but rather provide opportunities for clients to express what safety means to them.
2. **Trustworthiness and transparency** are directly related to one another. When organizational decisions are made with transparency, they build and maintain a sense of trust with clients, staff, and others involved with the organization.

3. **Peer support** is another principle that helps build trust, enhance collaboration, and establish safety and hope. By having support from others who have experienced trauma, survivors can begin to see the possibilities of recovery and healing.
4. **Collaboration and mutuality** refer to narrowing power differentials between clients and staff, as well as among staff. Collaboration helps demonstrate that healing happens within relationships and in the meaningful sharing of power and decision-making. By having all parties at the table when decisions are being made, the organization recognizes that everyone has a role to play in creating a trauma-informed organization.
5. **Empowerment, voice, and choice** refer to recognizing and building upon individuals' skills and strengths. Trauma-informed care is a **strengths-based approach** where the organization and its staff foster a sense of resiliency among the people they serve. They believe in the ability of people and communities to heal from trauma and recognize how they are experts in their own experiences. Staff understand how important it is for clients to be empowered and to have a voice and choice in their treatment. Clients are supported in shared decision-making, choice, and goal-setting to determine the plan of action they need to heal and move forward (SAMHSA, 2014b). Staff are also empowered to do their work.
6. **Cultural, historical, and gender issues** are the final principle of trauma-informed care. Trauma-informed organizations are aware of cultural biases, stereotypes, and systemic inequalities. In their work, they recognize the role of historical trauma and the importance of addressing that as part of the healing process. In conjunction with this, they have policies, procedures, and culturally responsive protocols that draw on the unique needs of the population they serve and leverage cultural connections to improve care.

These principles can be applied in many contexts, even though specific practices or terminology vary between settings. Developing a trauma-informed approach requires change at multiple levels of an organization to reflect these principles. Figure 3.4 combines all of the pieces of the trauma-informed care approach we've discussed.

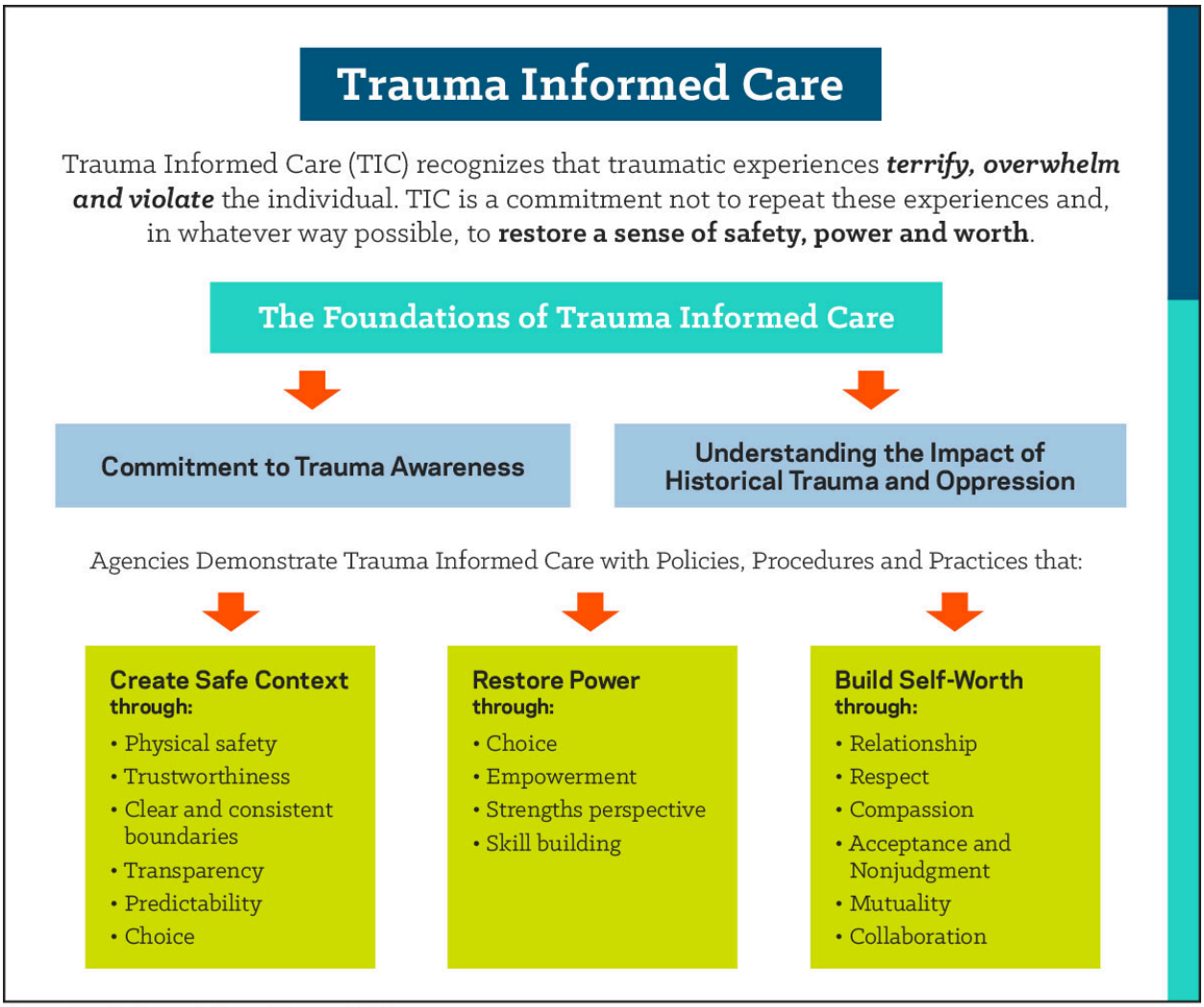


Image Credit: Trauma Informed Oregon, 2014

Figure 3.4. Concept map summarizing the framework of trauma-informed care Image description available. Image description.

Restorative Justice vs. Restorative Practice

To begin to understand **Restorative Justice** and Restorative Practice, we must first understand the origins of the practice. These origins are at the center of how restorative justice differs from the type of justice and repair systems currently practiced in the United States.

Restorative Justice, often misunderstood, is not a new concept in the criminal justice system. It's a well-established approach that is gaining recognition for its effectiveness. These vital practices have been braided into every aspect of Indigenous communities for generations. However, they have been colonized by the United States in ways that do not truly recognize how intense this practice is. It has best been described by Dr. Fania Davis and Dr. Howard Zehr in their work over the last several decades.

Restorative Justice is a theory or framework of justice that focuses on mediation and agreement rather than punishment. Participants must accept responsibility for harm and make restitution to those they have harmed. Indigenous people like the Maori have used this system successfully in their communities for generations. The well-known component is this community circle. The

video linked below describes the history of Restorative Justice and its practices, philosophies, and values. This is an **overview of Restorative Justice by Amplify RJ [Streaming Video]**. Although it is a bit long at 30 minutes, it is a deeply informative and approachable introduction to deeper concepts.

Restorative Justice is another method of achieving justice with Indigenous roots, both African and Native American. It views crime as a harmful act against the community as a whole rather than as a harmful act against the system or state. Numerous Indigenous communities practiced restorative justice for years until it was disrupted by colonization and the arrival of Eurocentric values.

Chapter Two of Davis's *The Little Book of* ***Race*** *and Restorative Justice* goes into great detail about the indigenous tribes in Africa and Native Americans in Canada who used restorative justice, which I highly encourage. Davis quotes an author who wrote a book about Indigenous teachings and the roots of restorative justice, Kay Pranis, to explain that restorative justice has a much deeper meaning and significance that non-indigenous people cannot see at the surface level (Davis 2019).

Without an understanding of how vital interrelatedness is to Indigenous communities, we will never understand restorative justice in its entirety. Davis also assures the reader that we can avoid cultural appropriation if restorative justice is appropriately performed. It is essential to recognize the Indigenous roots of the practice and name them in your space practice before utilizing restorative justice as community healing.

Restorative practices are often confused with restorative justice work. They are different, though they coexist in the same spaces in many instances. Some restorative practices that are most familiar to the public include restorative circles or talking circles, for example, as described by The Center for the Study of Social Policy:

> Talking circles is another approach rooted in restorative practices, which embodies ***hozhooji naat'aanii***, a Navajo phrase meaning "something more like 'people talking together to re-form relationships with each other and the universe.'" Youth circles underscore youth's interconnectedness with and responsibility for their community. In a paper exploring the use of restorative justice in residential placements in Northern Ireland, psychologist and advocate William McCarney observes that talking circles in residential care centers can help youth "develop prosocial skills and attitudes" and "a sense of community and civic spirit, **empathy**, and … a sense of belonging and connectedness." E Makua Ana Youth Circles in Hawai'i, which supports youth transitioning out of **foster care**, emphasizes the ability of youth to use their participation in the circle to not only recognize their strengths but also those of one's family, community, and social service workers as supports in their transition period (Marsh, 2019).

Many people in the United States were first introduced to restorative circles by the criminal legal system and have only connected it to this system. However, when these circles are used in these systems, which are not and cannot be restorative, their depth is superficial. The people who have been trained in running the circles have not done the necessary practices to do true restorative work, and the system as it is constructed cannot support long-term change.



Figure 3.5. Restorative justice practices seek to change the practices of the criminal legal system to center the victim; however, they do not seek to transform the conditions of racialized poverty and the criminal legal system. Image description available. **Image description.**

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3.3 Trauma and the Human Service Professional: Resilience

Human service professionals are often exposed to **trauma** during their work. Even this secondhand exposure to trauma can have significant physical and psychological impacts if human service workers do not have the tools to prevent and address its impact. When thinking about the trauma that **human services** professionals are exposed to, it seems that many think of resilience as the complete opposite of trauma. However, it is a bit more complex than that.

Resilience is the ability to bounce back from difficult times in life. It comes from the lessons and skills we absorb as we grow and as we face difficulties in life. Part of building resilience is having safety nets and relationships with the community, not just with friends and family.

When considering resilience, it is important to center **race**, as BIPOC people have been praised for the survival of a system that was not built for them to thrive in or even live in. While some people look or act more resilient, the idea of comparing one person's experience of resilience to another's is how resilience has been defined in the past.

Instead of calling people resilient, let us look at solutions for systems of oppression that have forced whole communities to find ways to survive. For an example of critical thinking about the term "resilient," listen to the trailer of the podcast *Don't Call Me Resilient* [Podcast] by host Vinita Srivastava. She has conversations with experts from different fields and real people to make sense of the news from an anti-racist perspective and how the word resilience is used in context to the systems of oppression they exist in.

As human service providers, it is up to us to consider our biases toward experiences we do not share. Even experiences we do share with others, including our clients, may cloud our reasoning as to why we think clients are behaving in certain ways.

Trauma Exposure

Secondary trauma, also called secondary traumatic stress, is an occupational challenge for people working in the human services field due to their continuous exposure to victims of trauma and violence. This work-related trauma exposure can occur from experiences such as:

- Listening to individuals, families, groups, communities, and systems recount their victimization
- Looking at videos of exploited children and families
- Reviewing case files, historical data, and stories
- Hearing about or responding to the aftermath of violence and other traumatic events
- Responding to mass violence incidents that have resulted in numerous injuries and deaths (Office for Victims of Crime, 2013)

Secondary trauma is associated with a sense of confusion, helplessness, and a greater sense of isolation from supporters than is seen with burnout (Administration for Children & Families, 2017). It is preventable and treatable. If unaddressed, the symptoms can result in problems with mental and physical health, strained personal relationships, and poor work performance (Pryce et al., 2007).

Evidence of **compassion fatigue** can be challenging to recognize in oneself or even in others. Symptoms often include cognitive, behavioral, emotional, and physical changes. They may also involve a spiritual component, such as questioning meaning or losing faith (Pryce et al., 2007). Common examples can be found in figure 3.6.

Category of symptoms	Examples of symptoms
Cognitive	Lowered Concentration Apathy Rigid thinking Perfectionism Preoccupation with trauma
Behavioral	Withdrawal Sleep disturbance Appetite change Hypervigilance Elevated startle response
Emotional	Guilt Anger Numbness Sadness Helplessness Anxiety
Physical	Increased heart rate Difficulty breathing Muscle and joint pain Impaired immune system Increased severity of medical concerns

Figure 3.6. Common secondary trauma symptoms: this table details the cognitive, emotional, behavioral, and physical symptoms of vicarious trauma.

Exposure to traumatic and troubling events, sometimes daily, influences one's personal and professional lives. Staff acquire different coping methods—some are adaptive, others are not (Administration for Children & Families, 2017). Some negative outcomes on the work environment from secondary trauma are increased absenteeism, impaired judgment, low productivity, poorer quality of work, higher staff turnover, and greater staff friction.

But the effect of the trauma we experience in the work we do is not isolated to our work life. It is also in the rest of our life. Our value does not solely come from what or how much we produce, no matter what the nonprofit industrial complex and capitalism may want us to believe. Rest is also productive, but most importantly, rest is resistance. It is an act of **self-care** and community care. It is a way to continue to push back against secondary trauma exposure and the systemic nature of secondary trauma.

A Holistic Wellness Approach

How can individuals working in human services help decrease the negative impacts of secondary trauma? Wellness and self-care, community care, and system accountability are essential to staying mentally healthy while working in the field.

By being aware that different areas of our lives impact our mental, physical, and spiritual well-being, we can become more aware of how we may be affected by secondary trauma. An essential piece of this is self-awareness of how to balance the different areas of your life.

Below are additional suggestions to help prevent the negative impacts of secondary trauma.

- **Life balance:** Work to establish and maintain a diversity of interests, activities, and relationships.
- **Relaxation techniques**: Ensure downtime by practicing meditation or guided imagery and other somatic ways of regulation.
- **Contact with nature**: Garden or hike to remain connected to the earth and help maintain perspective about the world.
- **Creative expression**: Draw, cook, dance, play music, or practice photography to expand emotional experiences.
- **Assertiveness training**: Learn to say no and set limits when necessary. Boundary identification can also be part of this work. Finding allies to help can be harder to do for some marginalized and cultural communities.

Decolonized nonviolent communication training (NVC): Take note of how colonization impacts our experience with our bodies and how we disconnect from them.

Nonviolent communication has four components:

1. **Observations:** Without judging, observe what is happening in the context of the conflict that has come up.
2. **Feelings:** Identify the emotions accompanying your observations. Following the decolonizing NVC approach, pay attention to the sensations within your physical body and ask yourself if you are comfortable engaging in the interaction.
3. **Needs:** State your needs. Check in with your body again, and notice whatever sensations arise.
4. **Requests:** Make a request to the person you are communicating with. When expressing a request, know that you must be ready to accept no as a potential response.

> *Decolonizing NVC invites us to reimagine our bodies as our best friend, to observe where and when we disconnect from ourselves, and to*

navigate new ways of coming home – both to ourselves and to the communities we love to serve. —Meenadchi

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=INd-KgBPEI-8**

Figure 3.7. The nonviolent communication model is a way of structuring communication to allow people to understand one another and meet each other's needs. **Transcript.**

Decolonizing nonviolent communication involves thoroughly examining and redefining the core principles and practices of this kind of communication. This requires a recognition of the traumas that have affected every individual raised in the United States. Meenadchi, a skilled facilitator and healer, teaches NVC techniques with a transformative justice and decolonial perspective. She notes that colonialism has distanced us from Indigenous knowledge, communal resources, and a sense of interconnectedness. Through a decolonial lens, we can dismantle the notions of scarcity and "otherness" ingrained in us and instead cultivate genuine, open-hearted **empathy** for one another while establishing healthy boundaries.

Meenadchi offers three conditions for being able to practice NVC:

- A person experiences themselves as having a choice
- A person experiences an aligned somatic awareness of their own body
- A person experiences an aligned somatic awareness of the collective body

After carefully reviewing Meenadchi's findings on the three essential conditions, it is pertinent to progress toward practicing and implementing NVC. Many individuals already possess some of these skills as part of their preparation for the human services field, and they are actively integrating them into their professional toolkit. Here is a comprehensive list of skills that advocate for an ongoing and active engagement in NVC practices, emphasizing the cultivation of whole body awareness, collective body awareness, and the empowerment of making conscious choices.

- **Interpersonal communication skills**: Improve written, auditory, verbal, sign, body, and technology-assisted communication to enhance social support.
- **Cognitive restructuring**: Regularly evaluate experiences and apply problem-solving techniques to challenges.
- **Time management**: Set priorities, remain productive and effective, and be open to what productivity could look like in different settings depending on the needs of communities.
- **Clinical Supervision:** Evaluation. Most providers do this one-on-one, but it is only sometimes a requirement. Students should request this both individually and in a group setting. Supervisors should be trained in trauma-informed, anti-oppressive leadership and supervision styles to support clients' and supervisees' wellness and growth.
- **Plan for coping**: Determine skills and strategies to adopt or enhance when signs of compassion fatigue surface. Every other human needs human connection as much as they need water or food for the body to survive. Let your plan evolve with time, and have the people who help you with these coping skills and strategies change. Build a community as part of your strategy and skill sets. However, this does not mean that alone time is unnecessary; isolation is unnecessary when using your skills.

Sometimes one area of your life takes up more physical, mental, or spiritual energy. This may be the case if you find yourself starting to experience

symptoms of **vicarious trauma**. If you have experienced the adverse effects of vicarious trauma, there are a variety of treatment strategies to consider:

- **Focus on self-care and community care**: Make food choices that meet your nutritional needs, move in a way that fuels mind and body connection, establish a regular practice of saying no to people or spaces that don't feed your health, and prioritize daily outdoor and regular sleep to reduce adverse stress effects.
- **Journal**: Write about feelings related to helping or caregiving, as well as about anything that has helped or been comforting to help make meaning out of negative experiences.
- **Seek professional support**: Work with a counselor who specializes in trauma to process distressing symptoms and experiences. If further support is needed, such as medication, this conversation can happen with a referral to a prescribing provider, such as a PsyNP or an MD.
- **Join a support group**: Talk through experiences and coping strategies with others who have similar circumstances to enhance feelings of optimism and hope.
- **Learn new self-care strategies**: Adopt a new stress management technique, such as yoga or progressive muscle relaxation, to reduce adverse physical stress symptoms.
- **Ask for help**: Ask social supports or coworkers to assist with tasks or responsibilities.
- **Cultural connection**: Active practice in your life. These can be expansive and include spiritual practices, language, food, music, family or racial/ethnic history, and stories or other things that connect you to your cultural experiences.
- **Recognize success and create meaning**: Identify aspects of helping that have been positive and important to others. (Administration for Children & Families 2017)



Figure 3.8. Self-care requires time and money. Community connections and care can help someone feeling stuck to find and maintain a sense of security. Image description available. **Image description.**

Activity: Self-Care and Community-Care Reflection

Review the questions from the following four categories: increasing health and well-being, promoting happiness and reducing stress, getting support from mentors, and developing supportive peer relationships. Choose a category in which you could grow, and answer the questions in that category in a reflective manner. As you answer each question, examine the reasoning or behavior behind your answer. Write about what might help, what might be getting in your way, and how you could move forward in that area.

In human services, we must challenge the notion that healing happens in isolation. We must move into a space of interdependence and look at leaning into each other for healing. This means our care must always be community care, but we can also provide individual care in a community setting. How do we begin to shift practices that we root for, not against, each other and center individual well-being as part of community well-being?

Increasing Health and Well-Being

- What is one thing I did in the past month to support my health?
- What is one thing I can do tomorrow to take a step toward better health? For example, you

could call your doctor to schedule a long-overdue appointment, commit to making one healthy food choice, or take a brisk walk to get your heart pumping and boost your energy.
- Do my nutritional choices support my health and well-being? If not, what positive changes can I make?
- What do I need to be happier and healthier?
- What is one phone call I can make or website I can visit to move forward on my journey toward a stronger sense of well-being?

Promoting Happiness and Reducing Stress

- Do I experience stress connected to my work? Are there other sources of stress?
- What tools or resources can I use to help me manage stress?
- In what areas of my life could I use some support?
- What resources are available in my community to help me meet these needs?
- What activities make me feel relaxed and happy?
- When can I schedule some "me" time, even just for a few moments, to do something that will help me feel balanced and reduce my stress?
- How can I say no to unhealthy or unhealthful relationships in my life?

Getting Support from Mentors

- Who do I know and respect that might serve as a strong **mentor**?
- How can this mentor help me in my work with clients, my secondary trauma, or other stress?
- When can I approach this person to schedule a time to talk about a possible mentoring relationship?
- How do I continue to encourage systems that I work within to become healthier so that the weight of care is not left to individuals but spread across communities?

Developing Supportive Peer Relationships

- Which of my friends or colleagues has professional beliefs and philosophies that are like my own? How can I spend more time with this person?
- In what ways can I confide in, listen to, and develop a mutually supportive relationship with this person?
- How might this person's positive outlook benefit my work with young children and their families? Or other communities I work with?
- How might I positively influence this person's work?

Developing a Self-Care and Community-Care Mindset

While it is important to align your behaviors and actions with self-care and community-care skills, it is even more critical that professionals adopt a self-care mindset. This will keep you centered and aware of both what is happening around you and of yourself. In this section we will discuss two concepts: **mindfulness** and **trauma stewardship**. Each of these ways of thinking can be used separately, but they are most powerful when used together.

Mindfulness

Mindfulness encompasses several ideas:

- Being aware of our feelings, thoughts, and bodily sensations, and accepting them
- Staying in the present moment
- Being non-judgemental, curious, gentle, and kind

Mindfulness is different from meditation in that it is a state of mind that can be applied at any time, any place, while doing anything. Meditation is a more formal practice in which one uses a technique to focus the mind on a particular thought or object. This focus helps train the mind to be attentive and aware and to achieve a clear and stable emotional state (Walsh & Shapiro, 2006).

Mindfulness also helps one maintain a clear and stable emotional state, but it is a quality of mind rather than a scheduled practice. Meditations may be focused on learning mindfulness, but there are many other kinds of meditations as well. And mindfulness can be adopted without using the practice of meditation.

Have you ever heard the saying about not being able to control other people's behavior but being able to control your own response? Mindfulness can help with that. When a stressful situation occurs, whether it is personal, such as having an argument with your partner, or work-related, such as working with a client who has not been able to find a home, being mindful can help you to listen better, be less judgemental, and focus on what is happening in that moment.

It's not so much about controlling your response. It's about training yourself to listen more closely to your own feelings and thoughts as well as listening to others' experiences and viewpoints. Here's another way to look at it: "Mindfulness is awareness, cultivated by paying attention in a sustained and particular way on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 2016).

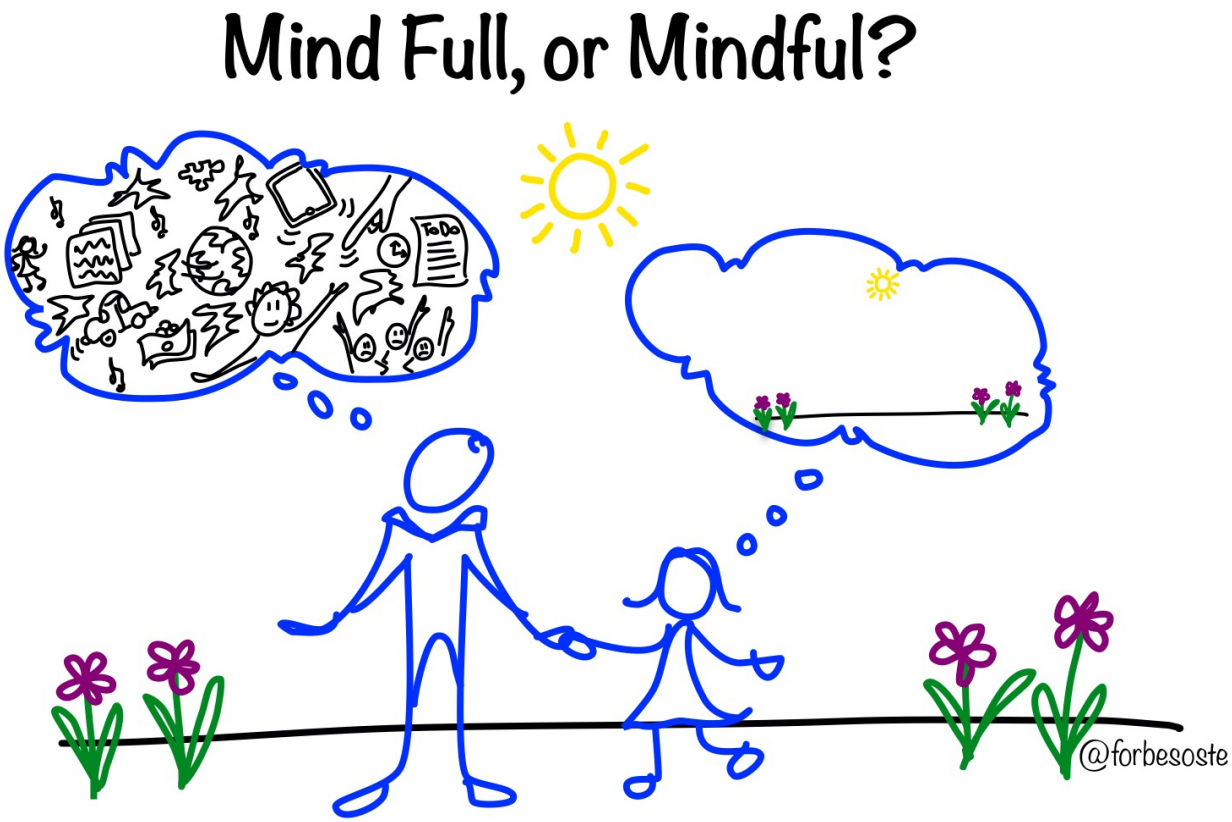


Figure 3.9. The practice of mindfulness allows you to truly experience the moment and cultivate the skill of not letting your thoughts ruminate on anxiety and stress. **Image description.**

Think about a stormy day near the ocean. You're watching big waves form and crash against each other far out at sea. You can see the storm clouds and the possibility of rain. Now imagine deep, deep below the ocean's surface, where it is quiet and still, with gentle oscillations of water, plants, and fish. Mindfulness is about accessing that deep part of your brain that can sway gently as the storm unleashes its turbulence. You observe the storm, you think about the storm, you have feelings about the storm, but you don't want you or your mind to *become* the storm.

Mindfulness helps human services professionals handle the varied and unpredictable work that is characteristic of serving other human beings. It also helps us to handle being exposed to the trauma that our clients face and that we may face in our own lives. It lowers our stress response and stress levels. It strengthens our resilience. Developing mindfulness is one of the best things we can do for ourselves and the people we serve.

Trauma Stewardship

Trauma stewardship recognizes that trauma has impacts that can be named and managed. It also acknowledges that the person who is helping someone who is suffering from trauma may also themselves suffer. In other words, this concept acknowledges the secondary trauma that helpers experience and allows you to identify ways to manage the trauma for yourself. This definition comes from the founder and director of the Trauma Stewardship Institute, Laura van Dernoot Lipsky:

> A daily practice through which individuals, organizations, and societies tend to the hardship, pain, or trauma experienced by humans, other living beings, or our planet itself. By developing the deep sense of awareness needed to care for ourselves while caring for others and the world around us, we can greatly enhance our potential to work for change, ethically and with integrity, for generations to come (van Dernoot Lipsky & Burk, 2009).

This model, which draws from multiple walks of life, cultural traditions, and spiritual practices, acknowledges multiple kinds of trauma. Trauma stewardship can be applied to

- working with people in crisis-oriented settings such as emergency rooms, domestic violence shelters, or homeless shelters;
- caregiving to someone who is disabled, has a chronic illness, or is in pain;
- working to dismantle systems of oppression such as **ageism**, racism, sexism, and others;
- being on the frontlines of environmental movements working to combat climate change; or
- caring for animals in veterinary offices and rescue centers, or working with wildlife as a scientist (van Dernoot Lipsky and Burk, 2009).

As you can see from this list, this view of trauma pays attention to the ways that oppression and power limit individuals. In fact, it views trauma stewardship within the context of power, oppression, and liberation.

Trauma stewardship begins with the idea of being present and practicing mindfulness. This involves paying attention to whatever is unfolding in your clients' lives and around us. Like mindfulness, trauma stewardship involves recognizing our response to trauma rather than trying to push traumatic thoughts away. Abundant thinking and feeling helps foster our compassion, which we need as we do this work.

As trauma stewards, we must first do no harm. In order to care for and with others experiencing trauma, we must be able to respond to humans, animals, and the earth in a sustainable way. In other words, we need to be able to sustain ourselves well enough to continue to work and care.

This **Tiny Survival Guide [PDF]** from the Trauma Stewardship Institute helps summarize some strategies for achieving these goals. It is important that we not assume others' problems as our own, at the same time, we must recognize the effects that these problems have on us. All of these actions help us to be true stewards and without adding to our clients' problems.

What would your Tiny Survival Guide Look Like?

ACTIVITY: BEYOND THE CLIFF



This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=uOzDGrcvmus**

Figure 3.10. In **Beyond the Cliff [Streaming Video]**, Laura van Dernoot Lipsky discusses her own experience with trauma stewardship. **Transcript.**

Watch the video in figure 3.10 with Laura van Dernoot Lipsky, then reflect on the following questions.

1. Lipsky begins by talking about standing on a cliff. What are a couple of the metaphorical cliffs that she stood on throughout her life?
2. Is laughter a part of trauma stewardship? What makes you think so (or not)?
3. What are some of the sources of trauma that take a toll on people?
4. How is supremacy, oppression, and power related to trauma?
5. Lipsky quotes her mentor, "When there is suffering, there is more to do than hold it together." What do you think she proposes that you do?
6. What does this quote mean to you: "Brutality and beauty, pain and pleasure, annihilating moments and sublimating moments"?

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Figure 3.8 **Self-Destructive Self-Care** by **Toon-Starterz** is licensed under **CC BY-NC-ND 3.0**.

Figure 3.9 **Mind Full v. Mindful** by **Heidi Forbes Öste** is licensed under **CC BY 2.0**.

3.4 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or

- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

Key Takeaways

- Traumatic experiences are incredibly common. These include **child abuse** and **neglect**, **intimate partner violence**, sexual violence, and household instability (for example, a household member with a mental health issue or substance use disorder).
- Traumatic experiences are especially impactful during childhood because of the adverse effects they can have on cognitive and emotional development. In the long term, these can lead to worse physical and mental health outcomes.
- Experiencing **trauma** is directly associated with being marginalized more broadly.
- Human service providers work directly with individuals who often have experienced a significant amount of trauma.
- **Trauma-informed care** is a set of principles that creates safe and inclusive environments to meet the needs of trauma survivors while avoiding retraumatization. These practices can be put into place in a wide range of contexts.
- **Trauma-specific practices** aim to directly address and reconceptualize trauma. These practices are more specialized and require additional training. This means that not every human service professional is qualified to administer these treatments. Organizations and agencies that provide trauma-specific practices should still take a trauma-informed approach to their work.
- Because of the large amount of secondary trauma that human service professionals encounter in their work, it is important to take preventative steps to avoid negative impacts of this form of trauma. These steps can include ensuring your organization is trauma-informed for its staff, engaging in **self-care** practices, and seeking treatment if symptoms arise.
- Restorative practice and **restorative justice** are becoming a key part of the work that we do as human service providers. These are related, just as trauma-informed practices and trauma-informed care are connected. One is a system, and the other is an individual way of supporting clients within systems.

Discussion Questions

1. Why is it important for human service professionals to have an understanding of trauma?
2. What kinds of self-care practices do you see yourself engaging in as a human service professional? How do you think that these will help you address the impact of **vicarious trauma**?
3. When you think of the phrase "rest as resistance," what comes to mind?

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CHAPTER

4

Ethical Standards

4.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

STANDARD 28: Human service professionals must pursue relevant consultation and supervision to guide their decision-making in the face of legal, ethical, or other complex dilemmas (NOHS, 2024).

One of the defining factors of a **profession** is that it contains a **code of ethics**—a written statement of values, ethical principles, and **standards** that meet an agreed-upon level of quality in selected areas. In this chapter, we examine the Ethical Standards for **Human Services** Professionals adopted by the National Organization for Human Services (NOHS). **Standards** provide a level of quality for professional behavior to meet. Depending on where you work and what your role is, you may use one of these codes or another set of standards entirely. In addition, you will have workplace standards and governmental laws that regulate your work. Ethical Standard 28 refers to the responsibility that you have to consult and review when there is an ethical, legal, or another **dilemma** that you face in your work.

LEARNING OBJECTIVES

1. Recognize the value of codes of ethical standards.
2. Describe the NOHS Ethical Standards for Human Services Professionals.
3. Relate the NOHS code of ethical standards, personal values, and the **social justice** implications.
4. Apply the code of ethical standards to identified dilemmas.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Code of ethics: one of the distinguishing features of a profession, it sets standards and values for workers to uphold.
- Dilemma: a situation in which one has to make a choice between two options that have competing values and are equally unfavorable.
- Ethics: moral principles.
- National Association of Social Workers (NASW): a professional organization for social workers and those studying social work.
- National Organization of Human Services (NOHS): a professional association for human services professionals and those studying human services.
- Professionalism: the conduct, qualities, and qualifications recognized as part of a profession.
- Social problem: any condition or behavior that has negative consequences for large numbers of people and that is generally recognized as a condition or behavior that needs to be addressed. Multiple factors contribute to the complexity of social problems. Typically the solution to the problem needs to be systemic in nature; in other words, it cannot be solved by any one individual.
- Standards: provide a level of quality for professionals, educators, and students' behavior to meet.
- Law: a system or set of rules created by legislative bodies of a governmental system of a town, state, or country. (*Encyclopædia Britannica*, 2024)
- Regulations: Specific agencies write rules to support laws written by legislative bodies, creating guidelines to oversee how those laws will be carried out specifically in particular practice areas. An example of this would be the Clean Water Act (a law) affecting the Environmental Protection Agency's ability to create regulations for that law to be carried out.

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4.2 Ethical Standards for Human Services Professionals

As you consider entering the **profession** of **human services**, it is important to think about the role you will play as well as the responsibilities that come with that role. One of the joys and challenges of working with human beings is that unique interactions occur every day. Whether you are a director, a supervisor, a receptionist, an assistant, or a case manager, you will encounter situations that you have not seen before. The field of human services was developed in response to human needs and human problems. It is a profession dedicated to helping diverse individuals solve the challenges they face while valuing each person's community, **culture**, and self-determination. While doing so, the professional must act with integrity and compassion, and with **social justice** in mind.

There is no set of directions to follow when you work with individuals. When putting together a piece of furniture or baking cookies, for instance, you might follow instructions or recipes. You might even deviate a little bit or add your own flair to the project. Working with individuals and families, however, requires a stronger internal set of values and principles. That foundation is one that you build inside yourself using the tools of education, experience, and an understanding of **ethics,** which are the moral principles of the profession. To make ethical decisions, we must be aware of the biases and pressures that influence our thinking. We must also be aware of the intersection of the systems of privilege that shape the lens we use to see the world around us and how we use the information and influence we have.

Codes of ethics for the human services profession will help you build your professional foundation. In fact, you will be required to use that code as soon as you start working, including during your **practicum** and **internship** experiences.

All professions have a **code of ethics**, and those codes have many similarities in terms of how they relate to being responsible toward clients, colleagues, and society. For example, psychologists, attorneys, medical professionals, and social workers all embed these obligations and duties within their ethical codes. In this chapter, we focus on the Ethical **Standards** for Human Services Professionals from the National Organization for Human Services (Figure 4.1).



Figure 4.1. The National Organization for Human Services regulates the profession of human services.

Any code of ethics is also embedded within the cultural norms of the local community, the country, and the ethos of the world. As we examine ethics, we must also look at values and culture. It is important to note that different countries and cultures have differing values and that subcultures within the United States may conflict with, complement, and/or mirror the country's overall norms.

It is critical to pay attention to the cultures and values of the families that you work with, as well as being mindful of your own ethics and values. Looking at all of these elements together is complicated, which is why ethics are being highlighted as you start learning about this profession. It takes time, experience, education, and reflection to develop your foundation. This chapter will support that building process.

Structure of NOHS Ethical Standards: Two Sections

The **National Organization for Human Services (NOHS)** is the professional organization that serves both students and working professionals. As a member of this organization, practitioners network, follow research, and support one another. The NOHS ethical standards consist of two sections:

- Preamble: a short narrative introduction to the overall profession and reason for codes.
- Ethical standards: forty-four standards grouped into seven categories— responsibility to clients, colleagues, profession, public and society, employers, self, and students.

The most recent set of ethical standards adopted by NOHS in 2024 begins with a preamble that outlines the importance of each professional's behavior and the fundamental values of the human services profession.

Preamble

The preamble focuses on characteristics of the profession, such as helping others and paying attention to the context of individuals and families. It emphasizes the role of education and professional growth.

A key part of the preamble is the acknowledgment of conflicts that may exist between the code and other policies and expectations, such as employer policies, credentialing boards, laws, and personal beliefs, as indicated in figure 4.2. Each entity has some shared but some differing priorities, and this can lead to inconsistencies in what is best in any given situation. We will look at ethical dilemmas later on to help us understand this section of the preamble better.

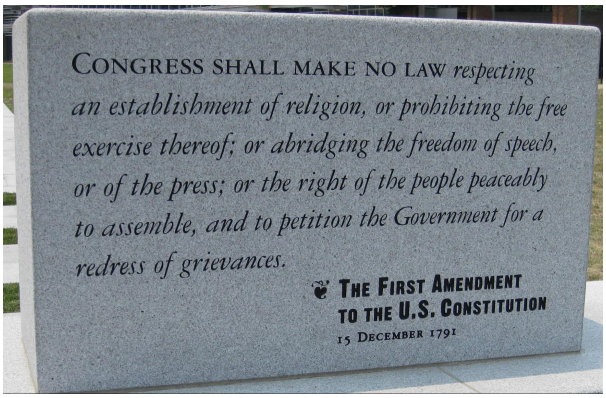


Figure 4.2. The First Amendment to the US Constitution establishes the right to free speech, but does that mean human service workers can say or do whatever they want? No. Laws against specific unsafe or debunked practices may exist, but codes of ethics go further in specifying which actions are unprofessional and why.

The fundamental values of human services are described as follows:

- Respect the dignity and **welfare** of all people.
- Promote self-determination.
- Honor cultural diversity.
- Advocate for social justice.
- Act with integrity, honesty, genuineness, and objectivity.

The preamble reminds us that professionals as well as students and educators are bound by these standards.

Ethical Standards

This next part of the NOHS ethical standards includes a brief introduction and then summarizes the forty-four standards into a bullet list. We will introduce some of the core codes that, in our opinion, will most help guide your introduction into the human services profession.

Professional Responsibilities

The NOHS ethical standards assign standards to seven groups: clients, the public and society, colleagues, employers, the profession, self, and students.

Responsibility to Clients

Clients are the first and most obvious group to highlight. The very first standard describes the responsibility of recognizing and building on individual and community strengths. The prominence of this statement emphasizes its importance. Overall, these standards focus on the professional–client relationship and how to maintain standards during your interactions with the client. There are nine total standards:

- Be strengths-based.
- Obtain informed consent.
- Observe privacy and confidentiality.
- Protect from danger or harm.
- Avoid dual or multiple relationships.
- Prohibit sexual or romantic relationships.
- Ensure that personal values or biases are not imposed.
- Protect client records.
- Utilize technology in legal and confidential ways.

This set of standards contains concrete actions, such as preserving the privacy and confidentiality of clients, as well as more abstract concepts, such as maintaining a **strengths-based approach**. Which of these standards might be most challenging to implement? How are we making considerations for communities that have limited language or cultural resources that will require some dual or multiple relationships, like those in rural communities, Native communities, and communities that have small numbers of people that speak a language? How are we evolving to make our services more accessible for people with different abilities? How can we advocate expanding internet access to communities that, according to the National Telecommunications and Information Administration, 58 percent of the United States population does not have?

Responsibility to the Public and Society

Human services professionals are not always focused on a singular client, or discrete clients and families. Listed second in the NOHS ethical standards is the responsibility to see how greater society affects individual problems as a requirement of the profession.

Understanding social problems, which involve any condition or behavior that has negative consequences for large numbers of people and is generally recognized as a condition that needs to be addressed by society, helps the professional to avoid blaming the client for their **personal troubles**. Multiple factors contribute to the complexity of social problems. Typically the solution to the problem needs to be systemic in nature; in other words, it cannot be solved by any one individual. For example, both **houselessness** and racism are considered social problems. Human services professionals need to recognize the effects of the social problems on individuals, as well as to work toward solving those social problems systematically.



Figure 4.3. The rights of gender nonconforming and transgender students is one area in which public policy may conflict with professional ethics, requiring advocacy to overturn unjust laws that endanger minoritized genders.

These nine standards remind us of the social justice mission of the profession:

- Provide services without discrimination or preference related to social characteristics.
- Be knowledgeable and respectful of diverse cultures and communities.
- Be aware of laws and advocate for needed change.
- Stay informed about current social problems.
- Be aware of social and political issues that differentially affect people.
- Provide ways to identify client needs and assets and advocate for needs.
- Advocate for social justice and to eliminate oppression.
- Accurately represent their credentials to the public.
- Describe treatment programs accurately.

Whether you work on the macro, mezzo, or micro level in human services, you must keep the macro—or societal—level in mind and work to decrease discrimination, disparities, and social problems. How are we using our social capital to bring voice to historically marginalized communities and center the experiences of those not in decision-making rooms?

Knowing the difference between having an interest in an area and having expertise in an area is essential. We must understand that we have to continue to learn and examine whether we are the best people to provide support or if we should uplift others within those communities to do so.

Responsibility to Colleagues

Being ethical in behavior toward colleagues is crucial to the healthy functioning of any agency, as well as across organizations. It's especially important to work together so that funding is used effectively and services are coordinated but not duplicated by multiple agencies. These four standards speak to the value of having integrity with everyone you work with:

- Coordinate, collaborate, but do not duplicate services.
- Deal with conflict by approaching the person directly; follow up with a supervisor if needed.
- Respond to unethical behavior of colleagues.
- Keep consultations between colleagues private.

You might not have considered having ethical responsibilities to colleagues, but you do! Are you practicing nonviolent communication principles or other communication with colleagues, as indicated in figure 4.4? Are you willing to challenge your colleagues, who may also be your friends?

Component	Communication
1. Observation	"When this happened..."
2. Feeling	"I've felt this way..."
3. Need	"Because I have a need/hope/value..."
4.Request	"Could you please...?"

Figure 4.4. Four components of the NVC Frame: Nonviolent communication involves observing what happened, stating one's feelings and needs, and requesting another person help you fulfill them.

Responsibility to Employers

The responsibility to your employer supports your commitment to clients and to the public. These three standards emphasize this, with a particular focus on seeking resolution if you experience a conflict of interest at work:

- Stick with commitments made to employers.
- Create and maintain high-quality services.
- In conflicts between responsibility to employer and responsibility to clients, seek resolution with all involved.

We must consider how the **intersectionality** of our identities impacts what this looks like for all parties involved: the client, the provider, the public, and the employer. What systems of power interact, and who benefits from each of these interactions? What will sticking to the commitments we made to our employers cost us in comparison to what sticking to the commitments to our clients cost us? Understanding the costs is a conversation we must understand how to navigate.

Responsibility to the Profession

Being responsible to the profession includes the commitment to lifelong learning and growth. It also means acknowledging that both workers and the profession itself need to be nurtured in order to continue to develop.

- Gain education and experience to work effectively with culturally diverse individuals based on age, **ethnicity**, culture, **race**, ability,

gender, language preference, **religion**, sexual orientation, socioeconomic status, nationality, or other historically oppressed groups.
- Know your own limits; serve others within those limits. Scope of practice is generally a term applied to professionals. It's essential when helping professionals/social workers/human service providers make a referral to a professional with knowledge, skills, abilities, and licensure/certification or the necessary training and experience to treat.
- Seek help when you need it. This does not only mean professional consultation from peers and supervisors. When we do not have the capacity to serve due to our personal resources being exhausted, we need external community and professional support.
- Promote cooperation among related disciplines. Transdisciplinary teams and interdisciplinary teams are good examples of what this could look like. Professionals who work in similar fields or fields adjacent to human resources—like early childhood, public health, education, occupational therapy, pharmacology, neurobiology, addictions, home visiting, community activism, conflict resolution, and **restorative justice**—are some of the fields are recommended to have a basic understanding of and make professional connections in to be able to not only have professional connections with but be able to do warm handoffs with when needed for referrals. We are all here to support and serve clients. We are just using different languages in our treatment plans. Let's learn each other's languages.
- Promote continuing development of the profession itself. This should be explored from different perspectives and sources outside the usual publishers. Consider looking at decolonized data authors, ethical data collection sources, more BIPOC and other diverse authors, open resources, and nonprofit and nonpartisan sources of information.
- Continue to learn and practice new techniques; inform clients appropriately. Use nonclinical language (also called plain language) when explaining what will happen in treatment to clients. Practice explaining text-heavy documents, such as informed consent and mandatory reporting requirements, to people of different ages, languages, and learning abilities. Can you explain that you are a mandatory reporter to a seventy-five-year-old monolingual English speaker as well as a seven-year-old for whom English is a second language? They both have the right to hear accurate information from you, and you have the ethical duty to explain this, or any new techniques, you may be using with them.
- Conduct research ethically. This is one of the most important ethical responsibilities that we have as a professional. Historically, helping professionals have caused irreparable damage to marginalized communities in the name of "science" and "helping advance" the field. Remember that there have ben hundreds of lives lost to unethical testing and non consensual testing done on Black and Brown bodies.
- Be thoughtful about self-disclosure, including on social media.

Being responsible toward your profession makes it more likely that everyone involved—agencies, professionals, and clients—will be successful.

Responsibility to Self

Being responsible to yourself is at the core of the ethical standards. The following three standards show that being self-aware of your emotions and health, as well as your own beliefs and biases, will make you a more effective and ethical human services worker:

- Develop awareness of your own culture, beliefs, biases, and values.
- Develop and maintain your own health.
- Commit to lifelong learning.

As a student, you know the challenges of balancing multiple responsibilities, including caring for yourself. While work life can be more focused than student life, prioritizing **self-care** is still challenging. Understanding the complex relationship with what health looks like for you includes the different domains of your life: spiritual, financial, mental, physical, emotional, friendship, familial, social, and environmental health. These form the umbrella of self-care in figure 4.5. Self-care is not a list of things to do, such as activities, but more about meeting your body's needs for sleep, nutrition, and human connection. Your whole life purpose is not to produce and center only work. Learn how to integrate work into your life and the other way around.



Figure 4.5. Self-care is essential to professionalism. If you are emotionally or physically exhausted, you will not be able to care for your clients and communities effectively.

Responsibility to Students

This is the only section of the standards that identifies a particular subset of human services professionals: the educators. Educators model the standards at the same time that they are teaching across the breadth of the profession. In particular the structure, quality, and adherence to the standards in the class setting, including field experiences, are the responsibilities of the educator. These eight standards emphasize the special duty that educators have to students who are in a relationship where power and status are unequal:

- Develop and implement culturally sensitive knowledge, awareness, and teaching methodologies.
- Commit to the principles of access and inclusion.
- Demonstrate high standards of scholarship.
- Recognize the contributions of students to the work of educators.
- Monitor field experience sites; ensure quality and safety.
- Establish guidelines for self-disclosure and opting out.
- Be aware of the power and status differential.
- Ensure students are aware of ethical standards.

Take a look at this set of standards from your position as the recipient of college faculty and internship supervisors' good faith efforts to meet these standards. Can you see the value and importance of educators adhering to a code of ethics? How do you do this within a classroom setting? How do you weave conversations about ethics into all course content and conversations?

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4.3 Complexities of Ethical Behavior

Let's dig a little deeper into some of the ethical **standards** and how they might lead to questions and dilemmas for practitioners. In this section, we will do the following:

- Focus on the ways that individual standards may support or conflict with one another.
- Contrast and compare common standards with national **culture**, policies, and practices.
- Focus on **social justice**.
- Draw attention to the importance of examining your own values more deeply and how those connect to the Ethical Standards for **Human Services** Professionals.

It is worthwhile to view the ethical standards in these multiple contexts, as in figure 4.6. Using and interpreting the ethical standards is a career-long process. Reminding ourselves that **ethics** is not something done when everyone is watching but when it is not always convenient and continual practice in the gray.

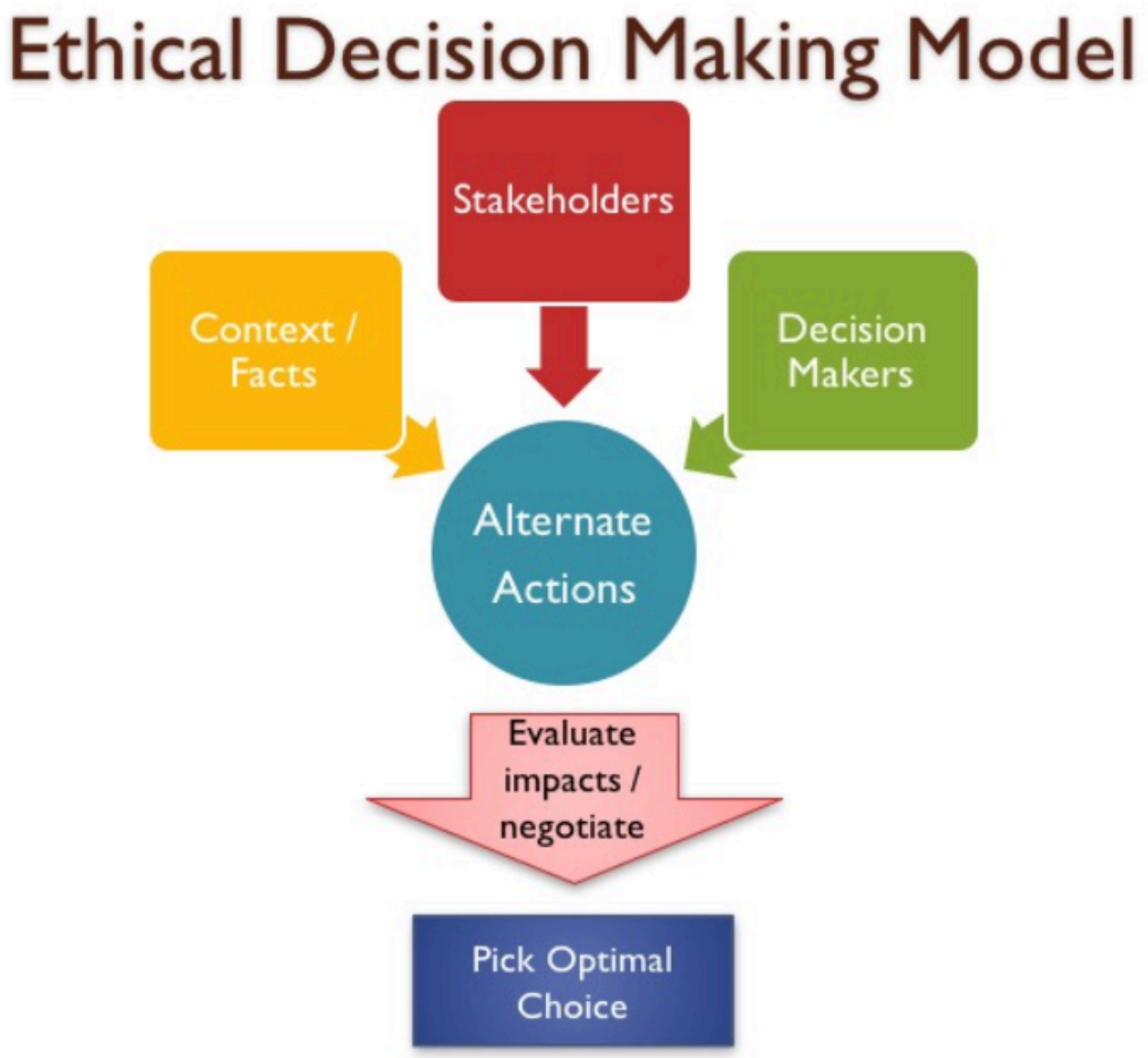


Figure 4.6. Often ethical questions do not have one straightforward answer. Gathering information from multiple stakeholders, evaluating alternative paths, and coming to the best possible decision can be a difficult and complex process.

Privacy, Confidentiality, and Safety

Let's start with something you may already be familiar with: privacy, confidentiality, and safety. While these may seem straightforward, there are other factors at play. Here are the full standards that describe these behaviors:

> STANDARD 3: Human service professionals protect the client's right to privacy and confidentiality except when such confidentiality would cause serious harm to the client or others, when agency guidelines state otherwise, or under other stated conditions (e.g., local, state, or federal laws). Human service professionals inform clients of the limits of confidentiality prior to the onset of the helping relationship.
>
> STANDARD 4: When a human service professional suspects a client's behavior may endanger themselves or others, they must take appropriate and professional actions to ensure safety, which may

include consulting, seeking supervision, or, in accordance with state and federal laws, breaching confidentiality. (NOHS, 2024)

These two standards helpfully highlight the conflict between them in the last sentence of Standard 4, which states that it might include "breaking the confidentiality of the relationship." Similarly, conflicting ethical standards appear in most codes for helping professions. Facing the **dilemma** of whether to break confidentiality in order to preserve someone's safety is one that many human services professionals will confront during their careers. In those circumstances, the worker should take into consideration:

- Applicable laws and regulations of the region (e.g., when and to whom are reports made)
- Workplace policies
- The worker's role (e.g., counselor, manager, student, receptionist)
- The Ethical Standards for Human Services Professionals
- Any other resources and expectations

Notice that the professional's own personal beliefs and values are not on this list. Nor are local or religious beliefs and values considered relevant to putting someone in danger. This relates to Standard 34 and the self-awareness that each professional is bound to keep regarding their own cultural backgrounds, values, and biases. What dilemmas might this pose for the professional?

Social Justice

Understanding that the systems of oppression and privilege have long-standing traumatic effects, as well as impacting clients' health, well-being, and socioeconomic status, contributes to your ability to be an effective professional. These standards articulate the responsibility of human services professionals to be aware and to advocate.

> STANDARD 14: Human service professionals are aware of social and political issues that differentially affect clients from diverse backgrounds.
>
> STANDARD 16: Human service professionals advocate for social justice and seek to eliminate oppression. They raise awareness about systems of discrimination and inequity that affect historically minoritized and marginalized groups and advocate for systemic change to address these inequalities within their workplace, communities, and legislative systems. (NOHS, 2024)

Let's look at a social issue, or **social problem**, currently affecting the United States and disproportionately affecting people who are in traditionally underrepresented ethnic groups. A social problem is typically defined as one that affects many people, affects the health and well-being of society, includes multiple causes and effects, and needs a systemic solution.

The COVID-19 pandemic is acknowledged to fit this definition. As a correlation, the disproportionate COVID-19 illness and death rate of people in ethnic minority groups could also be described as a social problem. In the United States (with data reported from 14 states), 33 percent of COVID-19 hospitalizations were among African Americans, although they made up 18 percent of the population in those states. With data from 51 states and territories, the reported death rates for Black, American Indian, and Alaska Natives was 1.4 times the death rates of White people. Latine people had a death rate that was 1.25 that of White people. Asians had the lowest death rate and were less likely than White people to die from COVID-19 (The Covid Tracking Project, 2021).

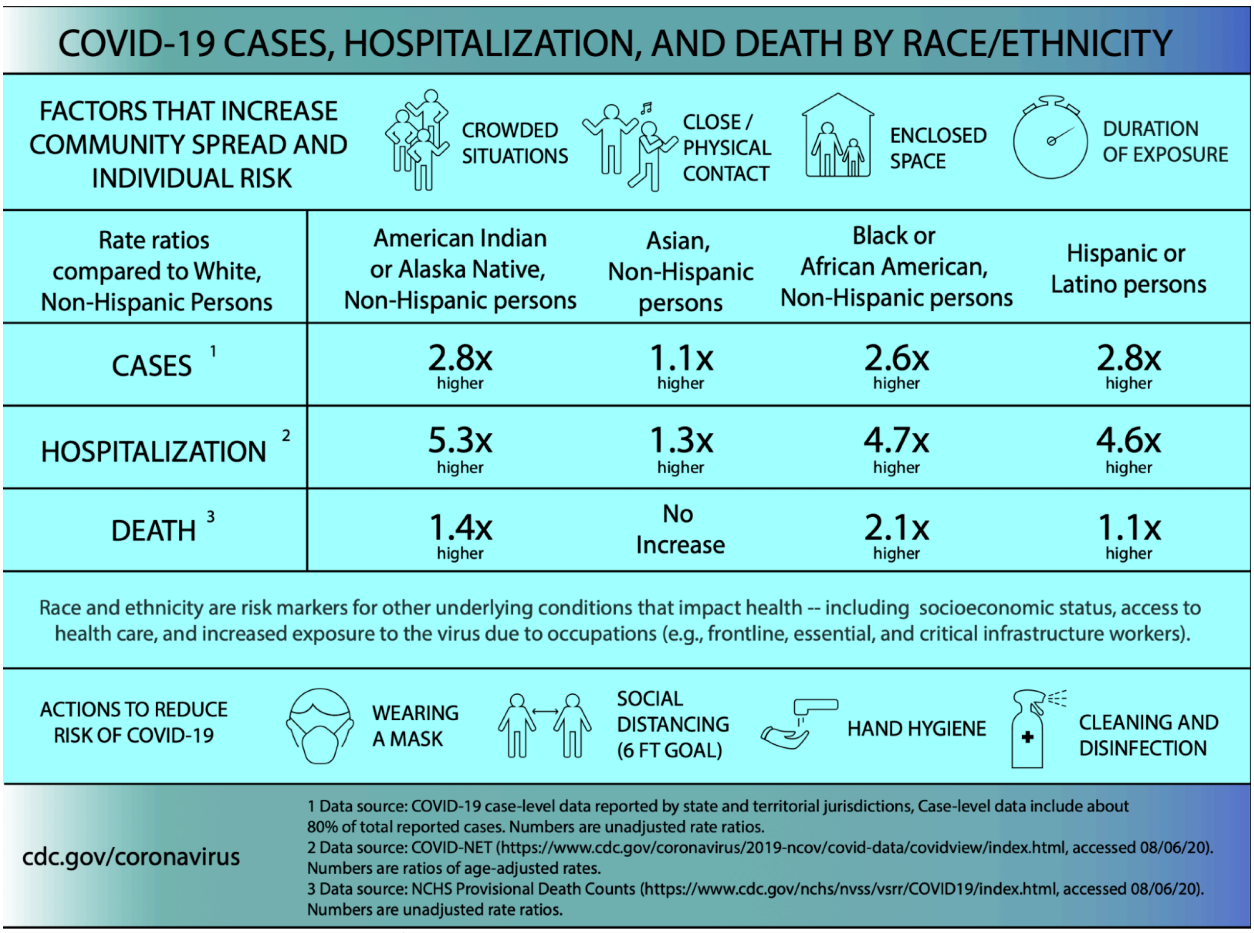
While we have the data to know that this is a social problem, how does this relate to the ethical

standards? Relatedly, what contributes to underrepresented groups being more likely to get sick and also more likely to die if they are hospitalized for the illness?

The answers are complex, but here are some conclusions drawn from the Centers for Disease Control and **Prevention** (CDC, 2020) and other data. People from underrepresented groups are more likely to experience the following conditions:

- Live in densely populated areas and housing with fewer services such as medical clinics.
- Use public transportation more.
- Work in jobs that are essential and/or require exposure to the public such as transportation workers, store clerks, and factories supplying food or other essential products.
- Work in jobs that have few or no benefits such as sick leave or health insurance, meaning that they may be more likely to go work even if they or family members are sick.

Although we have not discussed COVID-19 and age here, this chart is provided for contextual reasons (figure 4.7).



"CDC Chart" adapted by Katie Losier for accessibility purposes

Figure 4.7. The CDC collects data related to cases, hospitalization and deaths by race and ethnicity.

Access to health care services and health care insurance is inequitable in the United States. In particular, states that have not expanded **Medicaid** funding as allowed under the Affordable Care Act have higher populations of ethnically underserved groups.

Whether this information is brand new to you or you are familiar with this data, it seems obvious

that there are multiple social problems to be unraveled and examined. **Poverty** and low socioeconomic status intersect with the racial and ethnic inequities examined here. All of us have been affected by the pandemic. Some of us have personal experiences with illness and death related to the pandemic.

The question is, how does the human services professional adhere to ethical standards 14 and 16? Standard 14 talks about awareness. Just by reading this section of the textbook, your awareness has increased. What other steps could you take next to increase awareness? Standard 16 moves to another level, requiring the human services professional to advocate for social justice.

Advocacy takes many forms. Here are a few ideas:

- Educate yourself about information literacy. What are reliable sources of information? Help your clients understand how to understand information literacy in their own lives and how to ask questions of authority when they are unsure of their choices. Read and view those.
- Be aware of media bias and how it affects the information you consume. Evaluate media bias with questionnaires from organizations like the News Media Project, a nonpartisan education nonprofit that advances news literacy, is more engaged, is better informed, and empowers citizens. Look at this **infographic on news media literacy [PDF]** to improve your critical evaluation of news sources.
- Talk with people close to you. Share accurate information and inquire about why they have some long-held ideas that may be harmful. Are they open to hearing new information from you as their trusted source?
- Listen closely to people from underrepresented groups. Believe their experience. Stand by them. Bring stories that are not represented and use the systems of privilege that you are a part of to bring those forward in spaces where they are not normally heard.
- If you are from a historically and systemically underrepresented group and you feel comfortable and safe doing so, speak up and share your experiences. Your perspective is valid. Find people with whom you can build a community that shares similar identities to help you speak in spaces where you may be the only voices with your identities. Do so when ready to share your experience and not solely to educate others. This is an exhausting experience, and it can be dangerous, so know that you do not have to do this and that it is not your responsibility to do so. Your story is not the only story. (We), single stories, are not a monolith, so only do so if you have the time, energy, space, capacity, and community.
- Write a letter, send an email, call, or connect via social media to your political representatives and boards to change laws and policies that impact both how we practice ethically as human service providers and how all communities can have equal access to services. Remember, equality and **equity** are not the same thing. Do this through your local, state, agency, board, and national representatives and elections.
- Vote and help advocate for expanding and protecting voting rights for diverse groups. This includes stopping the movement to strip voter rights, the practices of gerrymandering and redlining, and using ID laws disguised as ways to restrict certain groups of people from accessing their right to vote.
- Take part in the U.S. Census and the American Community Survey. Help ensure that the census and other data-gathering instruments are valid and ethical. Consider diversity, how **trauma** impacts responses of the population, and how this information is kept anonymous and used. This also comes with a caveat that ethical data collection is critical. How do we

> store it? How long do we keep it? How do we keep it safe from parties that may want data in order to harm already vulnerable communities? How do we compensate people ethically for their time and information? How do we ask the right questions? Who is asking the questions? How is the data being collected? What are the right questions?

In the field of human services, there is an ethical responsibility to work toward a better society. The role a person plays in the workplace will define specific responsibilities and time allotment, but each professional will also have a commitment to the ethical standards and to working toward social justice.

Immersed in Values

Being aware of your own values is important self-knowledge, but it is even more critical to your work with clients. If you are not aware of your own values and beliefs, you may inadvertently make assumptions about others or project your own values onto clients.

> STANDARD 34: Human service professionals maintain awareness of their own cultural and diverse backgrounds, beliefs, values, and biases. They recognize the potential impact of these factors on their relationships with others and commit to delivering culturally competent services to all clients. (NOHS, 2024)

Our personal values and beliefs come from multiple influences: our families, geography, the time we live in, and one or more cultures, which may include **religion**. They also come from the broadly held values, policies, and culture of the United States, which we will focus on here for a moment.

Author David Foster Wallace, in a 2005 commencement speech, used a metaphor for the ways in which we can be unaware of the social constructs that we live within:

> There are these two young fish swimming along and they happen to meet an older fish swimming the other way, who nods at them and says "Morning, boys. How's the water?" And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes "What the hell is water?" (Wallace, 2009)

When we are immersed in something, we may not know exactly what it is. In the example above, the fish may not know to contrast water with other environments, like the earth or air. Living in the United States, we are grounded in ideas such as freedom, equality, and patriotism. But what do those words mean to you? And what do they mean in the context of the United States?

For example, the Declaration of Independence is commonly quoted to demonstrate that the United States is founded on equality: "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness."

But as we know, this declaration did not apply to all men in the United States, only to men who were White, and in some cases was limited to land-owners. (Early in the history of the United States, individual states regulated the right to vote, so there was variability about which White men had access to equality, including voting.) Not to mention women were excluded at a time when the White culture defined **sex** and **gender** using a binary system.

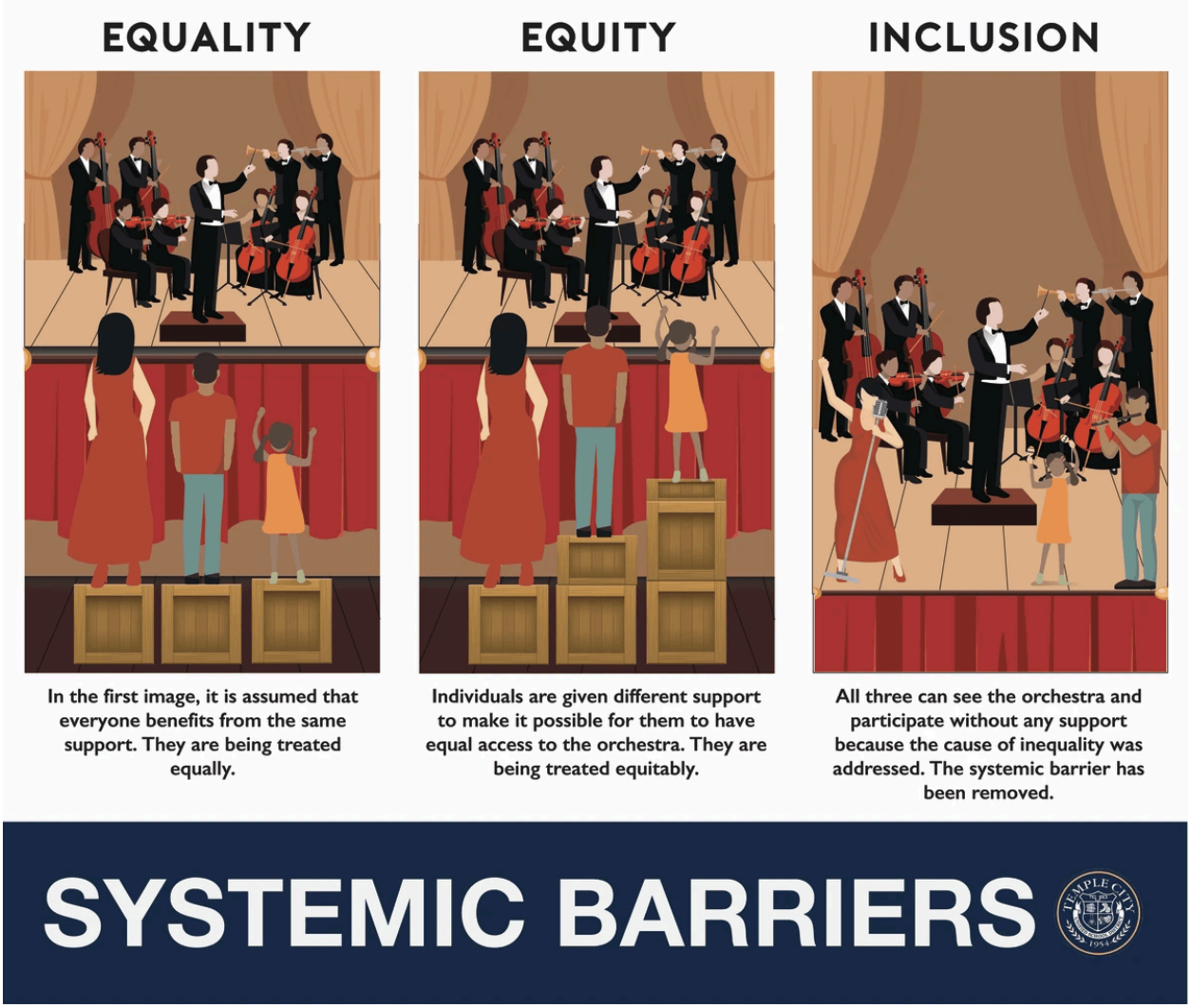


Figure 4.8. Visualizing equality, equity, and inclusion as a concert. What enables people to spectate and participate in other activities, like the concert? What prevents them? This figure shows another concept of equality, equity. However, it adds the complexity of inclusion of all of these concepts. As human service providers, these are going to be critical for you to consider depending on the system you are working in. **Image description.**

Remember that equality is one of the central principles of democracy and is based on the belief that all people should have the same opportunities to be successful and have a productive, enjoyable life. **Equality** is rooted in fairness, since it is linked to meritocracy. The idea of equality is key to the notion that everyone will be able to achieve based on their efforts and contributions to society instead of their status or position.

Equity recognizes that not everyone begins in the same place in society. Some people face adverse conditions and circumstances that make it more challenging to achieve the same goals with the same effort. Equity advocates for those who may have been historically disadvantaged, which made it difficult for them to be successful.

Inclusion ensures equal access and opportunities for all people, regardless of their **race**, gender, **disability**, medical, or other needs. It eliminates discrimination and intolerance, and removes barriers that might prevent people from fully participating in society. Inclusive practices promote fairness, respect, and diversity, and recognize the value of everyone's contributions.

Each professional needs to spend time thinking deeply about what their own values are and how they define those values. Examine the source of those values. If they come from the water that you are immersed in, it may be time to poke your head out to reexamine and redefine your perspectives and values.



Figure 4.9. Group consultation supports self-reflection by exposing you to other perspectives from valued supporters and colleagues.

Standard 34 is about awareness: deep knowledge about yourself and about how your culture, beliefs, biases, and values potentially interact with those of your clients and of society. This level of understanding does not come quickly or easily. While some of a person's core beliefs and behaviors may be stable over time, most people grow, change, and deepen in their thinking and beliefs. Age, experience, education, and action all contribute to greater self-awareness. Action can come in the form of reflective thinking and writing, interaction with other thinkers and practitioners, and thoughtful listening and discussion.

As a student in the field of human services or the social work field, you are engaged in this process simply by reading, reflecting, and discussing ethical standards. You are expected to have some answers and be engaged in the process. One way that students can engage in this ongoing process is through clinical supervision in both group and individual settings. This space, visualized in figure 4.9, will explore the interactions and clashes of personal and professional ethics. It will challenge how ethical decision-making processes explore not just the ethical code but also how laws, values, and intersecting identities impact these processes using an organizational structure.

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Figure 4.6. Ethical Decision Making Model by Shaun Taylor is licensed under CC BY-NC-SA 3.0.

Figure 4.8. "Systemic Barriers" by the Temple City Unified School District is in the public domain.

Figure 4.9. "Group talking" by RosZie is licensed under the Pixabay content license.

4.4 Ethical Decision Making

Human services workers must make difficult decisions, sometimes quickly, and sometimes without support or resources. It is helpful to have a model of decision making that you practice many times so that you can feel more confident about making decisions on your own.

The **ETHICS** decision-making model includes the following steps:

> **E**: Evaluate and define the problem. Examine relevant personal, societal, agency, client, and professional values. Gather information from all possible sources.
>
> **T:** Think about which ethical standard applies, as well as relevant laws and agency rules. Brainstorm possible actions and decisions.
>
> **H**: Hypothesize about the possible consequences of different actions.
>
> **I**: Identify who will benefit and who will be harmed.
>
> **C:** Consult with supervisor and colleagues about the most ethical choice.
>
> **S:** Select an action. Implement the action. (Ling & Hauck, 2016)

After the action has been implemented, an important final step is to evaluate the action. Who has been harmed? Who has benefitted? Did you gain any additional information that you wish you had known earlier? All of these questions will help you to evaluate the decision and inform your practice for the next time that you face a **dilemma**.

Activity: Ethical Dilemmas

As a human services worker, you are likely to face an **ethical dilemma**, a situation where there is not a clear answer right away, or when you are forced to choose between two or more decisions. Each choice might bring undesirable outcomes for one or more persons (Dolgoff et al., 2009).

For each dilemma outlined below:

1. Identify the **standards** that you would consider using to solve this dilemma.
2. Select the primary standard(s) from that group that speak most directly to this dilemma.
3. Make a note of all groups, both those you considered and those you ended up selecting.
4. Follow the steps of ETHICS and describe what you would do at each step and why.
5. What questions do you still have about the ethical dilemma?
6. What systemic barriers impact the ethical dilemma? How would your intersectional identities in the world influence how you relate to the experience of the clients described in the dilemmas?

Dilemma One: Fundraising

You work for an agency that serves middle school- and high school-aged youth. About one-third of the youth identify somewhere in the LGBTQAI+ community, and the agency hosts a regular support group for these youth.

It's time for the annual fundraiser, and your employer asks you to downplay any mention of the LGBTQAI+ support because some of the big funders are opposed to supporting people with this social identity. Another important factor is that you share an identity with the students you serve, so some of your own personal feelings are coming up as well.

Dilemma Two: Pediatric Surgery

You work as a peer support provider at a children's hospital, and you are present to help parents during complicated medical decisions. A surgeon at the children's hospital strongly recommends that a child have life-saving surgery. The parents of the child refuse to consent to the surgery due to their fears of the medical system, as they do not understand the medical system in this country. The surgeon asks you to convince the parents to agree to let her operate regardless of the parent's concerns, saying it is your job to "explain it so they will say yes."

Another factor to consider is that the parents' **first language** is not English. You are the only one who has been able to give them information in their language, as it is challenging to find interpreters for the language they speak. (Reminder: an interpreter mediates language using oral means, while translators use written means.) It would be helpful if you were better versed in medical terminology, as you have been in this position for only four months, come from law-focused interpretation training, and are still learning about the medical system.

Dilemma Three: Work Expectations

You are a volunteer youth appointment court advocate. A teen on your caseload calls you for help at a scheduled court hearing that has unexpectedly been moved up an hour. You had promised your employer that you would stay in the office to answer phones while the administrative assistant is at lunch.

This court hearing is essential, as the youth you are supporting has been making significant gains toward independence since the last court hearing. You are the only person with all the reports and updates from her therapist, teachers, and supervisor at work, which you are supposed to submit to the judge. The judge has made it clear that she needs to show responsibility, as emancipation would be the best option, rather than reunification with her parents.

You are unsure how to navigate your responsibilities with both your paid work and the commitment you made to your client as a court appointment advocate. Your supervisor is not very supportive of your volunteer time as an advocate for youth, but they cannot stop you as long as it does not interfere with your paid work duties.

WHICH CODES OF ETHICS WILL YOU USE?

In this chapter, you have developed an understanding of the NOHS Code of Ethical Standards. It's possible that you will use another professional code in your future work, such as:

- **The Code of Professional Ethics for Certified Family Life Educators, National Council on Family Relations (NCFR) [PDF]**
- **Code of Ethical Conduct and Statement of Commitment, National Association for the Education of Young Children (NAEYC) [PDF]**
- **Public Health Code of Ethics, American Public Health Association (APHA) [PDF]**
- **ACA Code of Ethics, American Counseling Association (ACA) [PDF]**
- **HS-BCP Code of Ethics, Center for Credentialing in Education (CCE) and National Organization for Human Services (NOHS) [PDF]**

If you are a human services worker in an early childhood education setting, you may be bound by the NAEYC code; if you work in a public health setting, it is likely that the APHA code will be used. You don't need to become an expert on all these codes just yet! But you should learn which code is used in any setting where you are doing volunteer work or an **internship**, or are employed. Even if your setting requires a different **code of ethics**, you should still keep the human services code in mind. Ethics are complicated, and these codes are designed to help you hold high standards and make the best decisions possible within your **profession**.

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4.5 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- An ethical code must be considered within the context of multiple systems. The most complicated involve the overlapping cultures that affect us: the cultural context of the individuals and families being served, the professional's own **culture**, societal values and policies, and workplace expectations. These are not to be given equal weight, but they are all factors in the work and ethical life of the helping professional.
- The purpose of presenting these interwoven concepts now is to give **human services** students an introduction to the ideas. Having an ethical code is a tool that will guide practitioners, the people they serve, and society.
- It is essential to understand that ethical codes are not the same as laws. Laws are enforceable and **ethics** are not, even if it seems it should be. Ethical codes are not enforceable by governmental agencies, like laws are. They are guidelines that carers have to function under set professional values and **standards**.

DISCUSSION QUESTIONS

1. What is the purpose of having a **code of ethics**?
2. What additional ways can you ethically advocate for clients, families, and their communities that are listed above?
3. What community or population would you struggle with the most when working ethically, as your personal and professional values do not match?
4. How will you use the systems of power you are part of to advocate for removing systemic barriers?

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CHAPTER

5

Social Safety Net Programs, Community Organizations, and Social Issues

5.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

STANDARD 13: Human service professionals stay informed about current social issues as they affect clients and communities. If appropriate to the helping relationship, they share this information with clients, groups, and communities as part of their work. (NOHS, 2024).

This chapter provides foundational concepts related to the work of **human services** professionals, including social safety net programs, community organizations, social problems affecting clients and communities, and social support programs found in communities outside formal government structures. Social problems affect all of society, yet they affect social groups differently. The relationship of social problems to **poverty** and **intersectionality** is essential for human services professionals to understand. Knowing that

problems are caused by social structures and not individuals helps us to be more compassionate.

This chapter provides an overview of conditions and characteristics that contribute to the environments where human services professionals work, the social problems they address, and the individuals and families they serve. This chapter will delve into the **origin** and evolution of community organizations that arose in response to their communities' unaddressed needs. These grassroots organizations were born out of a desire to take action where government agencies and other support structures needed to catch up in reaching these communities. Additionally, it will explore the reasons behind the lack of trust that some of these communities had developed towards governmental agencies, often stemming from historical experiences of harm.

LEARNING OBJECTIVES

1. Explain the concept of social safety net programs and their origins.
2. Describe the components of social problems and the responsibilities we have in the human services field.
3. Articulate the intersectionality between social identities and social problems.
4. Compare and contrast social safety net programs and **social insurance programs**.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

- Absolute approach: a way of defining poverty that designates a basic subsistence income level (the absolute version of a poverty line). Anyone who falls below that line is considered low income.
- Developmental approach: recognizes that social safety net programs are a necessary part of social and economic development
- Houselessness: (also known as housing insecurity) when a person lacks a reliable place to sleep and care for themselves
- Housing insecurity: conditions that might cause someone to become houseless or that are hazardous to the health of occupants of a residence
- Institutional view: the concept that social welfare programs are human rights and will always be a part of our society
- Intersectionality: a perspective that recognizes that individuals are impacted differently based on characteristics such as social class, race, ethnicity, gender, sexuality, ability, and age, and that it is important to look at the intersections of these identities.
- Poverty: the lack of material and social resources needed to live a healthy life

- Poverty gap: measures the difference between the poverty line and the actual income level of the average poor family
- Poverty line: minimum level of income needed to buy basic needs.
- Public issues: see definition for social problem
- Relative approach: a way of defining poverty that considers a person poor when their income is much lower than the typical income within a population
- Residual view: the concept that social welfare programs should exist only in times of particular need to avoid recipients becoming reliant on them
- Social insurance programs: a group of programs that take into account any contributions that the beneficiary has made to the program; these may be considered preventative
- Social issue: any condition or behavior that has negative consequences for large numbers of people and that is generally recognized as a condition or behavior that needs to be addressed (also known as public issues); systemic in nature
- Social safety net programs: a group of programs meant to alleviate the effects of poverty. Applicants must pass a means test in order to receive benefits.
- Sociological imagination: the ability to understand individual experience within the context of social structures.

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5.2 Social Welfare or Safety Net?

What comes to mind when you hear the word ***welfare***? If you're like some Americans, the word carries negative connotations. People often think of words like ***poverty***, *entitlement*, *handout*, or *free money* when they think of welfare. These terms have an association with poverty to many Americans, and they are connected to classist ideas and structures. They do not consider the ways systems of oppression have affected and continue to affect how different groups of people feel poverty. You may even have specific images of what people receiving any governmental support look like, learned from movies or media shown in previous literature. When our biases show up, it is critical the **human services** providers consider them when discussing clients and the definitions of words we use daily.

What the word *welfare* means is far less contentious and divisive. Welfare encompasses the overall state of well-being. Although welfare is often associated with specific public assistance programs, it is important to recognize that these programs are only part of a larger social safety net system. This system is composed of various organizations, programs, and agencies designed to provide support for individuals and communities in need.

The **social safety net system** is a comprehensive network of institutions that aims to address different aspects of people's lives. These include

their educational, financial, social, and health care needs. Institutions such as schools, colleges, and universities help people acquire knowledge and skills essential for their personal and professional growth. Financial institutions, such as banks and credit unions, help people to manage their money, save for the future, and access credit. Social welfare institutions, including community centers, social service agencies, and nonprofit organizations, aim to promote social well-being by providing assistance and support to those most in need. Health institutions, such as hospitals, clinics, and health centers, help people to maintain good physical and mental health.

In our daily lives, we encounter a myriad of social welfare institutions that are not only essential, but indispensable in supporting our well-being. Whether it is a childcare center that provides a safe and nurturing environment for children, a food bank that ensures access to nutritious food, or a shelter for the unhoused that provides temporary housing and support services, these institutions are the backbone of our communities. Here are a few more examples:

- Public education
- Police and fire departments
- Public libraries
- Hospitals
- Houses of worship
- City and state departments that determine funding for parks, roadways, bike lanes, and sidewalks, as depicted in figure 5.1
- Human services, social work agencies, nonprofit community organizations
- Counseling centers, food pantries, cultural community centers



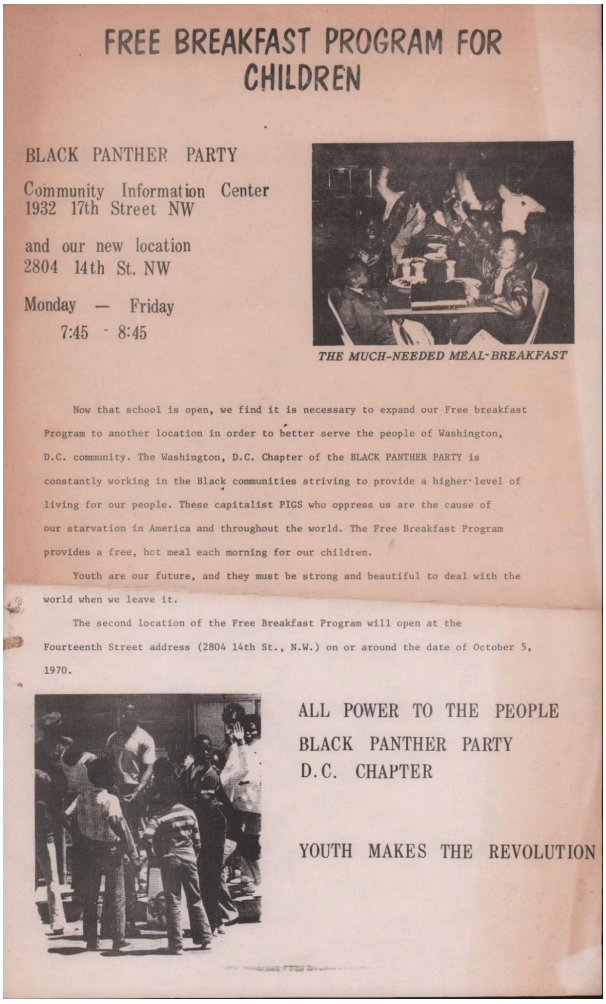
Figure 5.1 Places to walk, skateboard, bike, and drive contribute to the well-being of individuals, families, and communities.

The provided by human service workers in a variety of positions and roles have the common thread of working toward the well-being of individuals, families, and society. As you learned in Chapter 4, the Ethical **Standards** for Human Services Professionals states, "Human service professionals and those who educate them promote and encourage the unique values and characteristics of human services. In so doing, human service professionals uphold the integrity and **ethics** of the **profession**, promote client, and community well-being, and enhance their own professional growth" (NOHS, 2015). In other words, human services professionals are responsible for paying attention to all aspects of client and community well-being.

Safety Net Program Work and Its People

We need to consider how human services both as a field and as providers fit into this development and definition of the phrase safety net, as it encompasses so many social services for so many different populations of individuals, families, and communities. How can we fight against a system of harm while creating the system that is causing this harm?

The Developmental View of Social Welfare



FREE BREAKFAST PROGRAM FOR CHILDREN

BLACK PANTHER PARTY

Community Information Center
1932 17th Street NW

and our new location
2804 14th St. NW

Monday — Friday
7:45 - 8:45

THE MUCH-NEEDED MEAL-BREAKFAST

Now that school is open, we find it is necessary to expand our Free breakfast Program to another location in order to better serve the people of Washington, D.C. community. The Washington, D.C. Chapter of the BLACK PANTHER PARTY is constantly working in the Black communities striving to provide a higher level of living for our people. These capitalist PIGS who oppress us are the cause of our starvation in America and throughout the world. The Free Breakfast Program provides a free, hot meal each morning for our children.

Youth are our future, and they must be strong and beautiful to deal with the world when we leave it.

The second location of the Free Breakfast Program will open at the Fourteenth Street address (2804 14th St., N.W.) on or around the date of October 5, 1970.

ALL POWER TO THE PEOPLE
BLACK PANTHER PARTY
D.C. CHAPTER

YOUTH MAKES THE REVOLUTION

Figure 5.2. The federal School Breakfast Program arose from the success of the Black Panthers' mutual aid programs providing free breakfast to students. Its success also moved the director of the Federal Bureau of Investigation to dub the group "the greatest threat to internal security of the country."

Black Panther Party: Social Support Programs Began in BIPOC Communities

The Black Panther Party was founded with a clear purpose: to fight police brutality. However, it quickly expanded its mission and took bold steps toward social reforms. It advocated for prison reform, organized voter registration drives, established free food programs, opened free health clinics, and founded Freedom Schools. This innovative approach served as a model for many programs today that make a difference in the lives of people in need.

We see the evolution of those programs and models in action today: Women, Infants, and Children (WIC) programs, Supplemental Nutrition Assistance Program (SNAP), and free breakfast programs in public schools (as indicated in figure 5.2). But many people do not know that these programs have origins in the Black Panther Party and other nongovernmental entities.

It is essential that human services providers learn to explore networks and social support systems woven into communities. These networks have established trust in marginalized communities, where many people do not trust governmental agencies due to the systemic structures of racism and inequity the agencies were built on.

The Black Panther Party inspired other communities to establish similar groups. In 1968, José "Cha-Cha" Jiménez founded the Young Lords Organization (YLO) in the Lincoln Park neighborhood of Chicago, one of the city's most impoverished barrios. The YLO evolved from a Puerto Rican street gang into a community-based organization advocating for minority access to health care, education, housing, and employment, modeled after the Black Panther Party. The YLO welcomed individuals from diverse backgrounds, including African American, Latine, women, and LGBTQAI2S members, self-identifying as "revolutionist nationalists" advocating for Puerto Rico's independence and empowering people. The organization adopted a 13 Point Program and Platform, a set of policies, responsibilities, and principles that guided their work. The YLO expanded to other cities, including New York City. The YLO's success story demonstrates how a group of individuals can transform a community through advocacy and inclusivity.

Students' understanding of the history and overall how these groups started as "fringe" and

labeled as incredibly radical and now major governmental support programs that thousands of children and families benefit from daily. Considering the origins of programs and giving credit where credit helps innovate how we bring new perspectives to the field. Most importantly, push for less popular ideas now, as those can be the Head Start programs of the future.

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Figure 5.1. "Street" by Street Lab is licensed under CC-BY-NC 4.0.

Figure 5.2. "Black Panther Party Free Breakfast" is in the public domain.

5.3 What Is a Social Issue?

A **social issue** is any condition or behavior that has negative consequences for large numbers of people and that is generally recognized as a condition or behavior that needs to be addressed.

Multiple factors contribute to the complexity of social issues. A social issue emerges when a social change group successfully calls attention to a condition or behavior that it considers serious, like the protest in figure 5.3. Typically the solution to the problem needs to be systemic in nature; in other words, it cannot be solved by any one individual. This definition has both an objective component and a subjective component.



Figure 5.3. Protests like the one depicted here have raised the environmental consciousness of Americans and helped put pressure on businesses to be environmentally responsible.

Objectivity and Social Issues

The objective component of a social issue is this: for any condition or behavior to be considered a social issue, it must have negative consequences for large numbers of people. How do we know if a social issue has negative consequences? Reasonable people can disagree on whether such consequences exist and, if so, on their extent and seriousness. However, ordinarily a body of data accumulates—based on work by academic researchers, government agencies, and other sources—that strongly points to extensive and severe consequences. The reasons for these consequences are sometimes debated.

Let us look at two examples of trends that could be considered social problems: climate change and **(activation warning)** sexual assault or violence. Climate change, to simplify a complex scientific concept, refers to changes in the earth's climate due to the buildup of greenhouse gases in the atmosphere. Although the overwhelming majority of climate scientists say that climate change is severe and accurate, the percentage of Americans

who agree with scientists is lower. In a 2011 poll, 64 percent said they "think that global warming is happening" (Leiserowitz et al., 2011). While most Americans in 2020 believed that climate change is a **social problem**, there is still a discrepancy between the scientific community's and the public's views (Tyson & Kennedy, 2020).

Social identity and location influence viewpoints. Gallup polls have found that people in the West and Northeast, as well as younger adults, are more likely to believe that climate change is at least partially caused by human behavior and needs to be addressed (Reinhardt, 2018; McCarthy, 2019). Part of the issue is that the facts become subjective. How is this possible?

The social problem of sexual assault is, unfortunately, extremely common, especially among women. Sexual assault is defined as nonconsensual sexual touch according to the National Sexual Violence Resource Center (n.d.). However, sexual violence is experienced in different ways by different genders. According to a national study in 2018 completed by a non-profit Stop Street Harassment (SSH), 81% of women report some kind of sexual assault or harassment in their lifetime, and 43% of men reported some kind of sexual assault or harassment in their lifetime. SSH "is a volunteer-run nonprofit organization dedicated to documenting and ending **gender**-based street harassment worldwide through public education and community mobilization."

When looking at numbers alone, you can see that this is an issue that has a significant impact on a large number of people in this country. Resources must be dedicated to **prevention**, recovery, and repairing the trust of individuals who have been impacted directly and society as a whole. It has to consider consequences, if any, for the person for the sexual violence that was committed reported is made and the survivors are believed.

Subjectivity and Social Problems

The dispute over climate change points to the subjective component of social issues. There must be a perception that the condition or behavior needs to be addressed for it to be considered a social issue, and this viewpoint can change over time and location.

This component lies at the heart of viewing social issues as a social construction, which is something that can change over time and based on location (Rubington & Weinberg, 2010). In the social constructivist view, society must agree and develop a shared understanding that the problem, in this case climate change, actually needs **intervention**. We can see that multiple factors contribute to climate change and that if indeed it is to be solved, it will need a systemic solution.

An example of how perceptions of social issues can change over time can be seen in the history of attention given to **(activation warning)** rape and sexual assault or violence in the United States before and after the 1970s. Acts of sexual violence against womxn were common in the United States before the 1970s. Although men (most common people who committed assaults) were sometimes arrested and prosecuted for, sexual violence it otherwise ignored by legal policymakers. It was perceived as an individual problem.

Sexual assault received little attention in college textbooks and the news media, and many people thought that rape and sexual assault were just something that happened (Allison & Wrightsman, 1993). Thus, although sexual violence existed, it was not considered a social issue but more of a moral or a person's failure. This was a systemic way of blaming the victim and reinforcing patriarchy, sexism, and misogyny, with no room for **empathy**, accountability, or healing.

When the contemporary womxn's movement was recognized in the late 1970s, it soon focused on rape and other forms of sexual assault and violence as serious crimes and as manifestations of

womxn's inequality, as in the protest depicted in figure 5.4. Thanks to this focus, rape and sexual assault eventually entered the public consciousness. Views of these crimes began to change, and legal policy makers started to give them more attention. In short, sexual violence against womxn became a social issue.

In more recent years, with the #MeToo movement in 2017, many more women have come forward—and even some men—to tell their stories of suffering from sexual assault and violence at the hands of some prominent Hollywood studio people who can and have impacted many people's careers. Tarana Burke began the #MeToo movement in 2007, long before Hollywood (and, to be specific, white Hollywood) took up the hashtag. This made worldwide news and caused many to have serious conversations about consent in spaces that had not been open to it before. This does not mean that everything has changed; it is only that, as providers, we have seen societal shifts in ways we had not in years past. What other movements do we need to give more voice to?



Figure 5.4. Before the 1970s, rape and sexual assault certainly existed and were very common, but they were generally ignored and not considered a social problem. When the contemporary women's movement arose during the 1970s, it focused on sexual violence against women and turned this behavior into a social problem.

The social constructionist view raises an interesting question: When is a social issue a social issue? According to some sociologists who adopt this view, negative conditions and behaviors are not a social issue unless they are recognized as such by policymakers, large numbers of lay citizens, or other segments of our society. These sociologists would say that rape and sexual assault before the 1970s were not social issues because our society as a whole paid them little attention. We must consider that overall, men have more power in society than do women, and that this may affect the perception of rape as a social issue. The power differential is one of the multiple factors that affect this problem.

Other sociologists say that negative conditions and behaviors should be considered a social issue even if they receive little or no attention. These sociologists would say that rape and sexual assault before the 1970s were in fact social problems.

This type of debate is akin to the age-old question: If a tree falls in a forest and no one is there to hear it, does it make a sound? This thought experiment reinforces one of the key beliefs of the social constructionist view: perception matters at least as much as reality, and sometimes more so. Social constructionism emphasizes the idea that citizens, interest groups, policymakers, and other parties often compete to influence popular perceptions of many types of conditions and behaviors. They try to influence news media coverage and popular views of the nature and extent of any negative consequences that may occur, the reasons underlying the condition or behavior in question, and possible solutions to the problem.

We have an ethical duty to bring issues that impact marginalized communities to light when we are part of dominant systems. We need to start pushing back on the social construction of these definitions that do not benefit most or all of us, because when we uplift one group of people—the most marginalized groups—we uplift everyone. We cannot wait for things to be dire before taking action. Prevention is where we need to do work.

Social Problems and Human Services

You may be wondering what these large-scale problems have to do with the field of **human services**. There are several answers to this question. In Chapter 1, we discussed the macro, mezzo, and micro levels of human services work. Addressing these social problems would certainly be macro work. Helping to change the country's dynamics related to climate change or to rape and sexual assault would contribute to the well-being of many people. But social issues also impact humans on the mezzo and the micro scales, and many human services professionals will work with individuals who are experiencing these social problems along with overlapping **personal troubles**.

As a human services professional, you must be able to see the structural aspects of any problem that an individual is experiencing and avoid blaming the person as if there were a personal failing. Reviewing the criteria for what makes something a social issue can help workers understand the overarching nature of the problem: it affects large numbers of people, it is perceived to be a problem by many, there are multiple factors that contribute to it, and it needs a systemic solution.

ACTIVITY: HOW CAN YOU TELL IF SOMETHING IS A SOCIAL ISSUE?

To review, a social issue is typically identified with these criteria:

- negative consequences for large numbers of people (real or perceived)
- recognition from society as a condition that needs to be addressed
- complexity (multiple factors contribute to the problem)
- requires a systemic solution (can't be solved by an individual)

Which of the following examples meet the criteria for social problems? When do they become individual problems?

1. **poverty**
2. **houselessness**, **housing insecurity**
3. climate change effects, such as increasing wildfires and rising sea levels
4. unemployment
5. inequitable access to healthcare
6. food insecurity
7. food deserts or swamps
8. student (college/graduate) debt
9. disproportionate incarcerations of BIPOC communities
10. inequity in quality education

For each item you identified as a social issue, note the name of settings or programs that help address these problems in your local area. Review the list of social **welfare** and **social insurance programs** in Chapter 4 and use your own knowledge of community programs to answer.

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Figure 5.3. "**Financing Climate Change**" by Itzafineday is licensed **CC BY 2.0.**

Figure 5.4. "**Placards at the Rally To Take Rape Seriously**" by Women's e News is licensed **CC BY 2.0**.

5.4 Social Welfare Programs

Following the Great Depression (1929–1939), the United States developed its first programs meant to combat and prevent **poverty**. The programs discussed in this section fall under the category of **social welfare** or public assistance. This group of programs is meant to alleviate the effects of poverty, and applicants must pass a means test in order to receive benefits. The benefit levels are determined by factors within each individual case and depend on the program.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program that serves low-income Americans who are over the age of 65, blind, and/or have a **disability**. It is funded by general tax revenues rather than **Social Security** payroll taxes. The benefits provided under SSI are intended to help recipients pay for food, clothing, and shelter—the basic necessities (Social Security Administration, 2015a). The income level at which one qualifies is the same nationwide. Although it is a federal program, some states supplement the payments made to recipients (Social Security Administration, 2009). The maximum federal benefit payment in 2022 for SSI was $1,261 for an eligible couple and $841 for an eligible individual (Social Security Administration, 2022).

Medicaid

Established as an addition to the Social Security Act in 1965 under President Lyndon B. Johnson, **Medicaid** came into existence simultaneously with **Medicare**. People often get the names of these programs confused with each other; an easy way to remember the difference is to say "Medicaid is public aid." That is, Medicaid is health insurance available for the poor. Along with the Children's Health Insurance Program (CHIP), Medicaid provides insurance to 72.2 million Americans who might otherwise not be able to afford doctor's visits, emergency room visits, hospital stays, or medications (U.S. Department of Health and **Human Services**, 2021). Medicaid is funded through a combination of state and federal monies and is administered entirely by the states (Cox et al., 2016; Matthews, 2015). States had the option to expand Medicaid with federal funds designated by the Affordable Care Act; 39 states had done so as of 2022 (Kaiser Family Foundation, 2022).

Housing Choice Voucher Program

Commonly known as Section 8, the housing choice voucher program provides funding assistance to low-income families looking to obtain housing. There are four main kinds of vouchers: a Section 8 Project-Based voucher, Section 8 Housing Choice voucher, Section 202 Housing for the Elderly, and Section 811 Housing for Persons with Identified Disabilities, a voucher that can be used anywhere in the housing market.

To receive any kind of voucher, an applicant must qualify through the completion of a means application process. Different housing authorities have different income maximums for people to be eligible to receive assistance in these programs. The income limits for these programs are updated on an annual basis. For example, the top income for a family of four in Jackson County, Oregon, to qualify for a housing voucher in 2023 would need to be under $30,000, with the voucher being $621 for a two-bedroom. The family would be allowed two persons per bedroom, and details about how many people per bedroom depending on bedroom size, the relation of the occupants, and the ages of people residing in a bedroom.

Recipients of different kinds of vouchers still have to pay a portion of their rent every month, referred to as the total tenant payment (TTP). While many people who use housing vouchers live in housing projects, others live in residential homes, apartments, or other types of dwellings. The Department of Housing and Urban Development (HUD) sets eligibility limits based on family income and fair market rents (HUD, n.d.).

Supplemental Nutrition Assistance Program

Formerly known as food stamps, the Supplemental Nutrition Assistance Program (SNAP) provides financial assistance for low-income people to purchase food. Similar to the way the **poverty line** is designated, SNAP benefits are based upon a frugal but healthy meal plan. However, that plan (which the USDA calls "nutritionally adequate") requires nutrition knowledge, storage space, access to affordable markets, and equipment that may not be available or possessed by the poor (Levitan et al., 1998).

Food stamps began as a pilot program in several states thanks to an executive order by President John F. Kennedy, and they were made permanent by his successor, President Lyndon B. Johnson, in 1964 (Edelman, 2012; U.S. Department of Agriculture, 2014). By 1974, all counties in every state had to adopt a food stamps program, which made it "the country's single most effective **intervention** against poverty" and "unquestionably a successful public policy story" (Abramsky, 2013, p. 74; Edelman, 2012, p. 12). In 2019, 38 million Americans used SNAP benefits, just like the person in figure 5.5 (Hall, 2021).



Figure 5.5. SNAP benefits are now disbursed in all states via electronic benefit transfer (EBT), so people accessing their public assistance funds are virtually indistinguishable at the register from any other customer paying with a credit or debit card.

SNAP benefits currently give five million Americans an income boost that brings them above the poverty line, according to the Department of Agriculture (2014). SNAP benefits vary widely by state, with 2014's average monthly benefit per household of $463 in Hawaii at the high end and New Hampshire's $193 bringing up the rear. The average payment per household across all states in 2014 was $239 (or $139.50 per person, since the average SNAP household has 2.0 people). (U.S. Department of Agriculture, 2018).

There is an impression that people who use SNAP make bad diet choices, but the evidence doesn't support that assertion. SNAP participants are less likely to have excessive sodium in their diet, are less likely to exceed recommended maximum intake of saturated fats, and are just as likely to have adequate intake of vitamins and minerals (U.S. Department of Agriculture, 2015b). There are undoubtedly some people making unhealthy food choices, just as there are in other income groups, but SNAP participants face more stigma in general, including about food choices.

Healthy Meals for Healthy Americans

Formerly known as WIC (Special Supplemental Nutrition Program for Women, Infants and Children), Healthy Meals for Healthy Americans provides food, nutrition services, and access to health care for eligible women (typically pregnant women or new mothers), infants, and children up to age five who are considered to be at nutritional risk (U.S. Department of Agriculture, 2015a).

Though the official title of the program is no longer WIC, that name continues to be used even on a number of government websites, and you may have seen food for sale at your local grocery store on shelves labeled "WIC item." Families with an income up to 185% of the poverty line (for instance, $49,025 for a family of four in 2021) are eligible to receive benefits (U.S. Department of Agriculture, 2021).

Temporary Assistance to Needy Families

Under the Social Security Act, one of the public assistance programs founded was Aid to Dependent Children (ADC). The program was originally designed to provide financial support to low-income single mothers, often widows. The prevailing social sentiment of the day was that a mother's place was in the home, so the government provided ADC so these single mothers could care for their children at home with the help of public assistance (Levitan et al., 1998).

From the beginning, however, the program's delivery has had an element of institutional racism to it. Several states implemented policies after the founding of ADC that gave state employees administering the program the ability to deny benefits to any applicants that were deemed not to have "suitable homes." In practice, this meant nonwhite and families with children born out of traditional heteronormative marriage were disproportionately denied benefits (Levitan et al., 1998; Morgen et al., 2010; Schorr, 2001). Ideologically, the thinkers behind the expansion of welfare recognized that racism had contributed to income inequality and poverty; sadly, the programs they succeeded in putting into place served as yet another part of the problem (Morgen et al., 2010).

The program was rechristened Aid to Families with Dependent Children (AFDC) in the 1960s as it expanded to provide financial assistance to two-parent families rather than just households headed up by single parents. By the 1990s, a program that had originally been designed to care mostly for widowed mothers was more likely to be taking care of mothers who had never been married (Schorr, 2001).

As a bipartisan initiative, "welfare reform" in the 1990s instituted major changes to the AFDC program. The new program, Temporary Assistance for Needy Families was time-limited, required parents to work and divulge deeply personal information, and limited the federal government's future spending. As a result of these reforms, TANF reaches only 21% of eligible families in poverty whereas AFDC reached a peak of 82% of families experiencing poverty in 1979 and 68% of families experiencing poverty in 1996, the year prior to "welfare reform" (CBPP, 2022).

TANF recipients receive cash benefits equalling less than 30% of the federal poverty level in the majority of states. Basic assistance to families used to comprise 71% of the spending on TANF, but now families receive only 22% of all TANF funds to support their basic needs (CBPP, 2022). A 2022 report involving former National Football League quarterback Brett Favre provides an instructive example on how $6 million in TANF dollars can be spent on a volleyball stadium instead of the basic needs of families (Pittman & Pittman, 2022).



Figure 5.6. Despite ample evidence to the contrary, many Americans think parents receiving public assistance intentionally have more children in order to increase their benefit; in reality, the average family on welfare is 30% smaller than in the 1960s.

The social climate began to favor more women, including single mothers, entering the workforce. However, the AFDC rules until the mid-1960s required AFDC mothers to report any income they made so it could be deducted from their benefits. Unless the mother found a job that could pay them more than their AFDC benefits plus the cost of childcare, it simply made more sense to stay at home. They got no further ahead by working a low-paying job; they would be less financially stable and spend less time with their kids (Schorr, 2001).

Families were also getting smaller, as shown in figure 5.6, despite popular belief that unmarried mothers on welfare were having as many kids as possible to maximize their benefits. While a third of AFDC families had four or more kids in 1969, that was true for only about 10% of families receiving these benefits in 1987; by 1995, the average size of a family on AFDC had fallen from 4.0 to 2.8 (Levitan et al., 1998; Schorr, 2001).

This all led up to the elimination of AFDC in the 1990s. Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 and President Clinton signed it into law. This completely replaced AFDC with a program whose name rang a bit ominously: (TANF) (Morgan, Acker, & Weigt, 2010).

That first word is the key: temporary. The belief was that the vast differences between AFDC and TANF's rules would push low-income parents to "get off the couch" and into the workforce, if for no other reason than the benefits would run out. There were further provisions put into place as well. AFDC didn't require work, but TANF benefits would end after two years in most cases if a recipient wasn't working.

Was it effective? The language and idea that was used and considered for these programs when started was mixed. It did not consider how some communities had systemic barriers that they needed to overcome and it was not just parents who needed these supports.

Social safety net programs are supposed to be temporary for people; however, over the implementation of the program, the population of people who are in need of support for TANF are in need of much more long-term supports become of the lack of change in the federal poverty guidelines

and the increase in cost of living in every other aspect. The idea is temporary in a society that has not had an increase in their federal poverty guidelines in decades and not considering how global pandemics, social unrest, racial tensions, and climate change have deeply impacted how everyone is not living. The fact that a single-income household still cannot make enough money for their monthly bills but makes "too much" for TANF or Free or Reduced Lunch at their children's schools is incomprehensible. But this is America.

All the programs noted in this section are not only social safety net programs but also part of the many systems that we human service providers will be working in and trying to reform to be more equitable for all clients and communities, including those that are underserved and marginalized.

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Figure 5.5. "**Buying food with the EBT card**" by **Bread for the World** is licensed under **CC BY-NC-ND 2.0**.

Figure 5.6. "**Family of Three**" by **iMorpheus** is licensed under **CC BY 2.0**.

5.5 Social Insurance Programs

Social insurance programs differ from social **welfare** programs in that they take into account any contributions that the beneficiary has made to the program. These programs may be considered more preventative in nature than **social welfare programs**.

Social Security Disability Insurance

Social Security Disability Insurance (SSDI) covers individuals who have worked enough years to qualify for Social Security payments if they become disabled with a condition that "is expected to last at least one year or result in death" (Social Security Administration, 2014, p. 4). Since this is not a public assistance program, applicants do not need to pass a means test. Benefits can also extend to some family members. After receiving SSDI benefits for two years, the recipient automatically becomes eligible for **Medicaid** benefits as well. (Social Security Administration, 2014).

Medicare

Medicare is a program funded by tax revenues that provides financial assistance for medical care for the nation's elderly, retired, and some people with disabilities, as shown in figure 5.7. Much more complex than Medicaid, Medicare's benefits come in various forms (Part A, Part B, Part C, Part D). Part A (inpatient hospital coverage) is free, with the remaining optional components requiring the payment of a premium. Medicare is addressed in greater depth in **Chapter 8**.



Figure 5.7. Medicare and Social Security are both programs which benefit older Americans, along with other groups of people.

Social Security

Old-Age, Survivors, and Disability Insurance (OASDI) is the formal name for the program we more typically call Social Security. It provides an income to "qualified retired and disabled workers and their dependents and to survivors of insured workers" (Social Security Administration, 2011). Over 50 million Americans receive benefits, including more than 85% of those aged 65 or older (Social Security Administration, 2011). Although it was never designed to be the primary source of income for the elderly, it is at least 90% of the income for 22% of married couples, and 43% of the income for other individuals aged 65 or older (Social Security Administration, 2011).

There is some concern about the long-term viability of Social Security due to the increasing average age and life expectancy of Americans, coupled with the trend of companies encouraging older workers to go into early retirement (Baker & Weisbrot, 1999). Some people will see little return on their Social Security tax payments, while others will draw much more out of the system than they put into it. The maximum monthly benefit payable to a retired worker in 2021 was $3,148, but they could only collect that much if they had earned $142,800 or more each year over a 35-year working career. The average retiree's monthly Social Security payment in 2021 was $1,543 per month (Brandon, 2021). Social Security will be discussed more in depth in Chapter 7.

Unemployment Insurance

Unemployment insurance (UI) is aimed at preventing recently unemployed workers from slipping into economic despair while they search for a new job. There is no means test, and benefits paid out are based on earnings from one's previous job. The program is funded by a tax paid by employers rather than employees (Conrad, 2008). Workers can generally apply only if they've been laid off, but in some cases people who have been fired are eligible (Kirst-Ashman, 2013). In order to continue to receive benefits, one must also be actively looking for work and be able to furnish proof of that fact (Stone & Chen, 2014).

Each state runs its UI program quite differently. Payment levels are determined by how much the worker earned while working and what the average income is in that state, and benefits are often capped at around half the worker's previous earnings (Levitan et al., 1998). During the COVID-19 pandemic, the federal government also provided additional payments beyond state unemployment payouts, adding $300 per week for many people in need (Guerin, 2021).

Workers' Compensation

Like UI, worker's compensation insurance is meant to help people stay out of **poverty** during temporary loss of income—in this case, due to an injury or disease incurred on the job. Workers' compensation is designed to cover lost wages, medical treatment for the condition, and possible rehabilitation, and to compensate one's family in the event of a workplace-related death (Levitan et al., 1998; Matthews, 2015). However, the total of

an individual's disability benefit payment (if any) and worker's compensation payment cannot exceed more than 80% of their working income (Matthews, 2015).

ACTIVITY: IS THE U.S. REALLY A MERITOCRACY?

Earlier in the chapter, we asked if most of the hardworking people in the United States could be concentrated in the top 10%, or the top 1%? A meritocracy, which many believe the United States to be, would make this possible. Imagine the following scenario, which illustrates vividly the relative lack of connection between hard work and economic success.

An educated white man, Mark, was laid off after over three decades working as a mechanical engineer. He was in his mid-fifties at the time, making over $100,000 a year, and had started working on his master's **degree** in business administration (MBA). He continued to go to school after being laid off and finished that degree, all while struggling to find new work in his field.

With multiple patents to his name, managerial experience, and decades' worth of knowledge—plus now an advanced degree—one would think that it would be easy for him to find another job. He did find a new job assembling bicycles at a bike shop for a few months, but he left because of the shop owner's racist views. Then, he was a shelf stocker in a grocery store's liquor section. Then, he took a job as a school bus driver. Over those years, he put out dozens, perhaps hundreds, of resumés and scored many interviews, but never an offer that would put him back into engineering or management.

Why couldn't he find a well-paying job? Why did he often have to settle for low-wage manual labor? A lot of factors led to his predicament. His decades of experience and his advanced degree had in some ways made him more difficult to hire because he legitimately would have commanded a high salary. When he applied for jobs that paid less but for which he was overqualified, he would not get offers, perhaps because the employers were afraid he'd leave once he got something better. Some people in the industry even recommended he take his MBA off his resumé so human resources managers didn't see him as too expensive to hire.

Mark was a lot more fortunate than most, since he had a well-paying career before his years of unemployment and underemployment. However, if the system favored those who got educated and worked hard, he would have had a lot more success in his job hunt. He has since become disabled, and now at age sixty-four he would have almost no chance of getting a job in his field since people would just see him as a soon-to-be retiree. It's likely that many readers know people with similar stories.

Reflection questions:

1. What public safety net programs would you recommend restructuring and why? How?
2. Can you think of other examples that demonstrate whether or not the United States is a meritocracy?

There are many factors that people cannot control that cause them to be unemployed, to file for bankruptcy, or to apply for public safety net programs. It is our job as social workers to know that what our clients really need is not judgment. They need someone to recognize that they are people who have a story and deserve an opportunity to get on their feet, regroup, and keep fighting against a powerfully unequal system.

Conclusion: Progress and Change

Social problems are persistent. They have continued for decades and even centuries, and some appear to worsen over time. In view of social problems' long history, certainty of continuing for some time to come, and serious consequences, it is easy to feel overwhelmed when reading about them, to think that little can be done about them, and even to become a bit depressed. As a result, it is easy for us to come away from a chapter about social problems and poverty with a rather pessimistic, "doom and gloom" outlook.

But there can be progress, and conditions change. Although social problems are indeed persistent, some problems are less serious now than in the past. Change is possible. As just one of many examples, consider the conditions that workers face in the United States. Many people today are unemployed, have low wages, or work in substandard and even dangerous workplaces. Yet they are immeasurably better off than a century ago, thanks to the US labor movement that began during the 1870s. Workers now have the eight-hour day, the minimum wage (even if many people think it is too low), the right to strike, and workplaces that are much safer than when the labor movement began. In two more examples, people of color and women have made advances since the 1960s, even as they continue to experience racial and **gender** inequality. To repeat: Change is possible.

How does change occur? One source of change in social problems is social science theory and research. Over the decades, theory and research in sociology and the other social sciences have pointed to the reasons for social problems, to potentially successful ways of addressing them, and to actual policies that have succeeded in addressing some aspect of a **social problem**. The findings from sociological and other social science research have either contributed to public policy related to this chapter's social problem or have the potential of doing so. Frequently, **human services** professionals are involved in making changes at the macro level or implementing those changes on a mezzo or micro level, alongside communities and individuals.

The actions of individuals and groups may also make a difference. Many people have public-service jobs or volunteer in all sorts of activities involving a social problem. They assist at a food pantry, they help clean up a riverbank, and so forth. Others take on a more activist orientation by becoming involved in small social change groups or a larger social movement. Our nation is a better place today because of the labor movement, the Southern civil rights movement, the women's movement, the gay rights movement, the environmental movement, and many others. Ordinary people can change America (Piven, 2006).

Sharing this view, anthropologist Margaret Mead once said, "Never doubt that a small group of thoughtful, committed citizens can change the

world. Indeed, it is the only thing that ever has." Change is not easy, but it can and does occur. In this optimistic spirit we see examples in this book of people making a difference in their jobs, volunteer activities, and involvement in social change efforts.

Change also occurs in social problems because policymakers (elected or appointed officials and other individuals) pass laws or enact policies that successfully address a social problem. They often do so only because of the pressure of a social movement, as pictured in figure 5.8, but sometimes they have the vision to act without such pressure. It is also true that many officials fail to take action despite the pressure of a social movement, so those who do take action should be recognized.

An example involves the former governor of New York, Andrew Cuomo, who made the legalization of same-**sex** marriage a top priority for his state when he took office in January 2011. After the New York state legislature narrowly approved same-sex marriage six months later, Cuomo's advocacy was widely credited for enabling this to happen (Barbaro, 2011). Other states legalized same-sex marriage, while some specifically outlawed it. This led to a Supreme Court case (Obergefell v. Hodges, 2015), and the federal decision to legalize same-sex marriage throughout the country.



Figure 5.8. Social Movements can contribute to change and increased equity.

Despite its great wealth, the United States ranks below most of its democratic peers on many social indicators, such as poverty, health, and so on (Holland, 2011; Russell, 2011). A major reason for this difference is that other democratic governments are far more proactive and collective-minded in terms of attention and spending than the U.S. federal and state governments are in helping their citizens.

A final source of change is the lessons learned from other nations' experiences with social problems. Sometimes, these lessons for the United States are positive ones, as when another nation has tackled a social problem more successfully than the United States, and sometimes these lessons are negative ones, as when another nation has a more serious problem than the United States and has made mistakes in addressing this problem. The United States can learn from the good examples of some other nations, and it can also learn from the bad ones. In this regard, the United States has much to learn from the experiences of other long-standing democracies like Canada, the nations of Western Europe, Australia (figure 5.9), and New Zealand.

As human service providers, we have become the front line in many ways of communities that are impacted by systems that have been harmful to them by oppressive systems that have often

blamed individuals for lack of "will" instead of those systems taking accountability for not being created or prepared to support the needs of diverse communities.

Our job as providers is to continue to expand how we look at welfare support systems to develop clients' access to those systems sustainably through community interdependence and decrease shame when in need of support systems.



Figure 5.9. Many other democracies, including Australia, rank higher than the United States on poverty, health, and other social indicators. For this reason, the United States may have much to learn from their positive examples.

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5.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- There is a tension between the residual and the **institutional view** of social **welfare** in the United States, resulting in a more realistic view, the **developmental approach**.
- Social problems have existed for decades or even centuries, but many of these have also lessened in their seriousness over time, and change in the future is indeed possible.
- Social safety net programs and **social insurance programs** help people to maintain a decent standard of living.

DISCUSSION QUESTIONS

- Select an example of a "private trouble" and explain how and why it may reflect a **social problem** in society.
- What makes **poverty** a social problem?
- Have you participated in any volunteer or other activity involving a social problem? If so, why did you do so? If not, why have you not participated in such an effort?
- What other social safety net programs do you know of that have some biased language around them that you can think of growing up? How have you unlearned that? What do you need to continue to unlearn?

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CHAPTER

6

Models of Care: Medical, Public Health and Human Services

6.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 14: Human service[s] professionals are aware of social and political issues that differentially affect clients from diverse backgrounds (NOHS, 2024).

In Chapter 5, we discussed social problems that affect many people in the United States, as well as social safety net programs that help individuals and families. In Chapter 6, we will begin to look more deeply at health and healthcare settings.

It is important for **human services** professionals to be aware that social problems and political issues can affect different populations disproportionately and in diverse ways. Standard 14 reminds us that we need to pay attention to the macro view of these problems and issues even when we are working one-on-one with a client or patient. We must practice cultural humility and be especially aware of populations in marginalized groups who have less power as they experience change, social problems, and political issues.

LEARNING OBJECTIVES

1. Describe how different models of care and social determinants of health affect health outcomes.
2. Explain the different types of human services agencies that are organized within health care settings.
3. Analyze the difference and overlap between three models of care: medical, public health, and human services.
4. Describe the roles for human services workers in the three models of care.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Health disparities: preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations
- Intervention: action taken to improve a situation or address a problem
- Medical model: providers address the needs of the consumer when problems are presented.
- Prevention: strategies developed to fend off problems
- Public health: The three fundamental aspects of public health are prevention, protection, and promotion. These functions play a crucial role in keeping individuals and communities healthy. Public health professionals primarily focus on preventing illnesses, injuries, or fatalities, protecting vulnerable groups, and promoting healthy lifestyles, actions, and laws that can enhance health and safety.
- Social Determinants of Health (SDOH): health disparities directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.
- Rehabilitate: relearn or reform behaviors
- Remediation: the correction or reversing of actions or behaviors
- Wellness model: help consumers maintain their health, prevent illness, and work with sick patients to make long-term improvements to their health, holistic care.

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6.2 Understanding Health Care Settings

Human services practitioners work with many clients who are also interacting with the health care system. Whether or not you are working in a health care setting, it is important to understand how health care and health insurance are organized in the United States.

In addition, workers must understand that physical and mental health are interrelated, although they have been socially constructed in the Western worldview as being separate, with mental disorders being stigmatized. Often mental illnesses, such as depression or anxiety, have been seen as something that a person should and could "get over," as opposed to a physical ailment, such as a sprained ankle or strep throat, that merits medical attention and assistance.

Over time the Western worldview has become more understanding of the connections between physical and mental health, but the socially constructed difference still affects individuals and families. In this chapter, we will talk about both physical and mental health; chapter 6 will focus on mental health.

Models of Care

One of the debates over quality health care focuses on whether the health care system should aim to treat or prevent illness. This is known as the medical model versus wellness model of health care. In the **medical model**, providers address the needs of the consumer when problems are presented. This can be compared to fixing a machine when it breaks down. This reactive approach is dedicated to diagnosing and treating illness when a patient presents with a problem. This has been known as the Western medical model of care, which treats the symptoms but does not always look toward healing as the primary reason for interactions with clients. The **wellness model**, on the other hand, focuses on helping consumers maintain their health, on preventing illness, and on working with sick patients to make long-term improvements to their health, holistic care.

In 1978, the World Health Organization (WHO) proposed moving away from the medical model to view health as a dynamic way of being instead of a specific goal to achieve (Ghebreyesus, 2020). Today, we use the wellness model of healthcare to better understand how daily habits and regular preventative care can add to the positive health of an individual. If you are a human services worker in a medical setting, you may be involved with helping to educate individuals or a community about the benefits of preventative care and to teach them how to get and stay healthy.

Health and Well-Being

Current longevity in the United States has been greatly impacted by advances in medicine. We have come a long way from the medieval practices of bloodletting and using bottled flatulence to ward off the Black Death. It seems that every day there is a new study, revolutionary drug, or innovative procedure that can improve outcomes for people of every age. Health care services, therefore, can still greatly improve someone's quality of life, whether that person gets cured, their illness is managed, or they are made comfortable as they approach the end of their life.

However, Americans lag behind their counterparts in other countries when it comes to our health. Compared to our peers in 16 similar high-income nations, such as Japan, China, Britain, and Australia, the United States fares worse in several areas, including infant mortality, injuries and homicides, heart disease, and **disability** (Institute

of Medicine of the National Academies, 2013). The same report identified inaccessible and unaffordable health care, poor diet and lifestyle choices, **poverty**, and convenience as factors in the disparity between the United States and similar countries.



Figure 6.1. Social determinants of health emphasize how health, disability, and early death are impacted by more than a person's genetics or life choices.

Differences in health status are not just the result of individual behavior but of **social determinants of health** (SDOH). These are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC, 2008). Populations can be defined by factors such as **race** or **ethnicity**, **gender**, education or income, disability, geographic location (e.g., rural or urban), or sexual orientation. Health disparities are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources.

Dimensions of Diversity and Health Disparities

The following text explores the significance and relevance of specific numbers in our work as human services providers. As we delve into the impact of social determinants of health on care models, we find that SDOH encompasses the various factors contributing to social disadvantages, which in turn lead to unequal access to care for specific populations. Race plays a significant role in determining access to care, ranging from basic medical insurance to dental services.

To be successful as human services providers, it is crucial to consider how our intersectional identities influence the analysis of the data we encounter. Our experiences, biases, and assumptions can affect how we interpret information. It is essential to recognize and challenge our biases to provide fair and equitable care to all individuals.

Moreover, we must consider how we address these disparities when navigating the care systems we work in. The lack of access to health care services can have truly devastating impacts on individuals and communities, underscoring the urgency of our work. It is our responsibility as human service providers to identify the root causes of these disparities, advocate for policy changes, and work toward creating a more equitable healthcare system for all.

By examining the significance of specific numbers and understanding the impact of social determinants of health, we can provide better care to those who need it most. This understanding also paves the way for us to work toward creating a fairer and more just healthcare system, a goal that should inspire and motivate us all.

Health disparities plague the United States as well. The environments in which people live, work, learn, and play affect family and individual health. Social determinants of health, such as social engagement, access to resources, safety, and security, are all impacted by the settings where families spend their time. Simply put, place matters when it comes to health. Health disparities result from multiple factors, including:

- Poverty
- Environmental threats
- Inadequate access to healthcare
- Individual and behavioral factors

Health disparities between Black and White Americans show a clear gap. In 2021, the average life expectancy for White adults was approximately six years longer than for Black adults: 76.4 compared to 70.8. An even more substantial disparity was found in 2008: the rate of infant mortality, which is the number of deaths in a given time or place, for Black infants was nearly twice that of White infants, at 10.4 compared to 4.4 per 1,000 live births (Hill et al., 2023).

Research has shown that individuals who identify as BIPOC are more likely to forgo medical care due to cost and lack of a personal healthcare provider compared to their White counterparts. According to recent data, a significant portion of Hispanic adults (34%), American Indian/Alaskan Native adults (24%), and Native Hawaiian/Other Pacific Islander, Asian, and Black adults (21%, 19%, and 18%, respectively) do not have a usual doctor or provider (Hill et al., 2023). Furthermore, individuals from Hispanic (18%), American Indian/Alaskan Native (15%), Native Hawaiian/Other Pacific Islander (14%), and Black (14%) communities are more likely to have missed a doctor's appointment in the past year due to cost. Asian adults (7%) are less likely to do so. Additionally, Asian (33%) and Hispanic (36%) adults are more likely to have skipped a routine checkup in the past year compared to White adults (30%), while Black adults (21%) are less likely to have done so. Lastly, as of 2020, all BIPOC adults are more inclined than their White counterparts to have missed a visit to a dentist or dental clinic in the past year.

Studies have revealed that individuals who identify as Black, Hispanic, American Indian/American Native, and Native Hawaiian/Other Pacific Islander are more likely to experience food insecurity compared to their White counterparts (Hill et al., 2023). As of 2021, approximately 12% of Black adults and 8% of Hispanic adults faced low food security, which is significantly higher than the 4% of White adults who experienced this issue. Additionally, Black (13%) and Hispanic (11%) children were over twice as likely to experience food insecurity than White children (4%). However, no disaggregated data is available regarding American Indian/Alaskan Native and Native Hawaiian/Other Pacific Islander adults and children (KFF, 2021).

Furthermore, research has shown that individuals who identify as Black, Hispanic, American Indian/American Native, and Native Hawaiian/

Other Pacific Islander are more susceptible to being diagnosed with HIV or AIDS compared to their White counterparts (Hill et al., 2023). In 2020, the rate of HIV diagnosis for Black people was approximately seven times higher than the rate for White people, and the rate for Hispanic people was about four times higher than the rate for White people. Similarly, the rates of HIV diagnosis for American Indian/American Native and Native Hawaiian/Other Pacific Islander individuals were also higher than the rates for White people. The same pattern was observed in AIDS diagnoses, with Black people having a roughly nine times higher rate of AIDS diagnoses compared to White people, while Hispanic, American Indian/American Native, and Native Hawaiian/Other Pacific Islander people also had higher rates of AIDS diagnoses. Fortunately, the diagnosis rates for most groups have decreased since 2013. However, the HIV diagnosis rate has increased for American Indian/Alaskan Native and Native Hawaiian/Other Pacific Islander individuals.

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Figure 6.1. "**The five social determinants of health**" by the U.S. Centers for Disease Control and Prevention is in the Public Domain.

6.3 Organization of Health Care Services

Services that support the health of individuals and families occur in a wide variety of settings, both as stand-alone services, such as an inpatient substance abuse center, and as services embedded in larger social structures, such as schools or hospitals. They can be funded entirely through state or federal monies and agencies, such as the Oregon Department of **Human Services**, or funded with a variety of funding streams that include public monies, fundraising, foundation grants, and ongoing donors. Many local agencies and small nonprofit programs fit into the second group.

Human services professionals are key agents in the communities they serve because they help

connect clients to the other programs and resources that they need to remain healthy. For example, someone who comes to a food bank to pick up a box of food may also need access to money for their children's school supplies or housing resources. The food bank worker who is skilled and knowledgeable about a variety of community programs will be able to help that family on a larger scale than merely supplying food for a week.

There is no overarching organization or resource bank that can keep perfectly up to date on what is available, although some communities have a coordinating agency that attempts to do this. Availability of grants, services, and programs tends to shift frequently in the social services field, so staying knowledgeable about what is currently available is key.

Agencies and services can be organized to serve public health in different ways. Some are organized around a specific problem. For example, most states have a public agency that looks out for the **welfare** of children, especially children who may be experiencing abuse or **neglect** in their home or in other settings. Other services may be embedded in a larger structure, such as a hospital, and serve primarily to support transition and access to a variety of resources rather than being focused on one specific problem. Yet other services are organized to serve a specific population, such as military members or veterans, or older adults. Let's take a closer look at each of these ways of organizing services.

Services That Address Social Support Needs

When working with individuals who need help, human services professionals can both identify whether the person is experiencing a **social problem** and also help the person to address their individual situation. There is value in identifying an issue as a social problem, meaning that the problem is systemic in nature. In addition, the human services professional may have the opportunity to address the social problem on a mezzo or macro level.

One of the places you might work in human services could be organized around serving those who are experiencing a particular social problem. Examples of these might be an inpatient substance use disorder rehabilitation center or a shelter for people experiencing **houselessness**, as in figure 6.2.



Figure 6.2. Emergency shelters can be used for many social problems, from houselessness to natural disasters.

In both cases, the primary purpose is to address one particular problem, with the expectation that resolving this problem will likely lead to the person being able to address other issues as well. Counseling might be provided at either of the example programs, as well as resources for employment and health care. While other resources are provided, the focus is on the primary problem. Advocacy may be embedded within a direct service organization, or it may be a separate agency altogether that primarily operates at a macro level on policy change.

Services Embedded in an Institutional Setting

Sometimes social services are embedded in an institution used by many, which makes it accessible to anyone using that setting. Most hospitals employ a social worker, human services professional, or other kind of care coordinator who works with medical patients and families. They assess a person's overall well-being in the hospital, as well as make referrals for transitioning from hospital to home. In another example, social services may be embedded in a school itself or immediately tangential to the school. All children, whether they are currently experiencing a problem or not, would potentially be able to use those services when needed. This will be discussed in more detail in Chapter 7. Some jails and prisons also house social services. These institutions sometimes include substance use disorder treatment, counseling, life skills coaching, or transition resources.

Services That Serve a Specific Population

Some social services are designed to serve a specific population, and there may be specific criteria that must be met to access these services. For example, both current military members and veterans of the armed services are served by designated hospitals, mental health therapists, and other social service agencies. Most veterans are eligible for these benefits, although there are limitations based on the amount of time served, whether they are considered to be combat troops, and how the member was discharged (Phillipps, 2022 and U.S. Department of Veteran Affairs, 2022). Similarly, services exist specifically to serve older adults and adults that have a **disability**. Typically organizations that serve a targeted population provide a variety of services for that population so that they can get as many of their needs met as possible in one location.

In the Pacific Northwest, there are a plethora of services that cater to specific populations. One such service is the **Native American Rehabilitation Association (NARA) [Website]**, which offers a wide range of services primarily focused on supporting the Native American community in the Portland area. NARA's services include not only physical and mental health care but also addiction treatment, support for LGBTGAI2S+ individuals, and cultural, community, and spiritual support for families.

The organization welcomes individuals from all backgrounds but remains dedicated to supporting the Native American population. NARA has a team of experienced professionals who understand the unique challenges faced by the Native American community and are committed to providing compassionate and culturally appropriate care. NARA's holistic approach to health care ensures that clients receive comprehensive care that addresses all aspects of their well-being.

NAYA, the Native American Youth and Family Center [Website] is a social service agency that also supports this community but does so from a different standpoint. It focuses more on the medical and mental health side of support. It also has a range of services, including housing assistance, college and career services, early childhood support and education, homeownership, health **equity**, community gardens, **foster care** support, and community economic development.

Grace Center for Adult Day Services in Corvallis, Oregon

There is only one certified adult day center in a three-county area of Oregon that has a population of about 303,000: the Grace Center for Adult Day Services (Oregon-demographics.com, 2022). The center offers **socialization**, exercise, health mon-

itoring, memory care, respite, and post-rehabilitation for people needing support to maintain overall functioning and personal well-being. Their mission is to "provide day services that optimize the cognitive and physical abilities of seniors and adults with disabilities so that they can remain as independent as possible and in their homes" (Grace Center, 2022). By providing stimulation and care for adults who need daily assistance and support, family and other caregivers are given valuable rest time.

Adult daycare is a planned program of activities in a professional care setting designed for older adults who require supervised care during the day, or those who are isolated and lonely. Adult daycare centers enable seniors to socialize and enjoy planned activities in a group setting while still receiving needed health services. At the same time, they offer family caregivers respite from caregiving duties while knowing that their loved one is in a safe place.

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Figure 6.2. "Homeless Shelter Stays Open in Preparation for Storm" by KOMUNews is licensed under CC BY 2.0.

6.4 Health and Health Insurance

Industrialized nations throughout the world, with the notable exception of the United States, provide their citizens with some form of national health care and national health insurance (Russell, 2018). Although their health care systems differ in several respects, their governments pay all or most of the costs for health care, medicines, and other health needs.

In Denmark, for example, the government provides free medical care and hospitalization for the entire population and pays for some medications and some dental care. In France, the government pays for some of the medical, hospitalization, and medication costs for most people, and all of these expenses for the poor, unemployed, and children under the age of ten. In Great Britain, the National Health Service pays most medical costs for the population, including medical care, hospitalization, prescriptions, dental care, and eyeglasses. In Canada, the National Health Insurance system also pays for most medical costs. Medical debt and bankruptcy due to accidents or disease is a uniquely American problem. The reality is that you can buy trips to countries for a week at a lower price than an ambulance ride, and a two-day hospital stay in the United States is both embarrassing and devastating to the most marginalized communities. People have called Lyft or Uber instead of ambulances to the hospital for medical emergencies.

These national health insurance programs are commonly credited with reducing infant mortality, extending life expectancy, and, more generally, for enabling their citizens to have relatively good health. Notably, the United States ranks 33 out of 36 for infant mortality among countries who belong to the Organisation for Economic Co-operation and Development (OECD). The infant

mortality rate in the United States is 5.9 deaths per 1,000 live infant births, compared to the average rate of 3.9 deaths per 1,000 births. Five countries have death rates lower than 2 per 1,000 births. Their populations are generally healthier than Americans, even though health care spending is much higher per capita in the United States than in these other nations. In all these respects, these national health insurance systems offer several advantages over the health care model found in the United States (Reid, 2010).

Access to Health Care Coverage and Insurance

Access to health care is inequitable in the United States, and as **human services** practitioners it is critical that we view this as a **social problem** and not a personal failing. When people have less access to health care, or have to choose between medical visits, prescriptions, food, and housing, they are less likely to be able to achieve and maintain good health.

There are many insurance options in America, and they disproportionately benefit some and disadvantage others based on factors like **sex**, income, geographical location, and **ethnicity**. In 2017, some of the most common ways people accessed insurance was through private plans—employer-based (56%) and direct purchase (16%)—or through government plans: **Medicaid** (19.3%), **Medicare** (17.2%), and military health care (4.8%) (U.S. Census Bureau, 2017). To learn more about how people accessed health insurance coverage and who remained uncovered, watch the seven-minute video provided by the United States Census Bureau in figure 6.3.



This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=0mZPDJhZ5Qc

Figure 6.3. 2019 Income, Poverty and Health Insurance – Health Insurance Presentation [Streaming Video] Transcript.

The Patient Protection and Affordable Care Act (ACA) was created in 2010 to make health care less costly and less discriminatory. In 2016, section 1557 provided new regulations to the ACA, including a way to enforce civil rights protections in health care by making it unlawful for healthcare entities to discriminate against protected populations if they receive any type of federal financial assistance. This included health insurance companies participating in the Health Insurance Marketplace; providers who accept Medicare, Medicaid, and Child Health Insurance Program (CHIP) payments; and any state or local health care agencies, among others. This marked the first time that discriminatory practices on the basis of **race**, skin color, national **origin**, age, sex, **disability** status—and in some cases, **sexuality** and **gender** identity—were broadly prohibited in the arena of public and private health care (Rosenbaum, 2016).

Some of the common ways that lower-income families and individuals access insurance in Oregon are through programs like Medicaid and (CHIP), which is referred to as the Oregon Health Plan (OHP) in Oregon. Oregon is one of 39 states that elected to expand Medicaid after the ACA made that possible in 2014. This has resulted in many more Oregonians having access to health care. Figure 6.4 shows eligibility requirements.

Family size	Adults (19-64)	Children (0-18)	Pregnant Individuals
1	$1482	$3274	$2040
2	$2004	$4428	$2759
3	$2526	$5582	$3477
4	$3048	$6736	$4196
5	$3570	$7890	$4915
6	$4092	$9044	$5634

Figure 6.4. Consult the OHP website for more information about what factors other than income relate to eligibility for the Oregon Health Plan in 2022.

Medicaid is a federal and state-funded program that is managed by individual states. It provides government insurance to those who need it. The fact that 39 states have expanded eligibility but 12 have not points out the inequities people face based on geography. This variance in Medicaid eligibility creates great inequity for low-income families based on location. Those in states that have not expanded Medicaid face a much larger coverage gap, meaning that many more families do not have access to healthcare insurance.

Each state has the power to decide who is eligible for Medicaid, and most states focus on low-income individuals and those with disabilities.

- The U.S. government's website about **Medicaid [Website]** provides state-by-state report cards on a wide variety of health access and health quality measures.
- For up-to-date information on each state, **consult this Kaiser Family Foundation interactive map and narrative [Website]**.

Those who are age 65 or older can access health care insurance through Medicare, which is federally funded. Medicare covers about half of health care expenses for those enrolled, and many retirees who can afford to do so purchase private insurance or additional coverage from Medicare itself to cover the gap (MedPac, 2020).

The Oregon Health Plan also provides transportation to and from medical appointments, which can include mileage reimbursements, lodging, and meals. This is something that medical providers would need to help clients request and get pre-approved for, but it helps reduce barriers for many people. This benefit is not only for long distances but also for weekly appointments, such as physical therapy or mental health appointments. Clients can be picked up and dropped off at different locations, such as school and home, which helps with consistency.

CASE STUDY: TAHIR

Tahir is a 53-year-old Black man who struggles with back problems he has had for many years. Tahir was a seasonal employee and found work when he could, though this did not provide him with any health insurance benefits through his work. So when he was in a car accident at age 44, he had to rely on his car insurance to cover any medical costs.

Though the accident was not his fault, the other driver had no insurance. Tahir's insurance had to cover the initial hospital bills. Not having a lot of money, he had opted for the least expensive insurance he could get, so his policy did not cover follow-up visits to the doctor. Because he earned too much to receive Medicaid benefits, Tahir would have to pay out of pocket for any additional services he needed, which he could not afford. He was slowly recovering and still able to work, though he was often in pain.

One day while on the job, he had an accident that caused further injury to his back. Since it was determined to be a preexisting condition, workers' compensation at his job refused to cover any care. Tahir could no longer perform his duties and was fired. He has since spent the last ten years taking odd jobs that did not last very long or for which he could not continue working at the level needed.

When his back pain became unbearable, Tahir's only option was to go to the emergency room. As he struggled with chronic pain, he also became depressed. Since he was without insurance, the hospital reduced and stabilized his pain but did not provide any treatment beyond that. Tahir's back issues are now only temporarily relieved, and he knows he will end up back in the hospital when things become intolerable again.

Questions

1. What services would help Tahir stabilize his health and work life?
2. How would universal health care help Tahir?
3. What other problems is Tahir at risk for if he doesn't have adequate health care?
4. How do you think Tahir's identities impacted his access to systems of support?

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Figure 6.3. "**Income, Poverty and Health Insurance – Health Insurance Presentation**" by The Census Bureau is in the public domain.

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6.5 Working in Health Care

Remediating problems, intervening in problems, and preventing problems are three ways that **human services** professionals help others. When working at an organization or with a specific population, you may be involved in all three activities, or you may be focused primarily on one of these actions.

Remediation, Intervention, Prevention

Let's start with **remediation**, which is the correction or reversing of behaviors. This is needed when a problem is chronic and when **prevention** and **intervention** have not worked to solve it. There are settings specifically situated to remediate and **rehabilitate**, which helps people to relearn or reform their behaviors. These include correctional facilities, probation offices, and addiction centers. In many cases, individuals are mandated or required to these kinds of settings, though in the case of someone with substance use disorders, that person might self-enroll.

In these settings, the problem is often chronic and has been assessed and identified, so the focus is on changes in thinking and behavior. Some patients or clients will be motivated to change, and others will be resistant. In addition, correctional and probation settings can contain a mixture of personnel and ideologies. While people coming from human services and social work education and philosophies are most focused on rehabilitation, other ideologies that focus more on punishment will also be present. This is a tension within the society of the United States, including the workplace.

Interventions, which help people address problems as they occur, typically precede remediation and may prevent someone from needing a more intensive treatment. When intervening, professionals help people solve problems as they occur. Intervention services take place in a wide variety of settings, including those that focus on remediation. For example, someone at an outpatient center for their addiction who is also experiencing food insecurity might be given referrals and access to food banks, food stamps, or other services.

When you work in human services, it is always important to see your clients as whole people who have multiple strengths and needs. Be prepared to support their efforts to solve life problems, even if this is not the primary purpose of the organization you work with or service that you provide. Other common intervention services include:

- employment offices
- food banks
- juvenile probation services
- resource centers that coordinate a variety of services such as childcare, food access, shelter, counseling, and others
- **child abuse**, domestic violence, and **intimate partner violence** services
- relief nurseries

Intervention is often paired with other interventions as well as with prevention services, like the Drug Abuse Resistance Education (DARE) program pictured in figure 6.5.



Figure 6.5. A Master-at-Arms and her graduating class in the Drug Abuse Resistance Education (D.A.R.E.) program, a common substance abuse prevention program in the United States.

Prevention services that help people develop healthy life strategies may involve education, counseling, or planning. These can occur in a variety of settings, including schools, public health agencies, mental health programs, and hospitals. Prevention work also includes helping individuals prevent the recurrence of problems by giving planning, budgeting, problem-solving, or counseling support.

Prevention services may be paired with other services, such as child care. For example, some child care centers offer parent education, home visits, and other child safety course opportunities. Providing a structure for education, networking, and support can give parents the opportunity to build their own social support structures. They can also learn from people with child development and learning strategy expertise, then apply that knowledge to their own parenting. Preventative work involves helping people build on their strengths to prevent recurring problems or new problems and can be very rewarding.

Human services workers can work at any level within **prevention, intervention, and remediation** services. In other words, human services professionals work one to one at the micro level with clients in all realms: incarcerated prisoners (remediation), people experiencing **houselessness** (intervention), and new parents (prevention). They also work at the mezzo level with groups like people convicted of intimate partner violence (remediation), support groups for people with substance abuse disorders (intervention), and communities working to solve a local problem, such as creating safe places for their children to play (prevention). And macro-level program and policy work is needed in all sectors. Examples include planning and advocacy for the incarcerated or formerly incarcerated (remediation), structuring and planning of government programs such as child **welfare** (add type here), **social security** and unemployment insurance (intervention), and creating health structures and systems such as parent education, community centers, and health care (prevention).

Human Services Jobs in Health Care

There are many different types of healthcare jobs and careers for human services practitioners. Some require specializations and a Masters **degree** in either social work or counseling. However, opportunities in health care for non-licensed or non-graduate-degree career choices continue to grow. Following is a sample of the jobs and careers for helping professionals work in health care.

Medical Social Workers

Medical social work is a specific form of specialized medical and public health care that focuses on the relationship between disease and human maladjustment. Medical social workers practice in a variety of healthcare settings, such as hospitals, community clinics, preventative public health programs, acute care, hospice, and outpatient medical centers that focus on specialized treatments or populations. These professionals help patients and their families through life-changing and sometimes traumatic medical experiences.

All medical social workers must familiarize themselves with cross-cultural knowledge in order to provide effective health care. They do this by familiarizing themselves with an array of different ethnicities, cultural beliefs, practices, and values that shape the clients' family systems. In addition, they must practice cultural humility, as described in Chapter 1, to learn about each client, their family, and their **culture**. Medical social workers must have the ability to recognize how oppression can affect an individual's bio-psycho-social-spiritual well-being.



Figure 6.6. The Social Work Hospice and Palliative Care Network is a professional organization with conferences, newsletters, and training opportunities for this social work specialty, and other specialties have similar organizations and networks.

Emergency Room Social Workers

Within hospitals, social workers may focus on several specialties. They may work in an emergency room to provide services to triage patients. One of their main functions is to diagnose and assess patients who show signs of mental illness. The medical social worker also performs discharge planning as a means of assurance that every patient will have a safety plan when discharged from the hospital (Fusenig, 2012).

The following is a list of tasks that emergency room social workers may perform:

- stress, mental health, and suicide assessments
- death notifications to family members
- counseling and other referrals
- child and adult protective service reporting
- domestic violence and **sex** trafficking screenings
- discharge planning

Hospice and Palliative Care Social Workers

Palliative care involves a team of professionals who provide comprehensive wellness services, including physical and mental health care, to patients with terminal and chronic illnesses. This is closely related to hospice care, which is specifically for those with a terminal illness. This is why figure 6.6 shows that these two fields share a professional organization and community.

The main idea of this treatment option is to provide respectful and compassionate care for patients to create as balanced a perspective as possible on the life they have remaining. Care can take place in a hospital, an assisted living center, or a patient's home.

The following is a list of tasks that hospice and palliative care social workers perform:

- ensure that patients and family members have access to resources that will provide physical comfort
- provide emotional and spiritual support to patients and their family members
- lead support groups for family members and in-service trainings to nurses, physicians, and other social

workers who are involved in the treatment process
- ensure proper medical transitions from palliative care to hospice care if needed
- act as care coordinators by providing treatment planning with other members of the patient's treatment team (SocialWorkLicensure.Org, 2017).

Pediatric Social Workers

Another kind of specialized care involves working with children and their families. Children who are experiencing chronic or terminal illnesses need support related to their mental health. A knowledge of overall child development, as well as family systems, is important to be able to perform this job. Pediatric social workers provide emotional and planning support to children and families in hospital, outpatient, and home settings.

Public Health Work

Public health work addresses communicable diseases, **poverty**, sanitation, and hygiene. It is defined as a collection of human service programs with a common goal: identify and reduce or eliminate the social stressors among the most vulnerable populations. A public health worker's main role is to establish preventative measures and intervene in the health and social problems that affect communities and populations.

Roles that helping professionals play in public health include:

- find people who need help
- assess the needs of clients, their situations, and their support networks
- create with plans to improve their overall well-being
- help clients make adjustments to life challenges, including divorce, illness, and unemployment
- work with communities on public health efforts to prevent public health problems
- assist clients in working with government agencies to receive benefits
- respond to situations of crisis, including child abuse or natural disasters
- follow up with clients to see if their personal situations have improved (Allen & Spitzer, 2015)

Public health work is also critical at the macro level where prevention, health **equity**, and building evidence are core principles (CDC, 2014). At the national or state level, this can improve access to quality care for those marginalized in society. Strategies focus on community resources, many of which are nonprofit agencies, to address behavioral aspects contributing to overall health.

Community Social Workers

Community social workers are key constituents in implementing these efforts. While programs and strategies might vary, social work practice in community health and prevention can focus on a wide variety of topics, including smoking, family nutrition, teen pregnancy, drunk driving, and sexual health to name a few. These problems can impact the overall physical and mental health of the community and its members' quality of life. Unlike primary care and mental health settings that address health care concerns aligning more with the medical model, community health and prevention follows the wellness model to identify and prevent physical and mental health problems on a broad scale.

Healthcare and Community Partnerships

There is a common misconception in health care and human services that work is confined to formalized settings. This is not the case, especially as the field evolves to meet the changing needs of communities, budgetary constraints, and technological advances. One such example is the BIKETOWN program in Portland, Oregon.

BIKETOWN is a bike-share system launched in 2016 through a partnership between Nike, the Portland Bureau of Transportation (PBOT), and Lyft. The program started with more than 1,000 electric-assist bikes and has since undergone multiple expansions. In 2018, the service area grew to include East Portland neighborhoods, including Grant Park, Creston-Kenilworth, Laurelhurst, Beaumont-Wilshire, Cully, and Hollywood, along the 50s Bikeway. An additional 22 city bike corrals were designated as "Community Corrals," providing additional places for riders to lock up their bikes for free.

In 2020, PBOT and Lyft launched a fleet of 1,500 pedal-assist electric bikes for BIKETOWN, expanding the program's service area to 32 square miles. This expansion included the Jade District and portions of Lents, Powellhurst-Gilbert, and the Gateway area. In January 2022, the services area was extended to historically underserved communities in St. Johns and East Portland. A "Super Hub Zone" was created to support this expansion, providing free parking for BIKETOWN bikes.

While using the BIKETOWN program, Nike has also considered accessibility and equity for its audience. They have provided information on their website to help those who require assistance, or reduced or free membership. This includes information on how to obtain prepaid cards and how to qualify for assistance. One of the program's newest aspects is having bikes accessible to people with different physical needs.

This inclusivity is a testament to the program's commitment to serving all community members, regardless of their physical abilities. **Adaptive BIKETOWN [Website]** is Portland's adaptive cycling resource for people living with a **disability** or unable to ride a traditional two-wheeled bike. A PBOT partnership with Kerr Bikes, a local bike shop, has made this possible. This includes free one-hour rides on any of the Adaptive BIKETOWN bikes.

The BIKETOWN program is a shining example of how health care and human services can extend beyond traditional medical clinics to promote community health and well-being. By providing a convenient mode of transportation and encouraging physical activity, it actively promotes healthy living. This underscores the importance of partnerships and innovation in meeting the evolving needs of communities, particularly in underserved neighborhoods. The continued growth of the BIKETOWN program is a testament to its value in promoting healthy living and accessibility across Portland.

As a human service provider, consider how you can promote similar initiatives in your community to bring in new and innovative ways of health and well-being that reflect your unique lived experiences in the field. Human Services is an evolving field, and understanding the new ways of meeting community needs with partnerships with government, private, and nonprofit organizations with culture at the center of decision-making for these projects.

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clarity, accuracy, and brevity; refocus of content within context of human services. Revised by Martha Ochoa-Leyva.

Figure 6.5. "Master-at-Arms 1st Class Stacey Carfley stands with her recent class of Drug Abuse Resistance Education (D.A.R.E.) program graduates at Pearl Harbor Elementary School" by United States Navy is in the public domain.

Figure 6.6. Social Work Hospice and Palliative Care Network logo is reproduced under fair use.

6.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter,
- summarizing an overarching idea, or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- **Human services** organizations come in all shapes and sizes. As you become aware of agencies and government programs, consider some of these questions so that you have a more complete understanding of the functioning of services.

- How is it funded?
- What size is it? How many levels of management or bureaucracy does it have?
- Who or what is the legal entity responsible for the organization?
- What is its primary purpose?

- Health and well-being are impacted by the social problems of **poverty**, privilege, and oppression.
- Health and healthcare are integral to the functioning of individuals, families, and communities.

DISCUSSION QUESTIONS

- What kind of initiative would you want to start in your community, like BIKETOWN, which increased the number of bikes in communities across the Portland, Oregon, metro area? You

should consider combining at least two types of funding: non-profit, governmental, private, or even medical.
- Discuss **prevention**, **intervention**, and **remediation**.

- What kind of work do you see yourself as well matched for?
- What are examples of agencies that do each?
- Can you think of organizations that focus on more than one of these?

- How does the medical model compare to the wellness model? What role do human services practitioners play in each?
- What challenges do human service professionals in health care fields face? What characteristics and skills would be most valuable to someone who wants to work in health care (refer to **Chapter 1**)?

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CHAPTER

7

Mental Health

7.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

STANDARD 4: When a human service professional suspects a client's behavior may endanger themselves or others, they must take appropriate and professional actions to ensure safety, which may include consulting, seeking supervision, or, in accordance with state and federal laws, breaching confidentiality (NOHS, 2024).

We closed Chapter 6 with discussions about healthcare settings, careers, and issues. Mental health is part of overall health, but we have devoted a separate chapter to it because of its prominence in society today.

Standard 27 reminds us that although **human services** professionals have a broad base of knowledge, we must also be aware that there are specialized professionals to meet specific needs. Mental health is an area where specialized professionals such as licensed counselors, social workers, psychologists, and psychiatrists are often the appropriate person for a client to see. It's important to make these referrals and not try to address problems that we may not be qualified to treat.

LEARNING OBJECTIVES

1. Define mental health, mental wellness, mental disorders
2. Explain in brief the history of mental health treatment in the United States.
3. Recognize the most common mental health disorders and bias considerations around diagnosis.
4. Recognize the special needs of particular populations in mental health treatment.

5. Explain various roles of human services workers in the mental health fields.
6. Evaluate **self-care** and community care for practitioners.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter. Key terms for this chapter are:

- Art or music therapist: specialized therapists who can assist in the healing process through the use of art, music, dance, and other means of creative expression and relaxation
- Community mental health center (CMHC): a small institution dedicated to serving people who have mental health struggles in contrast to large institutional hospitals
- Counselor: a person engages in assessment, diagnosis, and provision of therapy services.
- Employee assistance program (EAP): a benefit provided by some employers that allows workers to access quick, temporary mental health support
- Marriage and family therapist: a specialized area of counseling and therapy in family and relationship dynamics that helps people to resolve emotional and behavioral concerns impacting family relationships
- Mental disorder: A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning (American Psychiatric Association, 2022)
- Mental health: a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (American Psychological Association, 2018, para. 1)
- Mental illness: a condition that impacts a person's thinking, feeling, or mood [that] may affect their ability to relate to others and function on a daily basis (NAMI, n.d.a, para. 1)
- Play therapy: a specialized method for working with younger children that helps children to communicate and open up with a therapist about things they might otherwise struggle to put into words
- Psychiatric nurse: nurses who perform much the same functions as counselors, therapists, or clinical social workers, with additional specific training in the medical field and the ability prescribe medication in some states
- Psychiatrist: a medical doctor with a specialty in mental health
- Psychologist: conduct therapy, perform psychological testing, assess, and diagnose clients
- Mental wellness: an internal resource that helps us think, feel, connect, and function; it is an active process that helps us to build resilience, grow, and flourish (Global Wellness Institute, 2020, para. 1)
- Self-care: is defined as needs for overall well-being. It helps manage stress, reduce ailments, and foster positive emotions for a healthier life. Self-care can be viewed in nine domains:

environment, physical, social, emotional, spiritual, personal/relationships, professional, financial, and community.

- Community-care: is defined as the care that BIPOC and QTBIPOC communities emphasize the interconnectedness of individual and community well-being, fostering connections, recognizing systemic inequities, and creating new structures to address these issues. It aims to promote a more equitable future through mutual support, addressing social determinants of health and resource gaps. Community care seeks to create new structures and increase access to valuable resources through mutual support and aid provided by individuals and the broader community.
- Womxn: an inclusive term that began to be used in the 1970s to be inclusive of transgender women and nonbinary people's experiences.

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7.2 Mental Health and Connection to Human Services

Like many of the topics in this text, mental health is a subject in which you will need to be well-versed in order to be a professional working in **human services**. Clients are usually dealing with some sort of adversity in their lives, and those circumstances can take their toll on mental health. Struggling with mental illness can also cause a ripple effect of other problems in one's life—work or school performance issues, relationship problems, substance use, medical problems, and more.

Even if you do not plan to be a clinical social worker, counselor, or someone otherwise employed in the mental health field, it is imperative that you feel comfortable working with clients with mental health challenges. You will need to be able to recognize the signs and symptoms of many disorders so that you can help clients connect to the resources that can best assist them. Clients who are struggling with their mental health may not be able to work toward goals in any human services program until those needs are addressed or at least recognized.

This chapter is an introduction to some of the settings and problems you may encounter. Most importantly, we understand practitioners' ethical scope of practice in the human services field with our skill set and training, as we want to help and not harm the communities we serve.

What Are Mental Health Disorders, Mental Health, and Mental Wellness?

We have come a long way in the terms we use for various psychiatric conditions, though we continue to modify our terminology seemingly at every step. However, it is not unusual for people

still to use words like "crazy," "unbalanced," "nuts," "out of it," "psychotic," and "insane" to describe those who are dealing with mental disorders. These words reflect many things: misunderstanding, fear, misinformation, miseducation, and more.

Many people do not have a firm understanding of mental health disorders. It is easier to think in hurtful terms like these to describe those who are dealing with mental disorders. As human service providers, we must advocate and educate not just clients and their families but also colleagues, family, and friends about these words and topics that will help reduce the stigma around mental health disorders, as depicted in figure 7.1.

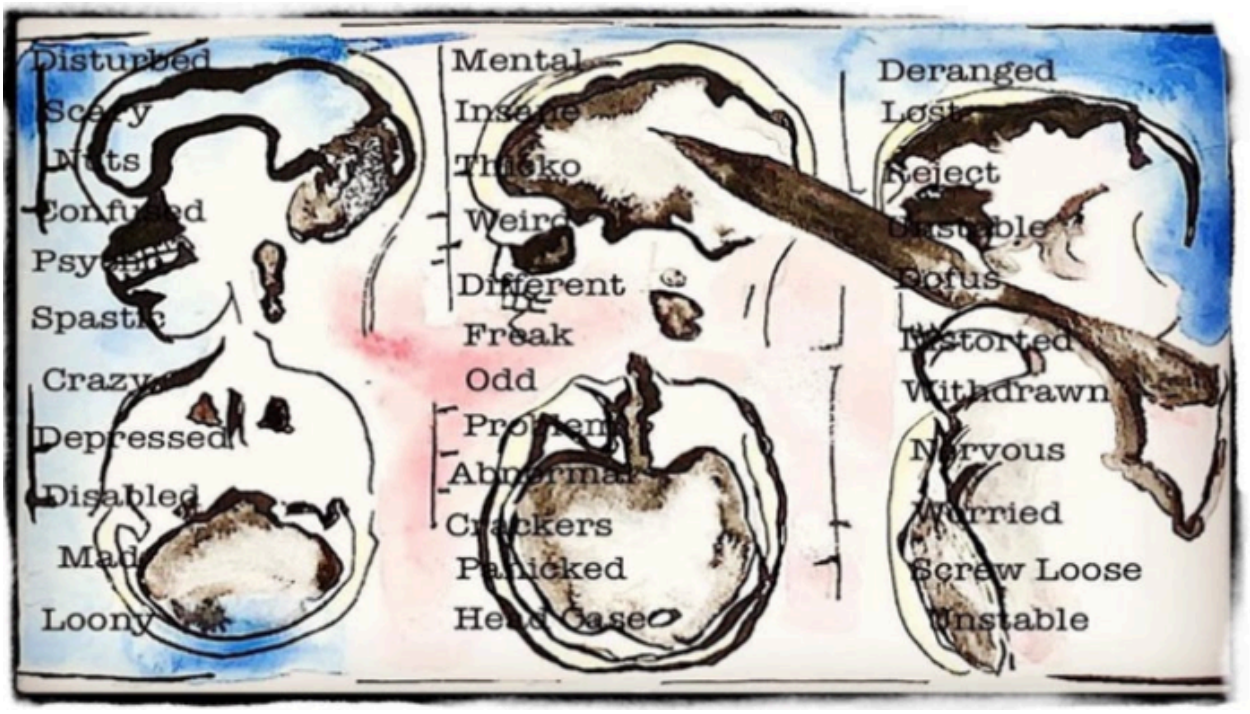


Figure 7.1. William Doan's "Crazy Brain" is a work of visual art that reflects the experience of stigma from the perspective of someone with a mental health disorder.

You may hear the terms "mental illness" and "mental disorder" used interchangeably, and there isn't necessarily anything wrong with that approach. The Diagnostic and Statistical Manual of Mental Disorders (Fifth Edition-Text Revision), commonly called the DSM-5TR, uses the term *mental health disorder* to describe psychiatric diagnoses, and that is what we will use in this text. The DSM-5's definition of mental disorder is as follows: "A syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning" (American Psychiatric Association [APA], 2022).

This is something they (mental health providers) have received unique and specific training to do. Human service providers will not be asked to diagnose clients in the field. Do not assume anyone's diagnosis or see someone's symptoms and think, "I know what they may have as a diagnosis." If you do not have the training and experience to do so, then do not diagnose anyone. It is unethical and outside the scope of your practice to do so.

Some people feel that the term "mental illness" sounds too negative and may stigmatize people who have been diagnosed with mental disorders.

Others are dismayed by the word "disorder" and what it implies about their functioning state. Plus, we have not yet considered intergenerational **trauma** and the centering of Western medical perspectives of what health and healing looks like.

If you won't be providing a diagnosis to clients, why should you be aware of the definition of a mental health disorder? Not only for advocacy and to help reduce the overall stigma of mental health disorders but because we cannot separate the human experience from the prevalence of mental health disorders you will encounter while working in the field. These disorders are common, and human services professionals must understand how various client needs will impact your approach to your work.

What about the terms *mental health* and *mental wellness*? First, humans have one thing: mental health. **Mental health** is a state of mind characterized by emotional well-being, reasonable behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with life's ordinary demands and stresses" (American Psychological Association, 2018, para. 1). **Mental wellness** is an "internal resource that helps us think, feel, connect, and function; it is an active process that allows us to build resilience, grow, and flourish" (Global Wellness Institute, 2020, para. 1).

How Common Are Mental Health Disorders?

As with many important topics, the available statistics on the prevalence of mental disorders vary. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that 33.7% of adults qualified for a mental disorder diagnosis in 2021; about one in four of those disorders (16%) would be classified as severe. In the 2022 National Healthcare Quality and Disparities Report, almost 20% of children and young people ages 3–17 in the United States have a mental, emotional, developmental, or behavioral disorder, and suicidal behaviors among high school students increased by more than 40% in the decade before 2019. Mental health disorders were the leading cause of death in this age group. These trends were exacerbated during the COVID-19 pandemic, which is not a surprise as it magnified the needs many have had for years. However, it (mental health needs) has not been highlighted or seen as necessary or as many people could not slow down enough to notice.

In order to assess these numbers, we need to consider how, as a society, we look at mental health disorders from a gendered view and a racial lens. We need to understand how intersectional identities impact who is receiving mental health referrals for support and possible diagnosis. We also need to think about how our own biases play into the way we interact with clients who may have mental health disorder diagnoses, even if we only suspect they've been diagnosed.

What Can Be Done to Support People with Mental Health Disorders?

This chapter will delve into some of the many different options available to people with mental disorders—both medications and various kinds of therapy and counseling. Although there are many disorders, there are also a lot of clinicians with expertise in a broad range of areas, as well as plenty of research to show how to handle particular issues. Though mental disorders can be difficult, upsetting, or even scary in some situations, there is plenty of reason to have hope for recovery and improvements in functioning.

Having a basic understanding of mental health and mental disorders will increase the effectiveness of any human services practitioner. What is

essential to understand is the scope of our practice and what we can do in our role. Suppose we are a peer support provider or a home visitor. In those cases, we understand our role limits and know that we are not the ones who will be providing the clinical mental health support directly related to diagnosing the disorder. Instead, we will be providing resources to support the symptoms we observe and that clients report as impactful to their lives or to help construct a treatment plan. We could help locate and build a community and network with families.

We can skillfully create a space of empathetic listening and care for clients without providing clinical treatment. One of the most supportive things we provide is learning how to be with someone but trying to fix something about them or their situation. The relationship is the center of everything, first and foremost. Building trust is critical.

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Figure 7.1. "**Crazy Brain**" by William Doan is licensed under **CC BY ND 4.0**.

7.3 Historical Context of Mental Health Treatment

At least as early as the 1200s, people with unpredictable or unusual behaviors were subject at times to institutionalization in Europe. As with many other elements of social **welfare**, a belief in this practice was carried over when Europeans colonized North America (Cox et al., 2016). Without a firm understanding of the nature of mental disorders, people were sometimes believed to be possessed or otherwise cursed in some way. Institutionalization was seen as necessary, for the individual's safety or the safety of the community. Sometimes when people were believed to be possessed by demons, they were tortured in an effort to free them from their demonic captors (Zastrow, 2010).

People in need of care in the 1700s and much of the 1800s were often confined to unsanitary and overcrowded asylums, placed in "almshouses with criminals and degenerates," or sometimes simply imprisoned (Farley et al., 2009, p. 153). Of course, there were no treatment facilities available when colonists first came to what would become America—the Native Americans did not have formal institutions, and the Europeans were working to colonize the country. Therefore, despite the fact that institutionalization was supported in theory by the European colonists, in practice it did not exist. People with mental disorders were, therefore, cared for by their families or left to survive on their own.

An early activist and crusader, Dorothea Dix, noticed during her time teaching classes to inmates at the East Cambridge jailhouse that criminals and those with mental disorders were being housed together, as though having a disorder were a crime to be punished (Wilson, 1975).



Figure 7.2. Dorothea Dix (1802-1887) was an important social reformer who championed the founding and expansion of hospitals for people with mental disorders.

Dix, shown in figure 7.2, traveled the country and worked to alert the public to the horrifying conditions that people with mental disorders were enduring in these prisons and almshouses. She acted as an advocate for more humane treatment and penned the following account for the Massachusetts legislature:

> *I tell what I have seen*—painful and shocking as the details often are…I proceed, Gentlemen, briefly to call your attention to the present state of Insane Persons confined within this Commonwealth, in *cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, and lashed into obedience!*…I have been asked if I have investigated the causes of insanity? I have not; but I have been told that this most calamitous overthrow of reason often is the result of a life of sin; it is sometimes, but rarely, added, they must take the consequences; they deserve no better care! Shall man be more unjust than God, who causes his sun and refreshing rains and life-giving influence to fall alike on the good and the evil? Is not the total wreck of reason, a state of distraction, and the loss of all that makes life cherished a retribution, sufficiently heavy, without adding to consequences so appalling every indignity that can still lower the wretched sufferer? (Wilson, 1975, p. 122–123)

Dix felt it was not cruelty but ignorance that caused people to treat those with mental disorders this way. Her passionate recounting of her discoveries to the Massachusetts legislature led to the passing of a bill in 1843 that charged the state with the proper and compassionate care of these individuals (Wilson, 1975). She went on in later years to lobby the federal government to give states land that could be devoted to the construction of facilities to properly care for those in need of mental health care. The attention she brought to the cause was a major impetus for improvements made over the next several decades in the mental health care system. In 1855, the Government Hospital for the Insane (later known as Saint Elizabeth's Hospital) was founded by an act of Congress, and by 1860, 28 of the 33 states in the union at that time had constructed at least one psychiatric hospital (Torrey, 2014).

The Saint Elizabeth's Hospital is the District's public psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care. However, although supportive in certain aspects, it was not immune to a prevailing issue that continues to impact mental health diagnosis and overall treatment: racism. The hospital began treating Black individuals who, at the time, were still primarily enslaved throughout the United States. As the hospital was situated in Washington, DC, a region whose population was around 20% of the Black population at this time, it also admitted Black patients.

However, the conditions offered to Black patients were markedly distinct from those afforded to their White counterparts. Hospital records indicate that Black and White patients were separated, with hospital staff contending that segregation was a necessary form of therapy for both Black and White patients. According to this rationale, White patients might encounter obstacles in their recovery if they interacted with Black patients.

White patients were accommodated in the center building, a brick structure featuring expansive wards. In contrast, Black patients were housed in smaller wooden lodges at a distance from the center building. These lodges were frequently overpopulated and would become incubators for disease. Black patients were also subjected to physical labor, such as digging trenches, building walls, clearing forests, and grading hills without access to the nutritious diets White patients were receiving. Although both racial segregation and occupational therapy were considered forms of moral treatment, they were implemented differently for Black and White patients (Gordon, 2024).

As we can see, the idea of "separate but equal" was in place even before Black Americans had been given their freedom—or rather, fought for their freedom and to be seen as fully human in this country. Yet we have benefitted from their bodies, souls, and experiences as we have learned many lessons from the clients at Saint Elizabeth Hospital about treatment and care. As **human services** providers, we must continue to undo systems of oppression that perpetuate these ideas of harm, such as "separate but equal."

In the early 1900s, Sigmund Freud's work brought to mainstream awareness the idea that mental disorders were truly illnesses and people suffering from them needed understanding and proper care to have a chance to recover. He pushed a very medical perspective of mental disorders, said that early childhood **trauma** had caused a lot of these individuals' emotional and behavioral problems, and encouraged psychiatric diagnosis and treatment of individuals (Greenberg, 2013). This led to a more humanitarian approach, though some of Freud's specific ideas were misguided (Zastrow, 2010; Greenberg, 2013).

At the same time Freud's work was gaining steam, social work was also focused on those with mental disorders. Social work was offered as a service in both Manhattan State Hospital and Boston Psychopathic Hospital by 1910, and Surgeon General Rupert Blue asked the American Red Cross to get social workers involved in the federal hospital system in 1919: "by January 1920, social service departments had been organized in forty-two hospitals" (Farley et al., 2009, p. 154).

Despite the increased presence of social work in mental health care, conditions still left a lot to be desired. In 1943, conscientious objectors to the war (often religious young men) were put to work in other ways, some in state mental hospitals. They reported scenes much like Dix had seen in correctional facilities:

> Here were two hundred and fifty men—all of them completely naked—standing about the walls of the most dismal room I have ever seen. There was no furniture of any kind. Patients squatted on the damp floor or perched on the window seats. Some of them huddled together in corners like wild animals. Others wandered about the room picking up bits of filth and playing with it (Torrey, 2014, pp. 22–23).

In 1945, following World War II, there was increased recognition of the impact of mental disorders on America's troops. Government leaders wrote the National Neuropsychiatric Institute Act, a nationwide mental health program that became the force behind the foundation of the National Institute of Mental Health in 1949 (NIMH) (Torrey, 2014; Cox, Tice, & Long, 2016).

The proposal that the government take a more active role in treating those with mental disorders

was fairly revolutionary. It included thousands of centers from coast to coast—at least one in each Congressional district. John F. Kennedy, who took the White House in 1961, was a powerful ally, as Kennedy's sister Rosemary had undergone a lobotomy and become incapacitated, though this was not information freely shared with the public at the time. Rosemary had been diagnosed with what was then called (activation warning) "mental retardation" (now "intellectual **disability**" APA, 2022). That, conversations about mental health, was first on Kennedy's agenda as president, but shortly thereafter he turned his attention to mental health treatment as well (Torrey, 2014).

By 1961, a committee appointed by the president had decided to push for the elimination of state mental hospitals, the deinstitutionalization of those with mental disorders, and the establishment of a network of **community mental health centers** (CMHCs), a plan approved by Congress in 1963 (Torrey, 2014; Frank & Glied, 2006). The plan provided federal funds to communities to build such centers and to get them up and running for a few years, with the expectation that each center would become economically self-sufficient thereafter.

However, the American involvement in the Vietnam War (1965–1975) severely curtailed the funding Congress had planned to provide. Congress simultaneously tasked the CMHCs with handling new groups of clients: substance abusers, children, and older adults (Frank & Glied, 2006). With these dual concerns, CMHCs had to keep costs down. This meant higher client-to-staff ratios and a pattern of treating people with less severe problems who were easier to help at a lower cost. This, of course, left those with more severe disorders again to public hospitals (Frank & Glied, 2006).

Deinstitutionalization, while well-intended, ended up having some notable negative effects. The desire to give people with less severe mental disorders a chance to be maintained in their communities on an outpatient basis wasn't a bad one. However, the closing of many of the hospitals and the inability of CMHCs to pick up all the slack meant that many people with severe conditions did not actually have anywhere to go that could provide the level of help they required. This is often seen as a major factor in the rise of houseless among those with mental disorders, as well as the high proportion of the prison population (estimated at up to 20%) that have psychiatric problems (Frank & Glied, 2006; Torrey, 2014).

To complicate the problem further, prisoners with mental disorders are less likely to access follow-up care, more likely to end up back in prison than other prisoners, and on average return to the correctional system faster (Barrenger & Draine, 2013). By the 1990s, leaders in mental health came to the conclusion that while CMHCs were an important piece of the solution, well-regulated and well-staffed state mental hospitals were also an integral part of a system that could fully address the needs of citizens with mental disorders (Farley et al., 2009).

The deinstitutionalization movement left many people with mental disorders houseless and resulted in a lot of people with mental health disorders having nowhere to go but to the streets. To get into housing, they often had to restart medications, maintain sobriety, and participate in other programs that posed barriers to long-term housing, as indicated in figure 7.3. Housing first is currently the best approach to working with people experiencing severe and chaotic symptoms to help them transition into housing and provide support within the safety of a person's own home.

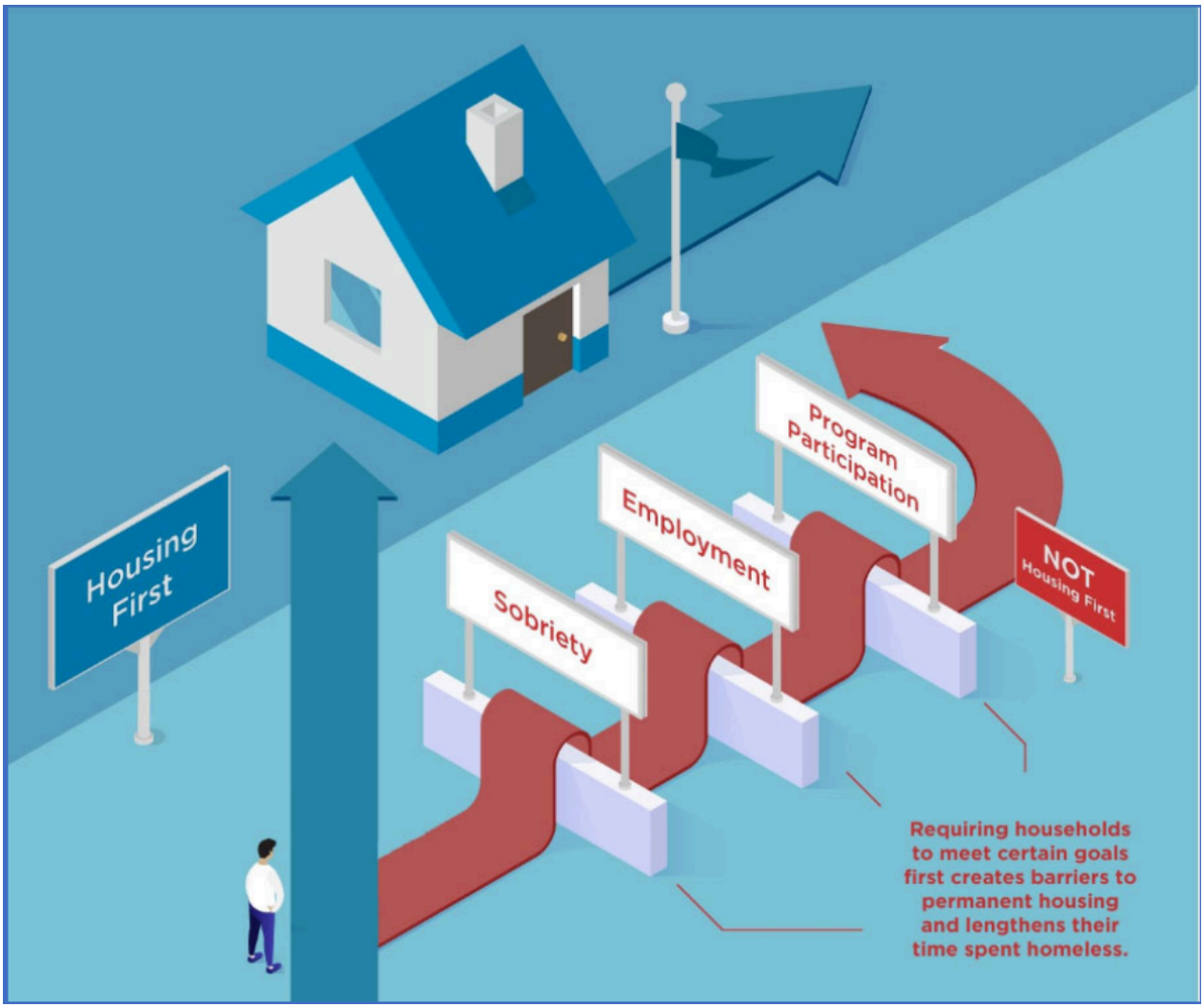


Figure 7.3. Housing first models help people with severe mental health issues avoid cycling from hospitals, treatment programs, jails, and the street by establishing their own home and providing multidisciplinary support to support mental health symptoms.

Most recently, laws have been passed on a national scale to reflect the increased recognition of the importance of treating mental disorders with the same **degree** of attention and coverage that physical illnesses and injuries receive. The Mental Health Parity Act of 1996, along with the Mental Health Parity and Addiction **Equity** Act of 2008, require insurance companies to approach the treatment of mental health and addictions in the same manner as medical or surgical treatment. Companies may not put stricter lifetime limits, higher co-pays, or higher deductibles on someone's plan for mental health or addiction treatment than the same person has for most medical or surgical treatments (United States Department of Labor, n.d.). Finally, under President Barack Obama, the Affordable Care Act of 2010 helped to expand **Medicaid** (now the nation's number one source of funding for mental health care) and paved the way for more coordination between the professionals involved in medical and psychiatric treatment of people with mental disorders (Kuramoto, 2014).

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Figure 7.2 "**Dorothea Dix**" by **exit78** is marked with **CC PDM 1.0**.

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Figure 7.3. "**Housingfirst-powerpoint-graphic**" by Kevin Anderson is reproduced under fair use.

7.4 Current Practices and Settings

This next section describes some of the common practices and settings focused on mental health services. The **human services** professional is likely to encounter people struggling with mental health disorders in almost any setting in which they work.

You are likely to encounter clients with mental disorders in almost any setting or job. Depressive and anxiety disorders are especially prevalent throughout the population. Any setting that addresses unmet needs such as homelessness, food insecurity, loss and grief, or abuse will include clients that may come to the service with one need identified but may also have treated or untreated mental disorders.

Inpatient and Outpatient Settings

Clients are served in inpatient or outpatient settings based on which environment is the least restrictive for meeting their mental health needs. The overwhelming majority of people experiencing the symptoms of mental health disorders do not need to be hospitalized; however, mental health crises can cause someone to be an immediate danger to themselves or other people, requiring hospitalization or residential treatment.

There are two medical practice settings where you as a human services professional are likely to encounter people with mental disorders: inpatient (hospitals, both medical and psychiatric) and outpatient (substance abuse centers, mental health clinics, counseling centers). Though there are some similarities in goals and strategies, the differences between these two settings are certainly worth noting.

Inpatient services in these settings are provided by social workers, counselors, and other professionals who work with individuals or groups to provide treatment in a variety of forms. The inpatient worker also works with the client's friends, family, and employers to help the person return to their outside life. The human services professional may advocate and work with other agencies to provide assistance or resources for individuals under their care.

When a patient is ready to leave a psychiatric facility or hospital, the practitioner may connect them to an outpatient clinic. In these settings, outpatient workers assist the individuals or groups in maintaining healthy functioning in their environment through therapy or clinical activities. The

social worker or counselor in this setting will conduct therapy or planning sessions, contact outside agencies, and advocate for their client's best interests.

Employee Assistance Programs (EAPs)

Many employers have come to recognize that it is to their advantage to handle mental health much like they address physical health, and that giving employees access to mental health treatment and resources not only is the right thing to do, but actually makes for good business. Mental health concerns can be a drain on employee productivity and cause increased absences from work. To prevent these workplace losses, more employers have instituted **employee assistance programs** (EAPs) to link workers with services that can assist them.

EAPs are free for employees to access (or part of an employee benefit package), and there is an understanding that what's shared with the EAP is kept confidential from one's employer as they are not employers or the companies that pay for this benefit. Naturally, if an employee had concerns that their personal struggles would be shared with a supervisor, the individual would be quite unlikely to access EAP services. In some cases, EAPs provide counseling directly, while in others they refer employees to specific agencies and may cover the cost of a predetermined number of sessions.

EAPs are now required benefits for employees in any federal government workplace (U.S. Office of Personnel Management, n.d.), as well as many state and municipal offices. Among the most common issues addressed by EAPs are:

- Mental health concerns (short term)
- Substance abuse/dependence
- Family relationship problems (short term)
- Job stress
- Financial concerns, wills and contract questions

Apart from these services, EAPs working with particular employers may also offer services for aging issues and elder care, debt and financial assistance, legal advice, nutritional counseling, smoking cessation, childcare, and much more (Employee Assistance Group, 2015).

The Multidisciplinary Provider Health Team

You may be surprised to learn that clinical social workers are the number one provider of mental health services in the United States. Clients seeking assistance with mental disorders have a 60–70 percent chance of seeing a licensed clinical social worker (Masiriri, 2008; NASW, n.d.). However, clinical social workers are often just one part of a multidisciplinary team working together for the coordination of the client's care. In certain settings—like psychiatric hospitals, residential treatment centers, and outpatient mental health clinics—these teams provide a convenient way for clients to get their needed services in one place, with a group of professionals who are all on the same page.

Some of the people with whom you may work on a multidisciplinary team include:

- **Psychiatrist**: A psychiatrist is a medical doctor with a specialty in mental health. Psychiatrists can assess and diagnose clients as well as prescribe them psychotropic medication, and assess any medical conditions that may be contributing to the issue.

- **Psychologist**: Clinical psychologists may conduct therapy, psychological testing, and/or assess and diagnose clients. They generally

have doctorate degrees in their field but cannot prescribe medication.

- **Counselor**: A counselor typically has a master's **degree** in counseling or a closely related field and may have a credential like LCPC (licensed clinical professional counselor), LMHC (licensed mental health counselor), or LPC (licensed professional counselor). Counselors may engage in assessment, diagnosis, and provision of therapy services.
- **Marriage and family therapist**: This specialized area of counseling and therapy involves the professional being trained in family and relationship dynamics and helping people to resolve emotional and behavioral concerns impacting those relationships.
- **Art or music therapist**: More and more treatment facilities are employing specialized therapists who can assist in the healing process through the use of art, music, dance, and other means of creative expression and relaxation. These individuals often have master's degrees in their area of specialty and are sometimes called expressive therapists (Neukrug, 2014).
- **Psychiatric nurse**: These professionals have a nursing degree and **license**, and typically additional schooling to a master's or doctorate level. Those without an advanced degree can still perform basic tasks like nursing diagnosis and care (Neukrug, 2014). Psychiatric nurses can perform much as counselors, therapists, or clinical social workers do, but they also have additional specific training in the medical field. If they are also licensed nurse practitioners or advanced practice registered nurses (APRNs), they can prescribe medication as well (American Psychiatric Nurses Association, n.d.; American Association of Nurse Practitioners, n.d.; Neukrug, 2014).
- **Play therapist:** A specialized method for working with younger children, play therapy is a process that helps children to communicate and open up with a therapist about things they might otherwise struggle to put into words.

Some multidisciplinary teams are part of formal treatment models like assertive community treatment (ACT). As visualized in Figure 7.4, ACT serves people with the highest service needs through intensive daily coordination about each client from providers across each discipline.

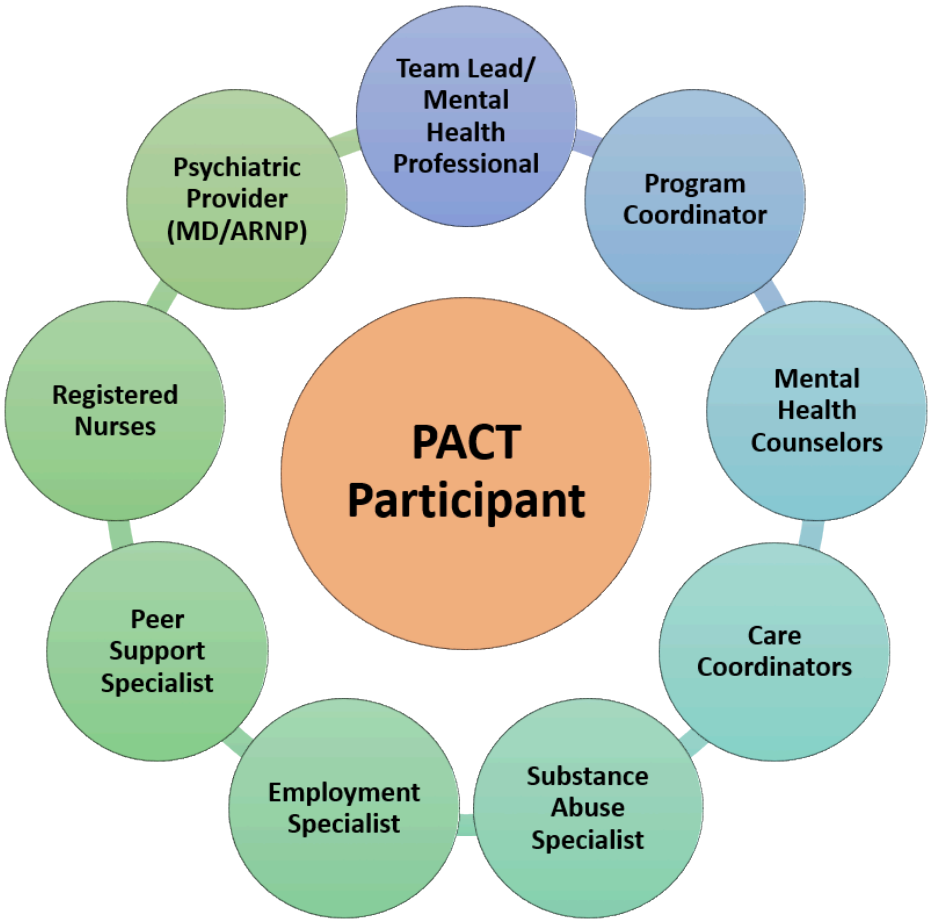


Figure 7.4. Psychiatric ACT (PACT) teams meet each morning for at least one hour to review each client's needs and support them in maintaining housing, wellness, and other goals.

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Figure 7.4. "PACT-diagram" by Kind County is in the public domain.

7.5 The Label, Not the Person

This section is an overview of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and briefly describes some common diagnoses. As a **human services** worker, you may encounter individuals diagnosed with one or more disorders as well as individuals without a diagnosis. Having a fundamental understanding of these conditions is essential. However, it is crucial to remember that these clients should be prioritized as individuals over their diagnosis or any symptoms observed. While categorization serves to help us make sense of the world, it is essential to remember that when

dealing with people, we must slow down and empathize with them, as they are not mere data points to be analyzed and categorized. They have personal histories, and our actions can significantly impact them. Therefore, prioritizing their humanity is necessary.

It is also essential to note that individuals not trained to diagnose should refrain from doing so. Still, basic knowledge of these disorders can help you navigate potential resources. Furthermore, the creation and influence behind diagnostic criteria should be considered.

The DSM is based on a Western medicine perspective of care, which can limit its perception of behavior, emotions, **culture**, **sex**, **race**, **gender**, social experiences of healing, what is considered medicine, and the providers who can provide advice. We must never forget that each person we encounter has a story and approach them with compassion and understanding. It is also necessary to consider that the DSM is imperfect and may not address every need of every person. Therefore, as human services workers, we must remain empathetic and open-minded.

The DSM has been referred to as the most important book of the twentieth century. Still, its imposing size disguises the intense uncertainty, factionalism, hostility, and political wrangling that has accompanied the development of each version of the DSM since its third edition in 1980. The first edition was first published in 1952 with 106 diagnoses; we now have over 300 conditions described in great detail, which only sometimes means more detailed diagnosis. The DSM has tried to consider language and cultural differences; however, it has yet to be as successful as it would like to believe it is.

Consider who participates in the workgroups for the DSM, which consists of more than ninety academic and mental health institutions worldwide. The selection of such a "diverse" group of professionals means that "many" viewpoints are being considered in each decision. Approximately 30 percent of individual participants in the workgroups are outside the United States. The following individuals were the committee members for the DSM 5 committee members. Nearly 100 are psychiatrists, 47 are psychologists, two are pediatric neurologists, and three are statisticians/epidemiologists. In addition, a pediatrician, speech and hearing specialist, social worker, psychiatric nurse, and consumer and family representative are also included. The were the members for the committee for the DSM-5.

The American Psychiatric Association (APA), as the leader of these task groups for the revision of the DSM, disclosed a conflict of interest with pharmaceutical companies. Still, in an "Honoria" way, a 2012 study showed that the members of the workgroups had not been entirely truthful with their financial disclosures by at least 20%, with as many of the workgroup participants having financially been complicated as shortly as a year before starting to partake in the workgroup and not disclose these connections? How can we not consider the close connection between pharmaceutical companies and the financial connection to many DSM diagnoses?

Something else to consider is that bilingual practitioners who must complete mental health assessments in Spanish are only trained in programs in the United States entirely taught 100 percent in English. It is difficult to find medical, especially psychiatric, diagnostic guides, let alone a DSM guide in Spanish that could be purchased locally (Portland, Oregon). In this case, some practitioners have to order from overseas from Spain, which can take multiple weeks and be incredibly costly. Not even a local medical school had a copy that could be bought from them, and even in Spanish, the diagnosis needed to be genuinely culturally sensitive. Just because something is translated into a language does not mean it is translated into a culture. This is just one language example; however, the DSM has been translated into 18 dif-

ferent languages, and nuance is essential, as is cultural context and knowledge.

Quick Reference Guide to DSM-5-TR Diagnoses

This feature was adapted from the DSM-5-TR. It is not intended to replace the use of the DSM in diagnosing a mental health disorder. It does not cover all of the diagnostic categories (e.g., eating disorders, sexual disorders, and others are omitted). Within each category, only a few of the more common diagnoses are listed, and summaries discuss common symptoms across diagnoses within a category. The guide also lists cultural considerations related to current and historical oppression as well as diversity in beliefs and assumptions about the world that impact **evidence-based practice** with clients with mental health disorders.

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). **https://doi.org/10.1176/appi.books.9780890425787**

Diagnostic category	Common symptoms	Most common diagnoses and their prevalence in the U.S.	Considerations for care across cultures
Neurodevelopmental disorders	– Specific or global limitations in social, intellectual, executive functioning & learning – Spectrum, or range of severity. – Manifest in early in life, often before school	– Autism Spectrum Disorder: 1-2% of U.S children (Christensen et al., 2019; Maenner et al., 2020) – Attention Deficit Hyperactivity Disorder: 7.2% of U.S. children. (Thomas et al., 2015) – Intellectual Developmental Disorder: 1% of U.S. children. (Maulik et al.,2011)	With similar symptom (a) White children are more likely to be diagnosed with neurodevelopmental disorders whereas Black & Latine students are more likely to be diagnosed with a conduct disorder (Mandell et al., 2007); (b) Men are more likely to be diagnosed than women (Rivet & Matson 2011). Foster-involved and justice-involved youth are more likely to develop these disorders (Ford et al., 2007; Lehmann et al., 2013; Moore et al., 2016)
Psychotic disorders	– Delusions (distorted thoughts) – Hallucinations (distorted sensations) – Disorganized thinking & speech – Disorganized or lack of movement – Diminished emotional expression, socialization, pleasure, or speec	– Schizophrenia: 0.3-0.7% of the population (McGrath et al. 2008; Moreno-Küstner et al., 2018) – Substance-Induced Psychotic Disorder: 7% and 25% of individuals presenting with a first episode of psychosis (Crebbin et al., 2009)	The content and meaning of delusions and hallucinations is informed by culture, which can make communicating about symptoms to people outside one's identity groups.(Bauer et al., 2011; Larøi et al., 2014)Commonly held in other cultures and religious traditions may appear abnormal in our cultural context (Campbell et al., 2017; Olfson et al., 2002; Rassool 2015)

Diagnostic category	Common symptoms	Most common diagnoses and their prevalence in the U.S.	Considerations for care across cultures
Bipolar disorders	Recurring episodes of depression and mania (type 1); or depression and hypomania (type 2)Mania is an excessively energetic, impulsive, euphoric, and grandiose state of mind. Hypomania is a less intense version that is less likely to occur with psychotic features.	– Bipolar I: 1.5% of U.S. adults (Blanco et al., 2017) – Bipolar II: 0.8% of U.S. adults (Merikangas et al., 2011) – Cyclothymic Disorder: 0.4-2.5% of children and adults, including European samples (Regeer et al., 2004; Van Meter et al., 2012)	African-Americans with Bipolar I are more likely to be misdiagnosed with schizophrenia (Blanco et al., 2017; Gonzalez et al., 2010; Haeri et al., 011; Perlman et al., 2016)Countries with a reward-oriented culture have higher prevalence of bipolar disorder (Johnson & Johnson 2014) For every one woman diagnosed with bipolar I, there are 1.1 men diagnosed with bipolar I. (Merikangas et al., 2011)
Anxiety disorders	– Excessive fear – Anticipation of future threats – Panic attacks – Usually develops in childhood – Phobias (like snakes, bridges)	– Separation Anxiety Disorder: 4% of U.S. children (Cartwright-Hatton et al., 2006; Pine & Klein 2008) and 0.9%-1.9% of U.S. adults (Kessler et al., 2012; Shear et al., 2006; Silove et al., 2015) – Specific Phobia: 8-12% of U.S. population (Kessler et al., 2005; Kessler et al., 2012; Stinson et al., 2007; Wardenaar et al., 2017) – Generalized Anxiety Disorder: 0.9% of U.S. adolescents; 2.9% of U.S. adults; and 9% of U.S. population across their lifetime (Kessler et al., 2012)	For many anxiety disorders, women are more likely to be diagnosed than men (e.g., LeBeau et al., 2010; Wardenaar et al., 2017).Cultures interpret anxious behaviors differently and have unique presentations of panic attack symptoms. (Lewis-Fernández et al., 2010) Body-focused symptoms are more common in non-Western cultures. (Ruscio et al., 2017)

Diagnostic category	Common symptoms	Most common diagnoses and their prevalence in the U.S.	Considerations for care across cultures
Obsessive-compulsive disorders	– "Obsessions: recurrent and persistent thoughts, urges, or images that are experienced as intrusive and unwanted" – "Compulsions: repetitive behaviors or mental acts that an individual feels driven to perform in responseto an obsession or according to rules that must be applied rigidly." (APA, 2022, para. 2)	– Obsessive Compulsive Disorder: 1.2% of U.S. population (Kessler et al., 2005; Ruscio et al., 2010) – Body Dysmorphic Disorder: 2.4% of U.S. adults (Koran et al., 2008) – Excoriation disorder: 2.1% of U.S. adults in the past 12 months and 3.1% across their lifetime (Grant & Chamberlain, 2020)	There are wide cultural variations in how clients express symptoms and how they make sense of their symptoms. Some clients attribute their symptoms to various physical, social, spiritual, and supernatural causes (Fernández de la Cruz et al., 2016; Grover et al., 2014; Pang et al., 2018).Body image concerns are impacted by culture. Clients are more concerned about eyelids in Japan (Hunt et al., 2008; Phillips et al., 2010) and muscle dysmorphia in Western countries (Sreshta et al., 2017).
Trauma and stressor-related disorders	– Directly experiencing, witnessing, learning about traumatic events (not related to media consumption) – Recurrent dreams about the traumatic event – Flashbacks, memory lapses, persistent negative thoughts about the traumatic event – Emotional numbness, loneliness, sense of disbelief about loss or death	– Post-Traumatic Stress Disorder: 4.7% of U.S. adults in the past 12 months and 6.1-8.3% of U.S. adults across their lifespan (Goldstein et al., 2016; Kilpatrick et al., 2013) – Prolonged grief disorder: 9.8% of adults in any country (Lundorff et al., 2017)	Women are twice as likely as men to be diagnosed with PTSD (Goldstein et al., 2016; Kilpatrick et al., 2013) partially due to greater likelihood of child abuse and interpersonal violence (Kessler et al., 1995)Somatic (body) symptoms are more common in non-Western cultures (Gupta 2013; Rasmussen et al., 2014) Grief responses may manifest in culturally specific ways. For example, cultures vary in the expected duration of grief (Goldstein et al., 2018; Stelzer et al., 2020a; Stelzer et al., 2020b) and interpret the significance of nightmares in different ways (Hinton and Lewis-Fernández 2011; Hinton et al., 2013; Smid et al., 2018). Death rituals impact the spiritual status of the deceased in the eyes of clients, and the inability to perform them appropriately may prolong grief (Hinton et al., 2013).

Diagnostic category	Common symptoms	Most common diagnoses and their prevalence in the U.S.	Considerations for care across cultures
Personality disorders	One's thoughts, emotions, and behavior are very different from the norms and expectations in the broader culture.Same across a variety of personal and social situations It affects all areas of a client's life, beginning in adolescence Depending on the cluster, client may appear (A) odd & eccentric; (B) erratic & emotional; or (C) anxious & fearful	– Any personality disorder (Cluster A, B, C): 10.5% of people have a personality disorder, including international samples (Huang et al., 2009; Morgan & Zimmerman, 2018) – Obsessive-compulsive personality disorder: Between 4.7% (Morgan and Zimmerman 2018) and 7.9% (Grant et al., 2004) of adults, including international samples – Borderline personality disorder: Between 2.7% (Morgan & Zimmerman, 2018) and 5.9% (Grant et al., 2008) of adults, including international samples	Clients can appear to have symptoms that are actually adaptations to cultural barriers including: (1) rigid or dysfunctional behavioral patterns (Balaratnasingam & Janca, 2017; Fang et al., 2016; Ronningstam et al., 2018; Ryder et al., 2014), (2) guarded or defensive behaviors (Iacovino et al., 2014; Raza et al., 2014) (3) supernatural beliefs and practices outside of Western norms ((Fonseca-Pedrero et al., 2018; Pulay et al., 2009)
Depressive disorders	"Sad, empty, or irritable mood." (APA, 2022, para. 1) Lack of pleasure in previously fun tasks Disruptions in eating, sleep, movement, energy level, concentration. Suicidal ideation and feelings of worthlessness	– Major depressive disorder: 7% of adults in the past 12 months (Kessler et al., 2003)	Major depressive disorder is three times as common in young adults (18-29 years old) than adults over 60 (Kessler et al., 2003) Women are two times more likely to develop depression (Salk et al., 2017) partially due to greater likelihood of child abuse and interpersonal violence across the lifespan (Altemus et al., 2014)Somatic (body) symptoms and other symptoms not in the DSM are more common in non-Western cultures (Kirmayer et al., 2017)

Suicide: We Need to Say the Word

The topic of suicide is a sensitive and challenging issue to confront. As a human services provider and mandated reporter, it is imperative to ask clients direct questions about their emotional well-being and comply with legal requirements. It is not enough to pose the questions; the language used and the relationship established with clients must be carefully managed. Therefore, comprehensive training is essential to prepare service providers to support clients in reducing the number of deaths by suicide and destigmatizing the conversation. The ultimate goal is to prevent suicides, even if it means engaging in difficult conversations, as visualized in figure 7.5.

Suicide and suicidal behavior stem from adverse conditions in which people live, work, learn, and play. These conditions, also known as social determinants of health, include but are not limited to economic hardship, **poverty**, racial discrimination, limited affordable housing, lack of educational opportunities, and obstacles to accessing physical and mental healthcare. Factors such as relationship problems or feelings of social isolation, easy access to lethal means, experiences of violence, **adverse childhood experiences**, bullying, and severe health conditions can increase the risk of suicide.



Figure 7.5. Human service professional assess for suicide risk and help clients plan for safety. Threats of suicide should be taken seriously. Download the **SAFE-T Pocket Card: Suicide Assessment Five-Step Evaluation and Triage for Clinicians [PDF]**.

While suicide risk affects anyone, some groups are more susceptible to negative social situations and other factors that contribute to suicide, making them vulnerable to higher rates of suicide or suicide attempts. Some communities of those communities that have a disproportionate burden of suicide are veterans, rural communities, sexual and gender minorities, older adults, people of color, and tribal populations.

Preventing suicide and suicide attempts entails creating favorable social conditions and identifying and managing factors that contribute to suicide risk. The Centers for Disease Control and

Prevention (CDC) is mainly concerned with groups disproportionately impacted by suicide and uses a comprehensive public health approach to reduce suicide risk and promote resilience and well-being in communities, ultimately saving lives.

According to a 2021 report by the Substance Abuse and Mental Health Services Administration (SAMHSA), more than 48,000 individuals in the United States died by suicide, equivalent to one death every 11 minutes. Shockingly, 12.3 million adults have experienced severe thoughts of suicide, 3.5 million adults have made plans, and 1.7 million have attempted suicide. Notably, Native communities and males have the highest number of deaths by suicide. Firearms remain the leading cause of death by suicide, followed by suffocation.

Oregon legislators have acknowledged the importance of providing more resources to support mental health and suicide prevention in schools. Consequently, the introduction of SB 52, also known as Adi's Act, "mandates that all school districts in Oregon must have a policy in place that addresses the issue of youth suicide and works towards destigmatizing mental health struggles."

Oregon also has a law that allows students to take up to five excused absences within three months for either mental health or sick days. However, exceeding this limit requires a written excuse from a medical professional. The bill was signed into law by Oregon Gov. Kate Brown in June 2019 to combat the high suicide rates among teens, making it one of the first state laws to explicitly instruct all schools to treat mental and physical health equally.

In 2018, Utah passed a similar law, but Oregon's legislation is a more decisive and assertive step toward prioritizing the well-being of students. The State of Oregon wanted to move supporting the well-being of students forward with Transformative Social Emotional Learning (TSEL), the teaching **standards** that will be required to be rolled out starting in July 2024 to all K-12 schools, charter schools, alternative schools, and other non-traditional educational settings (Oregon Department of Education, n.d.). TSEL focuses on **equity**-centered, **trauma**-informed social-emotional learning, starting with adult social-emotional learning and systems, not curriculum. This shows the field of human services is also moving to a holistic view of mental health support, as we should. As human services practitioners positions in schools such as SEL coaches, McKinney Vento Liaisons, attendance coaches, are all going to be required to be aware and trained in TSEL as this will be a standard of care and support that all staff, students and families will be using across the State of Oregon.

Nonsuicidal Self-Injury, or Self-Harm

Cutting, burning, scratching, punching, pinching, puncturing, unprotected sex, or picking at wounds to prevent healing: there are many methods of nonsuicidal self-injury (NSSI) or self-harm, despite "cutting" being the often-used euphemism. Seventy-eight percent of people who engage in this behavior use more than one method (Adler & Adler, 2011). NSSI is a complex behavior that can accompany a number of mental health disorders or stressors: depression, borderline personality disorder, eating disorders, bipolar disorders, PTSD, negative body image, **sexual abuse** or trauma, and more. People of any age and gender may engage in this behavior (McVey-Noble et al., 2006; Plante, 2007).

It can be very difficult for some people to understand why someone would engage in NSSI behavior, especially because many people who do so do not appear outwardly to have mental disorders, and may even be safety-conscious or risk-averse in other areas of their life—wearing seat belts, abstaining from tobacco use, etc. NSSI can present at any age and in any gender; however, it has been

socialized to be recognized more in teenage girls. We must be careful to not assume that they are the only people impacted, as self-injury or self-harm behavior can look so many different ways, as indicated in figure 7.6.



Figure 7.6. Recognizing the various types of self-harm can help you support those who are harming themselves.

Many people who engage in nonsuicidal self-injury say that they do so to relieve what some may consider "negative emotions" like frustration, jealousy, loneliness, sorrow, or anger. The physical pain, in a sense, distracts them from their emotional pain. The neurotransmitter rush that may accompany self-injury helps to counteract the negative emotions (McVey-Noble et al., 2006; Walsh, 2012; Plante, 2007). Others report that they feel numb to the world around them, or think they've forgotten what it's like to feel anything. Nonsuicidal self-injury reminds them that they can indeed feel, and that they are alive.

Still others have intense negative feelings about themselves and hurt themselves because they feel they deserve it. These individuals (as well as those mentioned in the previous paragraph) may very well injure themselves in places that will not be seen by others due to being covered up by clothing. Some may be intentionally cause injuries in conspicuous, visible places that they know will get the attention of loved ones or authority figures who will then help the self-injurer receive the necessary treatment to address whatever is going on (McVey-Noble et al., 2006; Plante, 2007; Walsh, 2012). Nonsuicidal self-injury is often seen in ado-

lescents and young adults who are exceedingly perfectionistic (academically, regarding body image, etc.) and/or dealing with family dysfunction or divorce (McVey-Noble et al., 2006; Walsh, 2012; Plante, 2007).

When self-injurious behavior is noticed, it is important to address it as quickly as possible. The longer one waits, the more difficult it can be to get treatment. Self-injury can become addictive, may be the only coping mechanism the individual uses for negative emotions, and may be bringing them a lot of attention—though not a healthy sort (Plante, 2007). Ignoring the behavior, or hoping it goes away, may inadvertently send a message that it is nothing to take seriously or that you are not concerned about the person who is self-injuring. Without **intervention**, the behavior can escalate as the self-injurer builds up a tolerance of sorts and begins to cut or otherwise hurt themselves more severely (McVey-Noble et al., 2006; Adler & Adler, 2011).

An important and common question is whether there is a link between nonsuicidal self-harm and suicidal behavior. There is definitely enough of a connection to cause concern. Most people who self-injure do not wish to die, and nonsuicidal self-injury should not automatically be taken as evidence of suicidality; however, research has placed the percentage of self-injuring individuals who also display some suicidal behavior at 50 to 90 percent, and 28 to 41 percent of those who self-injure have suicidal thoughts while self-injuring (McVey-Noble et al., 2006). People who engage in non-suicidal self-injury, regardless, are almost certainly suffering from some **degree** of pain and turmoil, whether they want to die or not. Successful treatment methods exist (Walsh, 2012). Cultural considerations are important.

Working with Womxn

It is important to have a shared understanding of how the word *womxn* will be defined in this text. *Womxn* is a term that is much more inclusive of many more people than only those assigned female at birth based on external genitalia. The concept began to be used in intersectional space in the 1970s to be inclusive of nonbinary people and transgender women. Not every nonbinary person connects with the experience or identity of being a woman; however, there are some that do, and this term is inclusive of such.

Womxn has also caused some pushback in other communities, as some feel it takes from other experiences, though it is not meant to. When one group is uplifted, it does not take from another; it brings up everyone. This comes up many times when considering the women's movement. Many believe that "allowing" transgender women into such movements takes away rights that earlier feminists—specifically White feminists—had fought for. If we begin to exclude who counts, we become the oppressors pretty quickly.

Without womxn as clients, we would need a lot fewer providers, yet many of our approaches are focused on men. We have not devoted as much research to problems that specifically impact womxn, like perinatal mood disorders or an understanding of how specific disorders like major depression or substance use disorders manifest differently for womxn. To give you an example, a quick search of the EBSCO research database in 2021 revealed 8,730 articles with a mention of perinatal depression, formally known as postpartum depression, but a whopping 15,041 when the search is for erectile dysfunction. The Federal Drug Administration (FDA) did not even start testing on female bodies until 1993 which shows how little we actually know about how many of the drugs or other medical devices on the market truly impact over half of the world's population. We are starting to pay more attention to

these imbalances in treatment knowledge and the increase in funding needs and supports in treatment programs, providers and overall research.

Critics have also recognized problems in using treatment approaches that were designed by men from their own perspective of what would be helpful and using those same approaches to help womxn. For example, feminist practitioners and theorists have been critical of the traditional twelve-step approach of programs such as Alcoholics Anonymous as it relates to womxn.

The first step involves admitting powerlessness. Women who have stated in groups that they already felt powerless, and that this may be part of what led them to abuse alcohol, have been at times "shamed, threatened with abandonment, and called resistant" to the twelve steps (Matheson & McCollum, 2008, p. 1028). Submitting further to an admission of powerlessness may actually increase women's insecurity and sense of oppression, putting further roadblocks in the way of their recovery. Those who already feel disempowered are not likely to find it helpful to start a program that insists on an admission of powerlessness (Matheson & McCollum, 2008). Powerlessness got them into their addiction in the first place, feminists might say. These women need to feel empowered and transformed instead of powerless.

From a macro perspective, we have to recognize that there may be a reason women seem to have higher rates of depression and other mood disorders, and it may not necessarily be physical or neurochemical in nature. "The mental health of women and their low social status are intricately intertwined…Any serious attempt to improve women's mental health condition must deal with the ways in which their mental health is affected negatively by social customs and cultural considerations" (Wetzel, 1995, p. 177). When women are treated as if they are lesser than men—as they are in virtually every society today, to some degree—it should be no wonder that they suffer from various mental illnesses. They may find themselves relegated to lower-paying jobs and have a greater likelihood of ending up in poverty. The patriarchal system tells them they cannot succeed, puts limits on their abilities to improve their lives, and then calls the natural emotional and psychological results of systematic oppression a "mood disorder" or "mental illness."

Men are less likely to feel they live in unsupportive, controlling environments and therefore are more likely to feel comfortable being assertive. Women in counseling may have to be assisted in learning assertive behavior to help them have better chances of achieving what they would like for themselves and their families (Wetzel, 1995).

Janice Wood Wetzel (1995) has several macro-level suggestions that she feels could make a bigger impact on the overall mental health of women. It requires more than simply continuing to treat individual women's problems as they present in social work and counseling offices. They include:

- "Raising consciousness regarding gender roles and the importance and worth of every female." (p. 181)
- "Addressing the fundamental right of every woman to live without fear and domination, whether in the home or society, and to be educated and treated with respect." (p. 183)
- "Sharing home maintenance and child care with men on an equal basis; restructuring the family and society from a human rights perspective." (p. 184)
- "Teaching fundamental rights regarding health needs, both emotional and physical, including the individual and mutual need for nurturance, freedom from exhaustion, and participation in decision making, within and outside the home." (p. 185)

- "Teaching women that both personal development and action, as well as collective social development and action, are essential if their lives are to change for the better." (p. 186)
- "Engaging in participative social action research, culminating in new policies and laws, as well as participative psychosocial programs for social change" (p. 187).

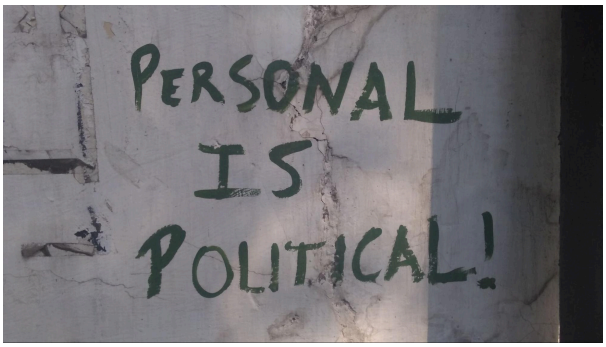


Figure 7.7. Feminist therapies, like those of Janice Wood Wetzel, demonstrate the truth of the feminist slogan "the personal is political," connecting mental illness and trauma with oppression–transforming society to transform how one functions within it.

Addressing women's individual mental health concerns, while still important, may be treating the symptom of a systemic problem. In order to make a more significant change in the overall mental health of women in the United States and abroad, efforts toward greater equality may be more productive. This is an issue that can be approached from micro, mezzo, and macro angles.

LGBTQIA2S+ Clients

Though there is greater acceptance than ever in America for LGBTQIA2S+ people, substantial prejudice still exists and is at times even socially sanctioned. Having to deal with oppression, disenfranchisement, and discrimination from society at large is difficult, but LGBTQIA2S+ clients also deal at times with similar behaviors from family and friends. Needless to say, this treatment from strangers and loved ones alike can bring about significant mental health concerns.

LGBTQIA2S+ people are impacted by depression at a higher rate than the general population, and counselors who behave in heterosexist or heterocentric ways can become barriers to LGBTQIA2S+ people seeking treatment (Bellenir, 2012). However, before moving on to anything else, it needs to be clear that LGBTQIA2S are not all the same; some are communities of sexual attraction, and others are gender or intersex. It is essential to understand that as much as we may see all those letters together, they are not all the same and to understand the complexity of this community is part of our own.

Before moving on to what most students want, a list of "dos and don'ts" for quick reference, we must be clear about our language. What does LGBTQAI2S+ even mean? Does it even make sense to have all those letters together? Should more be added? Am I missing something or anyone? The answer to all of these is yes and no.

Barrett & Logan (2002) offer the following tips for working with LGBTQIA2S+ clients in counseling.

- **Be aware of your own internalized prejudice**: Being raised in a heterocentric society, it is natural for most counselors to exhibit some heterocentrism, often without recognizing it.
- **Be prepared to assist clients with coming out**: Be supportive and appropriately aware of the potential pitfalls and difficulties with the process; respect their desire to come out at their own pace. This also means that we need to consider how **intersectionality** plays a role and that many people do not feel they need to, want to, or are safe to come out. The experience of being a lesbian Native woman is different from that of a gay White man.
- **Be aware of the effects of prejudice**: Recognize that clients have been dealing with nega-

tive treatment by society and may be living in a world different from the one you inhabit if you are heterosexual. They may not have experienced society as a supportive and helpful place, and therefore may anticipate different reactions from others than you would.
- **Actively address and combat societal oppression**: Think macro! If you want your LGBTQIA2S+ clients to have better mental health functioning, one way to help is to work on changing the environment to reduce those stressors of negative societal reactions and treatment toward your clients.
- **Be comfortable and able to talk about sex and sexuality**: Do not allow your client to feel like they need to approach the topic of sex indirectly. Be as willing to discuss their sex life and related concerns as you would with a heterosexual client.
- **Recognize that intimate partner violence and substance use does occur in same–sex relationships**: Make sure to have a list of LGBTQIA2S+ friendly resources at the ready for such situations, and react in the same supportive way you would to any other individual dealing with domestic violence.
- **Use the terms clients use**: If clients use terms like boyfriend/girlfriend, husband/husband, wife/wife, partner/partner, or anything else in their relationships, follow their lead. Don't feel the need to guess—if you are unclear what to say, just ask what the client(s) would prefer.
- **Avoid over-focusing on sexual orientation or gender identity**: Like heterosexual, cisgender clients, LGBTQIA2S+ clients have problems that they do not perceive as related to their sexual orientation or gender identity. Do not feel the need to connect every issue back to those elements of identity.

The bullet points above are not the only list we must follow as every individual has their own experience of the world, and neurodivergence, intersectionality, and unique needs are considered when we think about the cultural considerations of any community. Only some people from the LGBTQIA2S+ have the same belief systems, political set of values, family structures, and religious beliefs. So, it is unclear to many why this community's letters clustered together when they are sometimes not connected for some people in the community, and for others, they are interwoven. Some of the letters are much more well-known than others.

- **L**esbian: Women who are attracted to other women.
- **G**ay: Men who are attracted to other men.
- **B**isexuals: Someone who is attracted to more than one gender.
- **T**ransgender is an umbrella term that is used to represent a person who identifies with a gender that differs from the gender assigned at birth.
- **Q**: Queer is a term that the community has reclaimed in the last few decades, as it was used as a slur in the past, and some in the community may not feel that this term should be used, but the term Queer is not used by many as a way of encompassing questions, exploring or in general falling outside of society norms.
- The letter **I** represent Intersex, an umbrella term that describes a wide range of natural body variations that do not neatly fit into conventional definitions of male or female. Intersex variations may include but are not limited to, variations in chromosome compositions, hormone concentrations, and external and internal characteristics.
- The **A** stands for Asexual; Asexual is defined as people who have little to no desire for sexual attraction but desire emotional and spiritual attraction and relationships.
- **2S** The term "Two Spirit" may be unfamiliar, but it has a rich history in the pre-colonial

United States. Two Spirit individuals, often abbreviated as 2S, were respected as spiritual leaders in early Native societies. They embodied traits of both men and women and sometimes identified as male, female, or Intersex. They held notable roles, such as storytellers, counselors, and healers. However, these traditions have been threatened by colonization and historical trauma. Despite this, Two Spirit people across North America are working to revive their traditional roles.

Self-care and Community Care

Many professions talk about the importance of **self-care** and perhaps even created plans to support what self-care will look like in their lives. But what is self-care exactly? **Self-care** is defined as needs for overall well-being. It helps manage stress, reduce ailments, and foster positive emotions for a healthier life. Self-care can be viewed in eight domains: environment, physical, social/relationships, emotional, spiritual, professional, financial, and community. Self-care has often been talked about as bubble baths, getting manicures, going to dinner with friends; everything seems to be connected to some kind of monetary value and is made a check list item to complete. This often makes self-care seem selfish because people are spending money on themselves on what sounds like frivolous categories or an assignment to be completed and move on. However, self-care can be looked at in nine different domains and is anything but frivolous:

- **Environment:** This includes your living structure, is your space free of clutter and organized, you have a space that you feel comfortable and safe (this is up to you to decide what safe feels and looks like), privacy is a key component of this space also. It is important to know that privilege and access to resources is something that can limit what this can look like for some communities and people.
- **Physical**: It ensures enough sleep, nutritious food (consider cultural and decolonization needs), drinking enough water, physical touch, sexual needs, getting daily natural sunlight, limits on screen time especially during the morning and before bedtime and movement for your body's needs at least 15 minutes a day. Your needs will fluctuate based on the rhythm of your life and reminding oneself to have grace for the changes in life as trying to have a perfect balance is impossible. Consider each individual's differing (dis)abilities and mobility needs.
- **Social**: Prioritizing relationships is essential, and tending to your social well-being involves nurturing your connections. This can be accomplished by spending quality time with individuals who motivate and uplift you, be it friends, family, or trusted confidants. It's vital to distance yourself from negative social circles that do not contribute to your well-being. Social self-care may entail seeking new, meaningful friendships and connections. Joining like-minded groups, volunteering at special events, or exploring new activities are all effective ways to achieve this.
- **Emotional**: Emotional self-care helps us understand our emotions, navigate challenges, and build strong relationships. By tending to our emotional needs, we enhance compassion, kindness, and love for ourselves and others, contributing to our overall well-being. Acknowledging and discussing our feelings with trusted individuals or professionals is essential for managing our emotional well-being.
- **Spiritual**: The spiritual dimension of self-care is a deeply personal practice that allows you to align with the values and beliefs that give your life meaning. Even if you're not religious, connecting with the spiritual dimension remains

important. It can help you discover more meaning in life, cultivate a sense of belonging, and reduce feelings of isolation and loneliness. If you're trying to escape negative social circles, social self-care may involve seeking new, meaningful friendships and connections through joining like-minded groups or volunteering at special events.

- **Professional:** Engaging in professional self-care is important for maintaining overall well-being and growth. This can encompass a variety of practices, such as effectively prioritizing tasks, establishing realistic and achievable goals, delegating responsibilities when appropriate, and taking regular breaks to stave off burnout. Furthermore, ongoing learning and skill development are vital in fostering professional growth and job satisfaction.
- **Financial:** If dealing with personal finances stresses you out, practicing self-care in this area is important. Cultivating a healthy relationship with money is crucial for mental well-being, as it can reduce stress and anxiety. Financial self-care can also lead to a more positive attitude towards money, making us more open to discussing it and less envious of others' financial status.
- **Community:** It is about how our choices impact the community, not just the neighborhood we currently reside in but the future generations of people we interact with. Many cultures have interdependent beliefs in their way of life, community care, and environmental practices. They think of the lands they live on, the earth, and the people not as separate but as people in direct connection with each other, which significantly impacts future generations.

Community is the last domain mentioned above and directly related to the second kind of care that is interconnected to self-care. **Community Care**, is defined as the care that BIPOC and QTBIPOC communities emphasize the interconnectedness of individual and community well-being, fostering connections, recognizing systemic inequities, and creating new structures to address these issues. It aims to promote a more equitable future through mutual support, addressing social determinants of health and resource gaps. Community care seeks to create new structures and increase access to valuable resources through mutual support and aid provided by individuals and the broader community.

Remember that self-care and community care are not meant to prepare you to give all of yourself to others. These actions also do not genuinely care for anyone, including yourself. The idea that you cannot fill up anyone else's cup if your cup is empty is something that, as a Human Services field, we must stop saying. Caring for your well-being is not about sacrificing all your energy and resources for others; you should not compromise your own needs as a human for the needs of others. If that self-care you give yourself benefits others, that is amazing, but the purpose of self-care is not to turn around and give it all to others. You are enough; you, as a human, have value.

Both self-care and community care are parts of mental wellness that human services providers and this field can do a much better job in promoting starting from classroom and learning spaces, educators doing it during mentoring sessions, internships encouraging this with their interns and it being part of active conversations in codes of **ethics** conversions.



Figure 7.8. Self-care can look like self-indulgence, but the human body needs rest and recovery to maintain wellness.

Figure 7.5. "Suicide Assessment Five-Step Evaluation and Triage" by U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration is in the public domain.

Figure 7.6. "self harm awareness Nov 30 black ribbon" by TraumaAndDissociation is licensed under CC BY ND 2.0.

Figure 7.7. "Graffiti at the Ambedkar University Delhi, students 2018" by Frederick Noronha is licensed under CC BY SA 4.0.

Figure 7.8. "Self-Care" by Soozie Bea is licensed under CC BY SA 2.0.

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7.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- Mental illness has existed throughout history, but our understanding of it has grown and developed. Treatments have changed based on this understanding.
- Always check yourself for bias when working with clients, especially those who have less power in our society (womxn, LGBTQAI2S, and BIPOC). All of us absorb bias from society.

- **Self-care** is critical for the **human services** professional, even more so when working with clients who are struggling with mental health and mental illness.

DISCUSSION QUESTIONS

- What can be done to prevent, intervene, and remediate people who have mental health disorders?
- If the United States were to focus entirely on preventing as many mental health disorders as possible, what kind of programs and services would dominate?
- How is mental health impacted by bias?
- What self-care practices do you already practice? What can you add to your repertoire? Think about both short term and long term strategies.

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CHAPTER

8

Families, Children, and Schools

8.1 Chapter Overview

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 7: **Human services** professionals ensure that their values or biases are not imposed upon their clients (NOHS, 2015).

This chapter focuses on two of the most important aspects of children's lives: their families and educational settings. It applies the ecological **systems theory** that you read about in Chapter 1 to these relationships and settings. In addition, you will learn about child **welfare** programs, the impact of **poverty** on children, and human services programs that are based in schools.

Standard 7 reminds us that, as human services professionals, we must ensure that our values and biases are not imposed on clients. Many of us are passionate about protecting children, but we must remember that parents and educators are also deeply invested in caring for the children in their lives. Although we may have different viewpoints, it is important to recognize the responsibility that parents and educators each have for children. Our work is to help them solve life's problems using their strengths and support systems.

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LEARNING OBJECTIVES

1. Define family and the various structures it takes in the United States.
2. Describe how children and families are served in the human services field.
3. Explain how school-based programs and human services providers are connected.
4. Discuss how human services and the **child welfare** system interact.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Kin: people related to one another, family
- Adoption: the social, emotional, and legal process in which children who will not be raised by their birth parents become full and permanent legal members of another family
- Child welfare: typically refers to any situation where the child's needs are paramount and their immediate protection takes priority over the other family needs
- Foster care: a temporary placement of a child with another family while parents are resolving issues
- Socialization: process through which we learn the culture of the social groups that we belong to.
- Individualized Education Plan (IEP): a comprehensive plan that outlines the special education instruction, support, and services a student needs to succeed in school. It is a legally binding agreement created for eligible students who attend public school, including charter schools, and falls under the Individuals with Disabilities Education Act (IDEA).
- Individualized Family Service Plan (IFSP): a written legal document that outlines the support and services required for infants and toddlers with developmental delays to catch up with peers. It is created for eligible kids from birth to age three who need extra help with physical, communication, self-help, cognitive, or social-emotional skills. It is covered by the Individuals with Disabilities Education Act or special education law.
- Mandatory reporter: a person who has an individual legal duty to report known or suspected abuse or neglect relating to children, elders, or dependent adults.

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8.2 Families



Figure 8.1. While there can be great diversity in how families are structured, the functions of families and the essential contributions that families make to society are consistent.

When we are born, many of us are welcomed by parents, siblings, grandparents, aunts, uncles, cousins, and other **kin**. Being fed and held, and gazing into our carer's eyes, stimulates hormones that help us build strong biological and social bonds, especially in the earliest days of life. We experience love and learn about trust. The caring people fall in love with us too, and they recognize each other in us. Their shared love for us strengthens their bonds with each other and inspires them to work together to protect and provide for us and each other. These strong social bonds can be eroded by **trauma**, absence, illness, or abuse. Even then, we often go to great lengths to preserve these family bonds. For those who are unable to preserve them, the absence of these strong connections can be devastating.

If we lose the first people who care for us, we need to be welcomed, loved, and protected by other kin and caregivers. As we grow, we may cultivate new loves. Our kin will welcome our most dearly beloved, and their kin will welcome us, and we may welcome children of our own. The love, care, and commitment that flows between children, parents, siblings, grandparents, aunts, uncles, cousins, and other kin is embodied in culturally specific ways of being and doing that connect us to the memory of our ancestors and the hope of future descendants. We call this dynamic social system of love and kinship a family.

It is important to keep in mind that the historic legacy of settler colonialism and enslavement continues to undermine the traditional family structures of indigenous and immigrant, as well as under-resourced, communities. It is also important that **human services** workers understand the harm that is possible when we project our biases about what counts as family onto the people we work with.

Keep in mind the difference between a household and a family. Some human services workers, such as supportive housing case managers, work with household units, often a parent and children. In these situations, it is helpful to remember that a household may be part of a larger family unit that includes grandparents, siblings who reside elsewhere, and elder relatives.

Structures

Families can be understood as social units that consist of people who are biologically, socially, and/or legally connected to each other. It is a universal fact that every human comes from a family, but beyond this fact, it is hard to define the structure of families in universal terms. For example, many definitions of family also include shared residence, but parents and children don't stop being family when kids move out or parents divorce, and many family members share intimate familial bonds without ever living together. Many definitions, like the introduction above, center the care of children as a defining characteristic of families, but some families are childless.

It is hard to definitively describe family structure because family is a social construction. A social construction is a mutual understanding and accepted reality created by members of a society, something that is not determined by biology or the natural world (Pearce, 2024). Social constructions are determined by their social context, while biologically determined phenomena are constant.

The fact that families exist everywhere indicates that some things about families are constant. For example, pair bonding, reproduction, aging, and death are biological processes. The universal helplessness of human babies, the physical vulnerability of elderly people, and the human need for connection are also fixed in our biology. The diverse ways groups of people have organized themselves in families in response to these biosocial needs and processes are dynamic adaptations to their specific historical, political, and geographical contexts.

The nuclear family is dominant in the imagination of contemporary society and is sometimes idealized as "traditional." It is actually a relatively new family structure when compared with authentically traditional family structures in indigenous, non-Western, and pre-industrial European societies. For a quick rundown on traditional family structures, check out the video in figure 8.2.



This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=-T6v3DhGhTc**

Figure 8.2. The nuclear family is actually not the oldest or most common family structure. Watch **Where Does the Nuclear Family Come From? [Streaming Video]**. **Transcript.**

Many social science textbooks classify family structures by comparing them to a nuclear family, which has been incorrectly standardized as a normative family structure. This idealized self-sufficient family unit usually consists of two parents and one or more children. Contemporary variations on nuclear families have been expanded to include same-**sex** parents and children who may not be biologically related to one or both of their parents. Contemporary "blended" families can be understood as remixed nuclear families. Multigenerational extended families, in which a nuclear family expands to include elder relatives and adult children, are becoming more common and resemble more traditional family structures.

We must consider that families look and sound many different ways, depending on social constructs. They can evolve, so allowing flexibility to be part of the narrative we have with family understanding is critical. A children's book that can be helpful in understanding a wide representation of what different families can look like is *And That's Their Family!* (Coleman & Malone, 2023). The book goes into giving visual examples of polyamorous families, multigenerational families, and single-parent households that have siblings raising siblings, which for many is a common practice not seen in many mainstream conversations.

It is also common for people to live together and start families without officially getting married. In

2018, 9% of people ages 18 to 24 lived with an unmarried partner, compared to 7% percent who lived with a spouse. About 22% of young parents in the US live with a spouse, while 30% live in an unmarried partnership. Additionally, 6% of couples over age 65 who live together are not married (Gurrentz, 2019; Valerio, 2021). The birthrate in the United States dropped after COVID, according to the PEW Research Center, though it had been dropping since 2018. "Some 44% of non-parents ages 18 to 49 say it is not too or not at all likely that they will have children someday, an increase of 7 percentage points from the 37% who said the same in a 2018 survey. Meanwhile, 74% of adults younger than 50 who are already parents say they are unlikely to have more kids, virtually unchanged since 2018" (Brown, 2021, para. 2).

Functions

While there can be great diversity in how families are structured, the functions of families and the essential contributions that families make to society are generally consistent. Whatever their structure, families function to stabilize a society. They are a primary source for emotional connection and social identity for their members. They also help socialize children to the norms of their society. Because families operate in alignment with a society's existing power dynamics, they can either reproduce or interrupt social inequality present in their society. Families also help regulate sexual activity and reproduction within their society. Most importantly, families provide the context for children's social and emotional development.

We function at our best when our basic psychological need for connection is well supported (Deci & Ryan, 1985). Social identity theory describes how the social groups we belong to are foundational to who we understand ourselves to be, our sense of self. We identify with and favor people within our social groups, and we tend to "other" those who are not in our social groups. As the first social group where we experience belonging, our family profoundly influences our sense of who we are.

However, this experience of feeling like we belong to our families is unfortunately not universal. At times, this first interaction with families can impact clients so deeply that it can be the reason they reach out to human service providers. This is when we must consider our own bias when working with clients and what clients' needs may be as they move towards their **socialization** needs. What is our experience with feeling like we belong? How do we look at the word *family*? What structure does family have for us? What function does it serve?

Socialization

Socialization is the process through which we learn the **culture** of the social groups that we belong to. If social identity helps us understand who we are, socialization is the way we learn how to be. Families are primary agents of socialization and social control. On a biological level, socialization is integral to cognitive development. It includes learning about language, symbols, values, beliefs, norms, folkways, taboos, and culture. Power structures, which are embedded in culture, are also reproduced and sustained through socialization.

In monocultural societies, where family groups share an **ethnicity**, **race**, **religion**, and/or politics, families reproduce the norms and practices that define and sustain the dominant culture through socialization. This process assures continuity for the society as a whole. In multicultural societies, socialization can include both culturally specific learning to reproduce traditional life-ways and social learning related to the larger multicultural society, including how we navigate cultural differences and respond to people who are "not like us."

Socialization in families also reinforces the power structures of a society as we learn about our own social location. Social location includes our **gender**, class, race, and other indicators of social difference to which social power attaches. Internalized oppression, which can include ideas about identity-based inferiority and superiority, is a term that describes socially learned systems of social dominance.

Through direct and indirect instruction, play, and observation, we learn gender norms. We are socialized to class by the food and aesthetics we learn to like, the kinds of work we are prepared for, and our attitudes toward material resources. Our families are also where we first learn about race. In contemporary American society, socialization around gender, class, and race often includes overt messages of tolerance and equality that coexist with deeply internalized, though sometimes unconscious, attitudes that uphold and perpetuate classism, sexism, and racism. Cognitive dissonance is a term that describes the phenomenon of learning and holding conflicting beliefs and ideas.

Sexual socialization in families teaches and enforces culturally specific social norms about when sex is okay, what kinds of sex are okay (as in figure 8.3), and how unsanctioned sex and reproduction are tolerated or disciplined. In addition to being a primary agent of sexual socialization, the family as a unit functions to control and regulate sexual activity within a society.



Figure 8.3. Socialization of families includes affirming diverse family forms, often in public events like Pride festivals and membership organizations like the Parents and Families of Lesbians and Gays (PFLAG), pictured here.

Children are not an essential component of family, but for families with children, a primary function of families is to support optimal child development. However, as we know, child development may be essential but not the only part of socialization that happens within families.

As mentioned above, families are not just related by blood. For many communities the phrase "It takes a village to raise a child" is meant literally. The teachings of language, food, music, how one cares for loved ones, the responsibilities we have to the land, spiritual practices, coming of age rituals, and the views of life and death and how we are interdependent on one another: all are taught as part of how we function as a family and that translates to how we function in society.

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Figure 8.1. Photo by Tyler Nix is licensed under the Unsplash license.

Figure 8.2. "Where does the Nuclear Family Come From?" by PBS Origins is licensed under the Standard YouTube License.

Figure 8.3. DC Gay Pride 2011 by Tim Evanston is licensed under CC BY SA 2.0

8.3 Serving Children and Families

Many **human services** organizations focus on serving children and families. Whether it's addressing issues of stable housing, food insecurity, medical needs, child care, or mental health, to name a few, human services as a field is deeply engaged in the work of strengthening children and families. There is a natural alignment between the work of human services with children and families and that of the K–12 education system.

This does not mean that these systems work without any flaws or that we don't need to consider our own experience with our own families and schooling. As a human services provider, these environments are also filled with bureaucracy that is difficult to navigate. We must support both navigating these systems as a provider and helping clients do so. Consider, for example, how challenging the navigation of the education system in this country is when your **first language** is not English. It makes it nearly impossible to feel like the system was built to include you.

Human Services and Schools

Many of the issues that human services organizations address affect school-aged children. Increasingly, there has been an effort to bring human services to the schools in the hopes of improving the outreach and the effectiveness of services available to support our most vulnerable children and families. This effort has been particularly notable in the public education system. The growing partnership between human services organizations and public schools has resulted in expanded resources for children and families ranging from on-site medical and dental clinics for low-income families to laundry and shower services. In this section we will explore some of the most common issues faced by school-aged children and their families through the lens of school-based human services partnerships.

Schools try to provide reliable access to children and families, and the districts increasingly recognize the value of co-locating human services programs within school buildings. Schools may invite community partners in to offer services such as food banks, community health clinics, and vision and dental screenings for children. It is clear that students are better learners when their basic needs are met. Schools have a mission to provide education and academic foundations, and the work to ensure the security of basic needs may be seen as an investment in student learning.

School districts provide dedicated services through efforts such as Title I grants from the federal government to reach students navigating **poverty**. These services include targeted outreach

to housing-vulnerable students, weekend food backpack projects to improve student and family nutrition, and offering locations for community health clinics to provide free and low-cost medical care, including child immunization, well child physicals, and in some cases immediate care services for uninsured community members. Special education services may partner with occupational therapy programs to improve learning outcomes, another example of human services partnerships with public schools. Investments in student mental health may include **collaboration** with community mental health services.

Case Study: Creative Solutions

The human services **profession** values multidisciplinary knowledge and collaboration. As an example of leveraging multiple disciplines and funding streams, the school district in Corvallis, Oregon, funded its own mental health initiative. It brought certified mental health practitioners into each school and allowed family members of school district students to access these services alongside their school-age children (Mahoney, 2019). The program has become self-sustaining through obtaining status as a **Medicaid** insurance provider. This means the school district can bill Medicaid directly for the mental health services it provides to low-income students and their family members.

The integration of human services into the school district has reduced the wait time for students seeking services and drastically increased the amount of available youth-oriented mental health support. When schools invest in partnerships with human services, student learning outcomes improve. In this way, human services programs can help schools be more successful in their mission to launch today's youth into becoming tomorrow's leaders.

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8.4 School-Based Human Services Programs

While every state, school district, and individual school is unique, there are some common themes that occur in school programs and initiatives that meet the needs of children and families. These are just a few programs that can support and connect what we can do in **human services** directly to what happens within school systems. Integration of systems is crucial to help de-silo and demystify support systems for our clients, as many people don't know how or who to reach out to when they or their families have needs.

Mental Health Programs

The CDC has identified mental health as a leading health issue for children and adolescents. More than one in three students report experiencing persistent feelings of sadness or hopelessness. Depression, anxiety, and feelings of isolation are experienced by 70 percent of teens age 13 and older.

One in six U.S. youth aged six to 17 experience a mental health disorder each year, and half of all mental health conditions begin by age 14

(National Alliance on Mental Illness [NAMI], 2022). Attention deficit hyperactivity disorder (ADHD), behavior problems, anxiety, and depression are among the most commonly diagnosed mental disorders in children. Yet only about half of youth with mental health conditions receive any kind of treatment.

School-based mental health services bring trained mental health professionals into schools and connect youth and families to more intensive resources in the community. They play an important role in identifying needs and helping children get help early. School-based mental health services may reduce barriers to access for communities of color, immigrant and refugee families, and low-income students.

Trained mental health professionals deliver school-based mental health services. Sometimes school districts employ mental health staff, such as psychologists, counselors, and social workers. In other instances, school districts provide space for community mental health partnerships that can include school-based medical clinics with other health services that can serve students with **Medicaid** coverage, underinsured students, students with no insurance, and even at times students with private insurance. Many schools use a combination of school employees and community programs. This approach to help support students' various needs has become widely popular. Human services providers may be serving as peer support, case managers, confidential advocates, skills trainers, or sexual health educators.

One key aspect of school-based mental health is providing services on-site and during the school day. By removing barriers such as transportation, scheduling conflicts, and stigma, school-based mental health services can help students access needed services.

Early diagnosis and treatment are effective and can help young people stay in school and on track for achieving their life goals. The earlier the treatment, the better the outcomes and the lower the costs. However, accessing mental health can be a long process, with wait times that stretch to several months. For teens exhibiting signs of psychosis, NAMI found there is an average wait of seventy-four weeks for consistent, non-crisis care to be established. School-based mental health programs are an effective means of getting mental health care to children and families in a timely way, improving learning and mental health outcomes for the individual, the family, and the school community.

Houselessness and McKinney Vento Act

Education can provide houseless children a way out of housing instability. Still, practical barriers, such as residency restrictions, medical record verification, and transportation issues, often keep houseless youth out of school. The original McKinney Act, passed in 1987, focused on assistance to the houseless. The McKinney-Vento Homelessness Assistance Act, as reauthorized in 2015, attempts to overcome these barriers by mandating equal opportunity for free public education for houseless students.

Under the reauthorized McKinney-Vento, school districts must appoint a local liaison to ensure, among other things, that (1) children and youth eligible under McKinney-Vento are identified; (2) that they immediately enroll in, and have a full and equal opportunity to succeed in, the schools of the district; and (3) they receive educational services for which they are eligible, and referrals to health care services, dental services, mental health services, and other appropriate services.

In the state of Oregon, there are 197 school districts. In each of those districts, there must be an identified McKinney-Vento liaison whose role is to provide not only resources for identifying houseless families but also training for school dis-

trict staff on the legal responsibilities that the districts have to students and families. The current amount of money that the state of Oregon has dedicated to support these students, including the salaries for these liaisons, is only $1 million. This is calculated according to the school districts' reported number of houseless students and their families from previous years.

One of the biggest issues is that this is a severely underreported number of impacted students. This is due in part to the stigma of asking questions around **houselessness**. There is also lack of support and standard training for McKinney-Vento liaisons, and school districts are not required to have a full-time position for a liaison. That means many liaisons must perform multiple jobs.

A position as a McKinney-Vento liaison could be ideal for human services students. The skill sets and areas of study in this field enable students to not just see the families from an individual level of need but from a systemic one also.

There are conversations happening within the Oregon Department of Education about how the department can better support liaisons, including setting baseline **standards** for training expectations for liaisons, administrators, liaison supervisors, and even front desk staff, as they are the most likely to have contact with students and families. This is a great time for students to enter the field and impact the way families will experience support.

Special Education Programs

Passed in 1975, the Education for All Handicapped Children Act (EHA) required all schools that receive public funds to provide equal access to education for all children with disabilities. The act addressed four main objectives:

1. To ensure that special education services are available to children who need them;
2. To guarantee that decisions about services to students with disabilities are fair and appropriate;
3. To establish specific management and auditing requirements for special education; and
4. To provide federal funds to help the states educate students with disabilities.

The act also states that students with disabilities should be placed in the least restrictive environment that allows the maximum possible opportunity to interact with non-impaired students. Separate schooling may only occur when the nature or severity of the **disability** is such that instructional goals cannot be achieved in the regular classroom. EHA was revised and renamed the **Individuals with Disabilities Education Act** (IDEA) in 1990 to improve **special education** and **inclusive education**.

IDEA

The IDEA requires that public schools create an Individualized Education Plan (IEP) for each student found to be eligible under both the federal and state eligibility/disability standards. The IEP provides an overview of a student's academic ability and achievement as well as an assessment of how a student's disabilities affect or would affect the child's involvement in their educational environment. The IEP also specifies the services to be provided and how often, plus accommodations and modifications to be provided for the student. An IEP must be designed to meet the unique educational needs of that child in the least restrictive environment appropriate to the needs of that child.

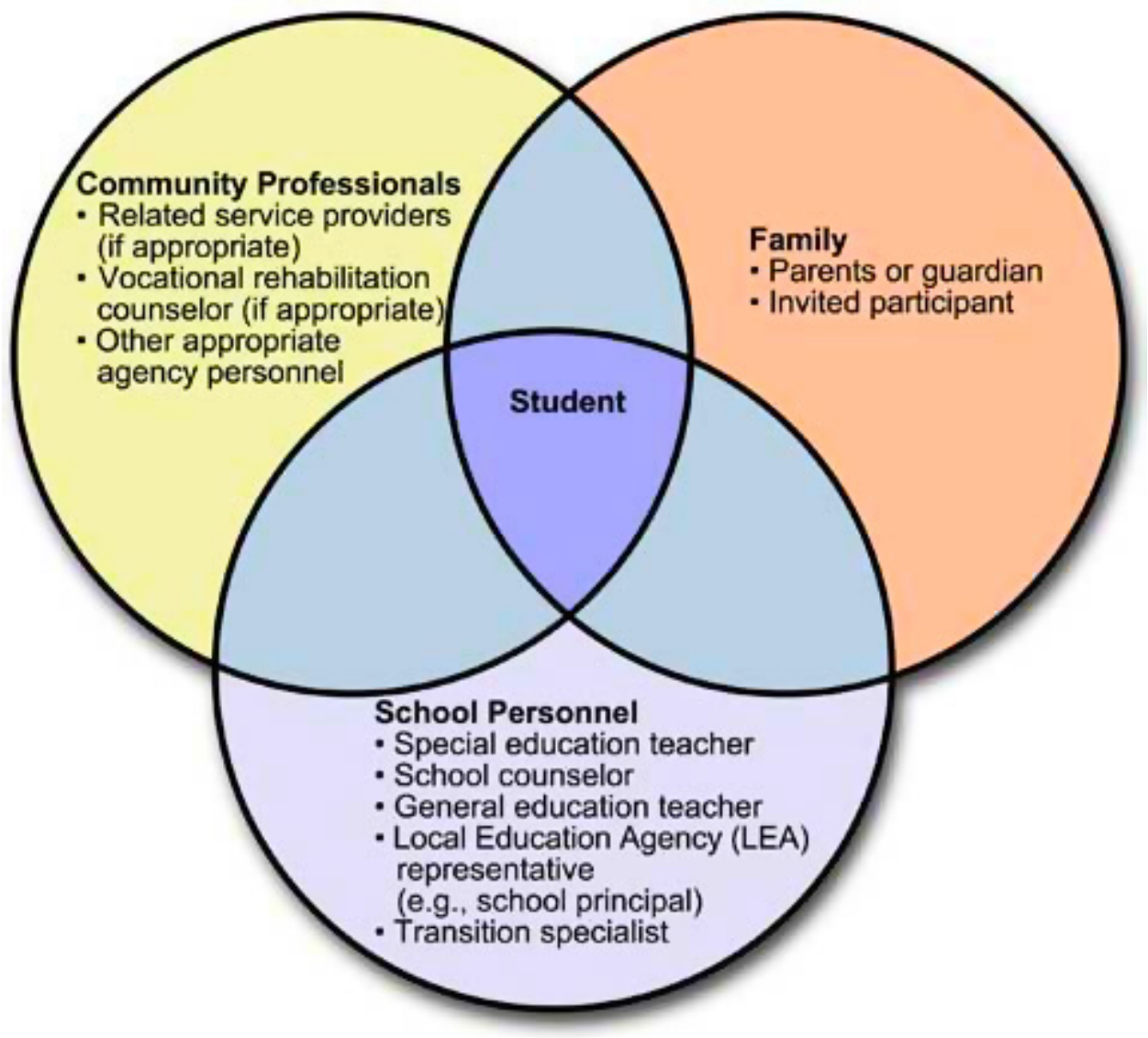


Figure 8.4. Students are supported by family, school, and community systems during the creation of the IEP and are often tasked with specific actions to perform for the child.

The key component of an effective IEP is **collaboration**, which is visualized as a circle in figure 8.4. When a child qualifies for services, a team is convened to design an IEP. In addition to the child's parents, the IEP team must include at least:

- one of the child's regular education teachers (if applicable);
- a special education teacher;
- someone who can interpret the educational implications of the child's evaluation, such as a school psychologist;
- any related service personnel deemed appropriate or necessary; and
- an administrator or Committee on Special Education (CSE) representative who has adequate knowledge of the availability of services in the district and the authority to commit those services on behalf of the child.

IEPs are based on the full educational evaluation results. This team collaborates to write an IEP for the individual child to provide free, appropriate public education. Access can start before kindergarten, which is where an Individualized Family Service Plans come in. IFSPs are used for children and their families before they enter kindergarten and require special education support, such as speech pathology or occupational therapy. Some students graduate from services and do not require IEPs when entering kindergarten. Others will have transition meetings, which are intended to be led by the family, to guide the best next steps for making their child's education path the most successful possible.

This last point is not a legal requirement; however, it may be an ethical one. As you gain decades of experience in education, you learn that some of your biggest assets are classified staff, including transportation staff, instruction assistants, front desk support, and special education case managers. As human service students today, some of you may already be working in these roles. You may not always be invited to IEP meetings, but you have a wealth of knowledge regarding how students you work with express their education needs daily, including what does and does not work for them. This information is critical for the IEP team to know. Your voice is important, and many times, you help make the plans successful.

We must also not forget to bring cultural, linguistic, and community partners into these meetings, as many families will not understand all the acronyms spoken. Jargon is used in these meetings, and the families may share an identity with you. The pool of paraeducators and instructional aides tends to have the most diverse educators working with students. When we are in these meetings, it is important to both help families advocate for themselves and model asking questions when families may not feel comfortable asking those questions themselves.

Youth Programs

One of the most common ways to work with youth in the context of human services is through youth programs. Sports, music, after-school clubs, and summer camps are but a handful of ways to invest in youth development. Youth programs may be organized through centers, such as the Boys and Girls Club of America, who often provide after-school care in addition to a variety of community programming. City and county sports and recreation departments may provide opportunities for youth to organize around a shared interest or be a source of summer camp experiences. These programs depend on energetic, knowledgeable, and passionate staff to provide opportunities for youth to grow and develop intellectually, emotionally, and physically.

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Figure 8.4. **The IEP Team** by The IRIS Center is licensed under **CC BY NC ND 4.0**.

Technology Programs

Have you ever made a robot out of Legos? Or turned a soda can into a solar-powered car? These kinds of activities have become a regular part of after-school activities made available through partnerships with public schools and youth programs. Kids can even learn computer programming while playing Minecraft!

Technology labs introduce new forms of hardware and software, and provide instruction on using technology safely. Youth programs that provide increased opportunities to learn about and creatively apply technology are important in addressing **gender**, **race**, and **ethnicity** differ-

ences in technology careers, bridging differences in rural and urban technology opportunities, and closing the gap in socioeconomic status by supporting lower-income neighborhood schools.

One way communities have introduced technology programs is through the use of 21st Century Community Learning Center (CCLC) grants. These federally funded grants are an example of public-private partnerships to improve educational outcomes. They are awarded to K–12 schools and youth partnership programs to expand resources through after-school programs, youth club activities, and summer camps. Communities can launch programs and work to make them self-sustaining. Projects accepted for the program will receive 100% funding for one year, 75% for the second year, 50% for the third year, and 25% for the fourth year. This provides time to evaluate the benefits of the program and work toward a community solution to sustain it.

As you can see, there are many ways to work with children and families in a school setting without being a licensed teacher. You may choose to work in any of the programs described here, or in a similar program in your local community.

As the increase of the use of technology happens in classrooms, so does the need for human services providers to understand how this impacts the work we will be doing. We also need to understand the ethical impacts technology has on the communities that we will be working with. The diversity of skill sets that human service providers come with will be crucial for how services will be delivered in the future, from how to set up a virtual classroom that can meet all student needs to creating online trainings that are **trauma** informed. All levels of educators must continue to understand how their own professional development will impact their students.



Figure 8.5 Organizations like Black Girls Code work with schools to provide additional education, mentorship, and programming related to software engineering.

Just as we consider DEI with every aspect of the work we do in the field, we need to likewise consider technology. Which communities typically get first access to technology? Who is represented in the media when you first think of STEM fields? We often forget the likes of Rodolfo Neri Vela, the first Mexican-born scientist and engineer to travel into space, or organizations like Black Girls Code. Its CEO, Cristian Jones, has made it the program's mission to increase the number of girls and gender-nonconforming youth who have coding skills as well as to increase leadership skills through training and resources. Black Girls Code partners with local schools and organizations and holds graduation events, as seen in figure 8.5.

As human services providers, we must encourage community connections and partnerships like these not just to diversify the tech sector but to center communities that have not been considered as users of technology. Human services students can not only become peer mentors in tech but also help create a curriculum that decenters the typical stories and diversifies who students see in these spaces.

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8.5 Human Services and Child Welfare

Indian Child Welfare Act (ICWA)

In November 2022, the Supreme Court of the United States heard arguments in Haaland v. Brackeen, which challenged the constitutionality of the Indian Child **Welfare** Act (ICWA). Watch the video in figure 8.6 for a quick overview of the main arguments of the case. As of this writing, the court has not issued a ruling in the case. If the court strikes down portions of the law, this could have serious ramifications, not only in terms of the well-being of Native American and Native Alaskan (NA/AN) children and families, but for a broad slate of issues related to tribal sovereignty.



This interactive content is not available in this version of the text. It can be accessed online here:
https://www.youtube.com/watch?v=vi_7TmjAjL0&t=22s

Figure 8.6. Three-Minute Legal Talks: United States Supreme Court case Brackeen v. Haaland [Streaming Video] from the University of Washington School of Law explains the history and main arguments of Holland v. Brakeen. Transcript.

The practice of removing NA/AN children from their families and placing them in boarding schools and with non-Indian families had its roots in the assimilationist policies of the U.S. government. The government sought to "Americanize" NA/AN children, who were considered by White Americans to be "uncivilized." Over more than a century of Indian removal policies, the territory held by sovereign NA/NA people was significantly reduced, leaving many impoverished and vulnerable to illness and exploitation. Between 1819 and 1969, the United States operated or supported 408 boarding schools in 37 states or territories (Newland, 2022). Researchers are still trying to determine exactly how many children were removed from their families during this period.

We do know that by the time ICWA was enacted in 1978, 25 to 35% of all NA/AN children had been removed from their homes by state **child welfare** agencies, and of these, 85% were placed in homes outside of their communities. During the 1950s, '60s, and early '70s, more than 80% of NA/AN families had children removed from their homes by the government (Native American Rights Fund [NARF], 2007). In contrast, in 2020, the total number of removals for all children in the U.S was .03% (ACEF, 2022).

ICWA was considered to be a major advancement for tribal sovereignty and self-determination. Casey Family Programs (CFP), one of 26 child welfare and **adoption** agencies who filed a brief in support of ICWA (CFP, 2022), asserted that the principles of family preservation that ICWA advances are a gold standard in child welfare for all children and families (CFP, 2022). In

CFP's strategy brief, Strong Families, these principles include acknowledging and protecting children's rights to be connected to their families, supporting efforts to preserve and reunify families, valuing inclusive and diverse cultural practices, and prioritizing authentic tribal engagement.

CFP's strategy brief reflects a significant trend in the child welfare field toward family preservation and reunification. In 2018, the Family First **Prevention** Services Act codified this shift by providing prevention funds for mental health services, substance use treatment, and skills training for parents. According to the Children's Bureau, which is part of the Administration for Children and Families, "This law significantly shifts how the country provides services for families and youth. In particular, it changed the role of community service providers, how courts advocate and make decisions for families, and the types of placements that youth placed in out-of-home care experience" (Child Welfare Information Gateway 2023). This shifting posture is based on overwhelming data that demonstrates the profound long-term harms of out-of-home placement, which we will discuss in the next section.

Child and Family Services



Figure 8.7. "Facts about Child Abuse" from the CDC demonstrate that child abuse and neglect are a significant social problem.

As figure 8.7 illustrates, **child abuse**, **neglect**, and exploitation are significant social problems. The U.S. child welfare system is a public response to the **social problem** of child abuse, which is more formally known as child maltreatment. The three goals of child welfare are safety, permanency, and well-being. A network of federally funded state and tribal child welfare agencies provides a variety of county-level services to ensure the safety, permanency, and well-being of children, youth, and their families.

People who witness child abuse or think a child is being hurt can call 911 or the Oregon Child Abuse Hotline (ORCAH) at 1-855-503-SAFE (7233). Medical providers, school employees, clergy, and other people who work with children are mandated reporters who can face legal consequences for failing to report child maltreatment. It is important to note that each state and **profession** has a different set of numbers and expectations regarding where to call and what both your ethical and legal obligations are for reporting child abuse. Please look at what your individual state and professional requirements are; the numbers listed above are for the state of Oregon. The state of Oregon does have free online training that gives more information about the requirements for mandated reporters, including information in multiple languages.

In 2021, ORCAH recorded 162,184 contacts (calls to the hotline or police reports). Of those 78,775 were screened as reports of suspected child maltreatment. Screened-in reports can involve information only and referral to other services, not a situation that is child abuse or neglect, or possible child abuse and neglect.

Child Protective Services (CPS) and law enforcement agencies share responsibility for investigating child maltreatment. CPS workers assess reports by interviewing children, families, and others who may be familiar with the child's situation, such as neighbors and educators. The purpose of the investigation is to determine if the child has been abused and if they are safe in their present situation.

In cases where there is a finding of abuse or neglect, CPS workers and law enforcement will assess further to determine if the child can safely

remain at home. Safety planning may include requiring the offending parent to move out of the home or specific in-home services. There are two categories of in-home safety plans: In-Home Safety and Reunification Services (ISRS) and Strengthening, Preserving, and Reunifying Families programs (SPRF). These may include culturally appropriate in-home case management or supervision, assistance accessing stable housing, health care services, and other basic needs, as well as parenting classes, peer-based parenting supports, and respite care. The goals of in-home services are to stabilize families, keep children safe, and reduce removals. SPRF services also aim to support family reunification, reduce the length of time children spend in out-of-home care, and reduce the rates of re-entry into the child welfare system.

Black children, children who identify as LGBTQIA+, and children in **poverty** are significantly overrepresented in child removal statistics. For example, about 14% of the children in the United States are Black, yet Black children accounted for 23% of children in **foster care** in 2021(AECF n.d.). That number is down from 29% a decade ago, which indicates that the system as a whole, from the Children's Bureau to state agencies, along with nonprofits that work with youth in care, are taking racial inequity, **gender**, and class-based inequities seriously. Yet the disparities remain stubbornly high.

Many low-income families who interact with child and family services report feeling like they are being punished for being poor (HRW, 2022). Sixteen percent of children in the United States were living in poverty in 2020 (AECF, n.d.), yet the majority of children who are identified as victims of child maltreatment live in poverty. It is true that CDC cites poverty as a risk factor for child abuse and neglect (figure 8.6); however, children who are low-income are also more likely to be subject to mandated reporting because of their increased involvement with social services. In other words, families who are seeking help to meet their children's basic needs are more likely to be reported than families who are well-resourced.

Unconscious bias among child welfare workers and foster families has been identified as a significant cause of these disparities. Many who work in the field can easily remember being taught to treat people fairly and avoid discriminating against people. However, in a society that is stratified by **race**, gender, and class, those are not the only lessons we learn about difference. Recognizing the socially constructed biased ideas we internalize can sometimes be more arduous. Child welfare workers must proactively identify and question our biases to reduce harm. This is easier to do if, within systems, we implement changes to required training and orientations, including changes in supervision, both group and individual, for providers, along with employee assessments to help guide and encourage growth. This needs to happen at all levels, including leadership. At the same time, organizations must keep people with marginalized identities in the workforce in mind, as they may have the most they have to carry in these conversations.

LGBTQAI+ youth are twice as likely to experience foster care than children who do not identify as LGBTQAI+. They experience higher rates of physical and psychological abuse in their homes, and they are more likely to run away or be rejected from their homes. Once in care, LGBTQAI+ youth are not always well served by the child welfare system. They are more likely to experience discrimination and rejection from foster families, experience bias from case managers, and experience multiple placements (Fish et al., 2019).

Out-of-Home Placements

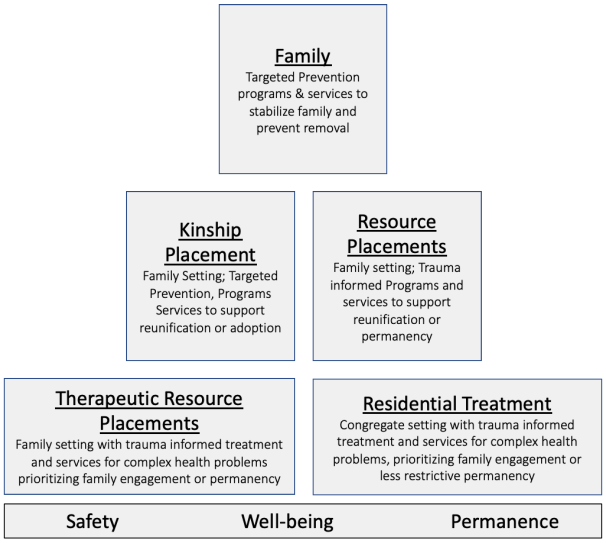


Figure 8.8. Types of foster placements include at-home family placement, kinship placement, resource placements, therapeutic placements, and residential treatment. Image description available. **Image description.**

The foster care system is supposed to support safety, well-being, and permanence for children who experience maltreatment, including abuse, neglect, and sexual exploitation. Figure 8.8 describes the range of placements available to youth. These include at-home family placement, kinship placement, resource placements, therapeutic placements, and residential treatment.

However, we must consider a few factors regarding these out-of-home placements. Not too long ago, Oregon did not have enough out-of-home placements available for youth, causing media outrage across the state and the country. The state of Oregon continued to pay millions of dollars to house youth in hotel rooms even after promising to curb the practice in a 2018 legal settlement.

Consider that LGBTQIA+ youth have an even more challenging time finding openly affirming placements, the small percentage of BIPOC placements available, and the additional difficulties for those youth whose **first language** is not English. Marty Beyer, who was assigned as a special master by a federal judge in the case, gave the following recommendations in 2018 (Dake, 2023):

- Create a system that triggers a response when a child is about to enter a third different placement. The response would bring together all the adults involved in the child's life, including teachers, therapists, nurses, parents, caregivers, and the child themselves.
- Increase the rates, training, and support for foster parents and relatives caring for children in care.

- Create more resources for BIPOC and LGBTAI+ children in care.
- Create staffed homes for one or two children, where staff are trained to meet the **trauma**-related and delayed development needs of children.
- Offer trauma treatment that is tailored to children's needs, and remove any barriers that might prevent them from accessing mental health services through coordinated care organizations.
- Ensure continuity of services and caregivers when a child transitions from one placement to another.

Consider all of these as we look at how to advocate and support growth and change in the systems that clients are participating in and that we will be working in ourselves.

Resource parents, also known as foster parents, open their homes to children and youth who are not safe with their parents or caregivers. When children are not safe in their homes, the support of caring child welfare professionals and loving resource families can provide safety and may provide meaningful relationships that serve as protective factors to mitigate against some long-term effects of abuse.

However, the research is clear that removing children from their families is harmful. Harms can

be measured in both long-term and short-term impacts, including disruption to school attendance, loss of peer support, higher rates of depression and anxiety, substance use disorder, criminal justice involvement, and a higher risk of **housing insecurity** later in adulthood.

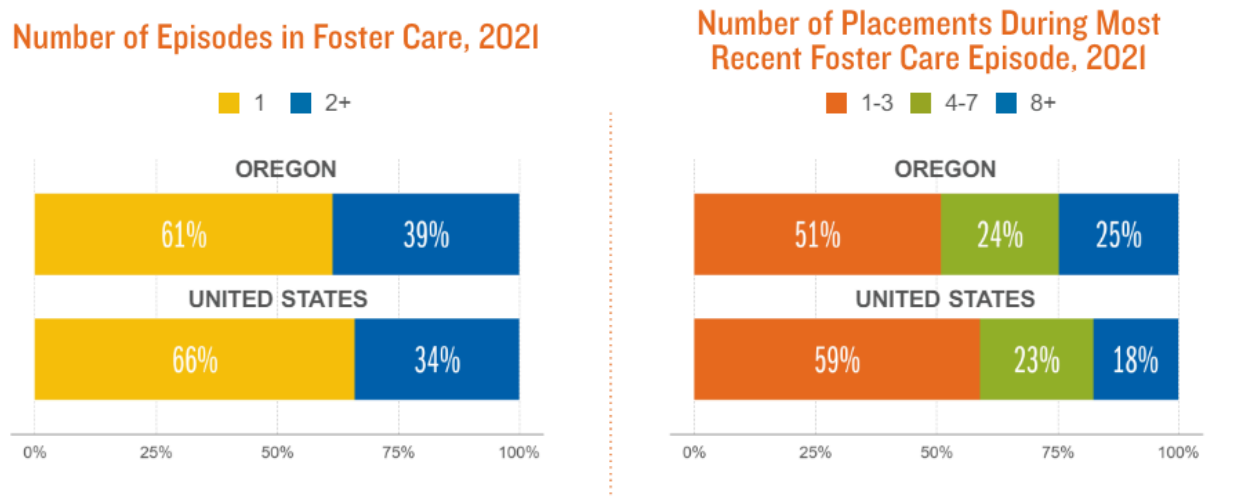


Figure 8.9. Children in Oregon are slightly more likely to be in multiple foster care placements than the national average. Additionally, one in four children assessed by the child welfare system in 2021 experienced eight or more placements.

These harms increase significantly with multiple placements, as seen in figure 8.9. Placement instability occurs when children experience two or more placements during care. While most children who are in care for less than a year experience two or fewer placements, placement insecurity increases the longer a child is in care. One-third of children in care for two years experience two or more placements, and that number doubles for children who are in care longer than two years. Youth who experience multiple placements are less likely to achieve permanency, have a harder time in school, and struggle to form meaningful peer connections.

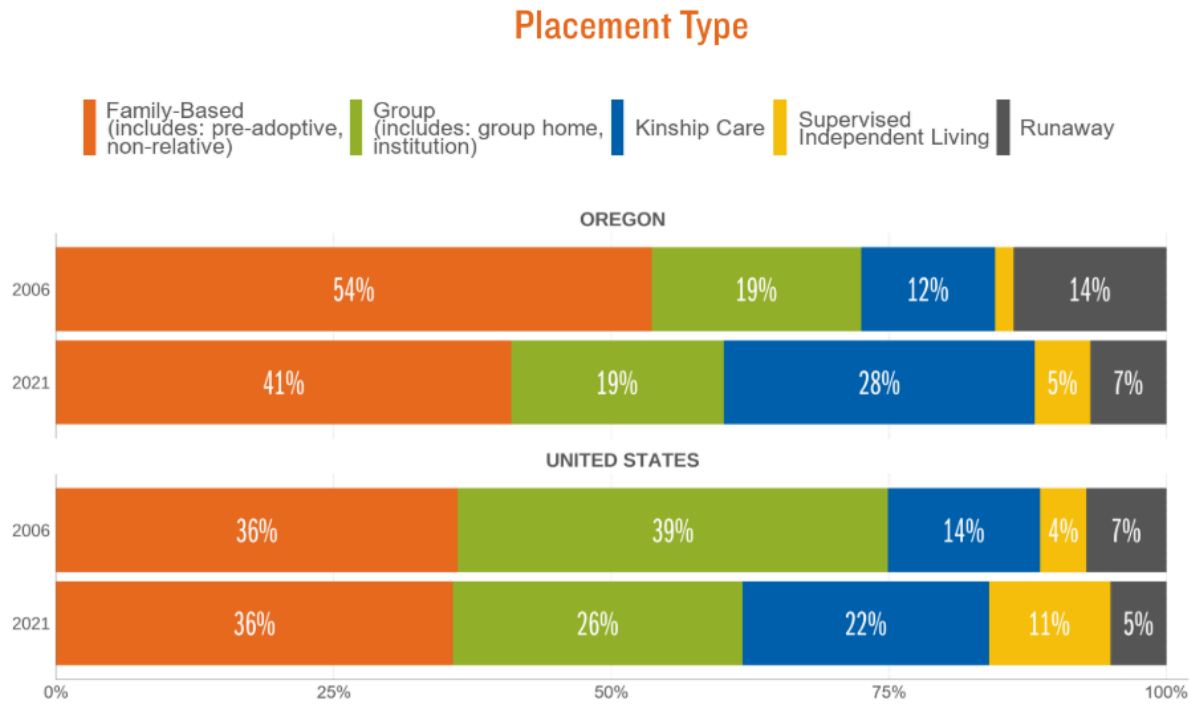


Figure 8.10. Oregon has fewer children in kinship care and more runaways than the rest of the United States.

In Oregon, every effort is made to find permanent placement, where a child can stay until they are reunified with their family or adopted by a new forever family. In cases where permanent placements are not available, a child may be placed in shelter care for up to twenty days, until a permanent placement is available. In order to reduce the harms of family separation, advocates for youth in care call for child welfare systems to strive for "first placement, best placement, family placement, only placement" (CFP 2022). Figure 8.10 compares Oregon's placement options for children under supervision.

Family-based kinship placements, in which children are placed with relatives, are given preference in Oregon. In the event that removal becomes necessary, every effort should be made to identify family (**kin**) or chosen supportive adults (fictive kin). Kinship providers are required to go though the same training and certification as other resource parents, and receive the same financial and material support. Supportive adults unrelated to a child can also become certified as child-specific resource parents. In 2021, 46.2 percent of youth in care were placed with their own family members.

All resource parents are required to attend an orientation and undergo a Structured Analysis Family Evaluation (SAFE) home study, as well as complete a 27-hour Resource and Adoptive Family Training (RAFT). Recertification requires 30 hours of ongoing training each year.

Therapeutic foster parents offer a safe home-based **intervention** for children with severe emotional and behavioral disorders. In Oregon, Treatment Foster Care Oregon (TFCO) offers evidence-based support in a nine-month program for at-risk youth that helps both youth and caregivers (TFCO, n.d.). Therapeutic foster parents receive specialized training and are supported with on-call clinical support.

For children with complex behavioral or physical needs who cannot be placed with a suitable resource family, residential treatment in a congre-

gate setting is an option. However, the unnecessary placement of children in institutional settings can exacerbate harm and should be a last resort. In order to reduce the overuse of reliance on congregant placements, the 2019 Family First Prevention Services Act redirected funding away from residential treatment centers and toward prevention and family-based placements.

Special attention is also given to maintaining connections between siblings in care. Whenever possible, siblings are placed together. When this is not possible, resource families and CPS work together to help siblings keep in contact with each other and have regular visits. In 2021, 83.6 percent of sibling groups were placed together in Oregon (Oregon Department of **Human Services**, 2022).

Exiting Care

In spite of the term, permanent placement, which specifically refers to the time a child is in foster care, is not intended to be permanent. Every child in care has a case plan that outlines the necessary steps to bring children home. During reunification, families, CPS, courts, and other community service providers work together to remove barriers to reunification. If it is safe to do so, parents are encouraged to maintain contact with their children and visit regularly. Steps to reunification can include substance use treatment, anger management counseling, parenting and peer support classes, and securing stable employment and housing. In 2021, 54.3 percent of the 8,620 children who were placed in substitute care were reunified with their families in Oregon (Oregon Department of Human Services, 2022).

The Oregon Department of Human Services (ODHS) is legally authorized to assume permanent custody of a child when a parent's rights are terminated by the court, when parents relinquish their rights, or when both parents are deceased. In the event that parents are unable to successfully reunify with the child within six months of removal, the case will be amended to include concurrent plans for permanency. Permanency plans can include placement with family or adoption by another family. However, as depicted in figure 8.11, permanency is not achieved for most children who enter foster care in Oregon, which lags behind the United States average.

Guardianship is a legal arrangement that does not require parents to relinquish parental rights and allows non-parental caregivers to exercise parental duties on behalf of a child. In some cases guardianship can also be an option if the child is already a ward of the state. Resource parents can become guardians, but it is more commonly used to make kinship placements more permanent. In Oregon, guardianship for youth exiting care must be approved by a permanency committee, which verifies that the child cannot be safely returned home; that the guardianship will meet the child's needs for safety, well-being, and permanence; and that the parent accepts the guardianship plan. In 2021, 356 Oregon children exited care via guardianships in Oregon (Oregon Department of Human Services, 2022).

Adoptive parents make a lifelong commitment to welcome a child into their family. Adoption requires birth parents to relinquish parental rights. Many children adopted out of care choose to maintain relationships with their birth parents and families. As with guardianships, adoptions require approval by way of a home study and a period of supervision. In 2021, 683 Oregon children were adopted out of foster care. As of this writing, there are approximately 200 children waiting to be adopted in Oregon. Most of them are older, are part of a sibling group, are BIPOC, or have disabilities (Oregon Department of Human Services, 2022). Nationwide, 32 percent of youth eligible for adoption wait more than three years (NACAC, n.d.).

While most adoptions are successful, as many as 5 percent are either disrupted before finaliza-

tion or dissolved after they become final. In these cases, children return to foster care and a new permanency plan is developed. Many failed adoptions are the result of families being surprised by unexpected stress and expenses from previously undisclosed or minimized needs. Families Rising, formerly known as The North American Council on Adoptable Children (NACAC), asserts that disruptions and dissolutions can prevent improved preparation, family selection, and support. They also recommend that state agencies and other placement entities fully disclose a child's background early in the selection process (NACAC, n.d.).

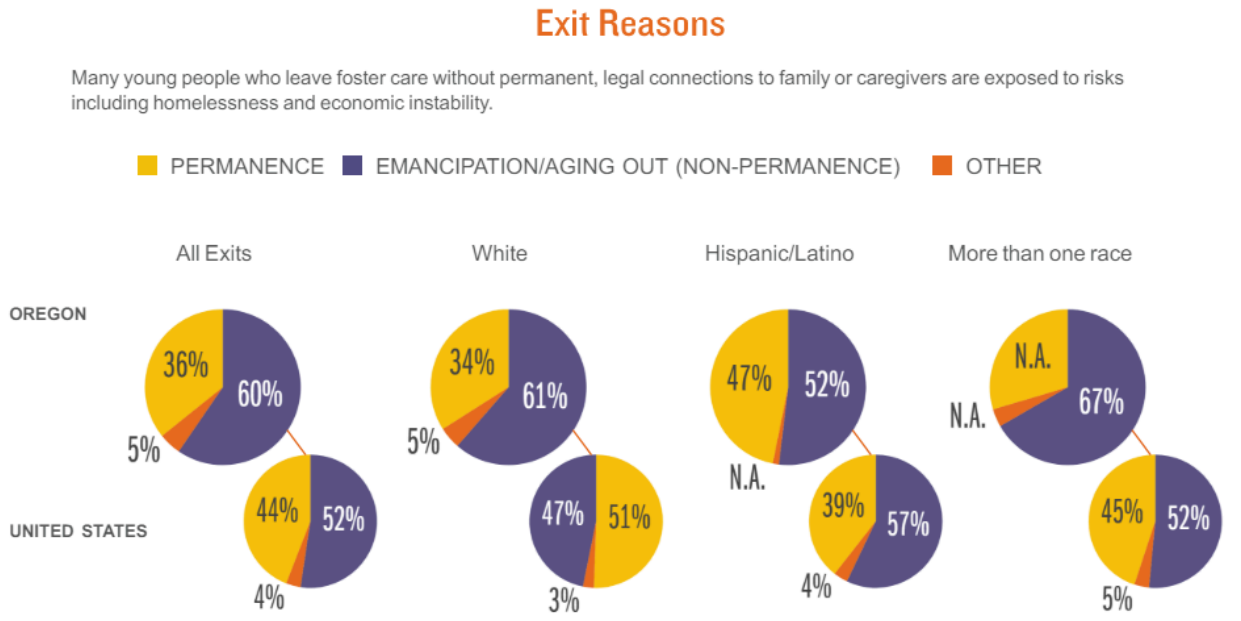


Figure 8.11. The majority of children entering the foster care system age out of the system without finding a permanent home. This is more common in Oregon than the United States. Latine children are more likely to find a permanent home in Oregon, and White children are more likely to find a permanent home in the United States overall.

Each year more than 23,000 young people in the United States age out of care without finding permanence. Of these, about 20 percent become instantly homeless when they are discharged from congregate facilities or can no longer stay with resource families (National Foster Youth Initiative, n.d.). Even when circumstances are not quite so dire, young people aging out of care face unique challenges. Independent living programs (ILPs) connect young people with the resources they need to make a successful transition out of care.

Think about all the things young people rely on their families for as they are moving into adulthood—not only deciding on a college, finding a job, or learning how to live on one's own, but things like filling out the parents' portion of a federal student aid application or signing for a driver's **license**, neither of which a resource parent can do. In these cases, the state assumes the responsibility of parents, and an ILP case worker becomes a critical resource. ILP case workers and youth collaborate to create a transition plan, which becomes an individualized roadmap to successful independence for young people exiting care. Youth can enroll in ILP programs as early as age 14 and remain eligible for aftercare services, including subsidized housing and educational support, until they turn 24.

As helpful as ILP programs are to many young people exiting the foster care system, these pro-

grams are not being created by those young people who are or who have been in the foster care system, so they may not feel relevant or helpful to all their needs. Programs may lack some of the soft skills that young people want and need, or feel out of date.

A past student recommends changes to three significant components of the ILP program:

1. There should be a **mentor** program for at least one to two years after exiting care. It need not necessarily be attached to the foster care system, but could be someone who also had experience in the foster care system, perhaps someone who had a couple of years experience outside of it to give accurate life advice.
2. There should be a clearly defined programmatic difference between BIPOC young people and non-BIPOC young people, as their experiences are very different, including mixed-race young people. People could self-select as, at times, state and federal demographic information is incorrect, which has caused harm to young people and their families. This would require guidance, conversation, and connection to community organizations with expertise and knowledge in these areas. It would help these young people build communities and networks with community organizations while they are still part of ILP programs, so when they exit care, they start these conversations with warm handoffs. Similar communities can be formed for LGBTQAI+ youth and community organizations.
3. The whole program should be examined using a trauma-informed lens, meaning it would be anti-racist. This would shift the conversation and determine what "accomplishments" would look like. It would also give young people opportunities to build more soft skills, like reflective communication, **empathy**, relationship building, conflict mediation, and advocacy skills.

Around the country, networks for former foster youth, known as alumni of care, are working to improve the child welfare system for children who are coming up behind them. Some alumni even choose careers in child welfare. All of the recent reforms in child welfare, including the FFPSA, have been inspired, informed, and championed by alumni. State welfare agencies are required to have youth advisory boards, and at the national level, former foster youth, and alumni-led organizations regularly lobby lawmakers, sign on to amicus briefs to the courts, and advise the Children's Bureau and other federal agencies on child welfare policy. They have also created robust peer networks with meaningful connections to help each other find permanence as they work together to make life better for young people impacted by child abuse, neglect, and expoliation. Resilience is a community practice, as visualized in figure 8.12.



Figure 8.12. Robust social networks of lasting, meaningful connection can help young people build the resilience they need for success.

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Figure 8.6. "Three-Minute Legal Talks: United States Supreme Court case Brackeen v. Haaland" @University of Washington 2023 Standard YouTube License.

FIgure 8.9. The Annie E. Casey Foundation. (2024). 2023 Oregon Profile. Baltimore, MD: Retrieved from **https://assets.aecf.org/m/resourcedoc/aecf-fosteringyouth-stateprofile-OR.pdf**.

Figure 8.10. The Annie E. Casey Foundation. (2024). 2023 Oregon Profile. Baltimore, MD: Retrieved from **https://assets.aecf.org/m/resourcedoc/aecf-fosteringyouth-stateprofile-OR.pdf**.

FIgure 8.11. The Annie E. Casey Foundation. (2024). 2023 Oregon Profile. Baltimore, MD: Retrieved from **https://assets.aecf.org/m/resourcedoc/aecf-fosteringyouth-stateprofile-OR.pdf**.

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2021 Oregon Child welfare statistics were adapted from the **2021 Child Welfare Data Book** @ 2022 Oregon Department of Human Services, Office of Reporting, Research, Analytics, and Implementation.

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8.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- There are many kinds of structures that produce healthy families and children. It is important not to judge one kind of family structure as being "better than the other."
- Child **welfare** programs are implemented at times when the children's needs are not being met by the family environment.
- Schools and **human services** make strong partnerships. Each school district will have programs that are tailored to that community's needs.

DISCUSSION QUESTIONS

- Of the family structures described in the chapter, which ones are you familiar with? What other family structures have you observed?
- Spend some time reviewing the website of your own local public school and your own school district. Identify and discuss programs related to human services that are available.

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CHAPTER

9

Serving Older Adults

9.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 27: Human service professionals must accurately represent their qualifications, encompassing, but not limited to, their skills, education, credentials, training, and areas of expertise, to the client, colleagues, and members of the public. When any intentional or accidental misrepresentation is discovered, they must take immediate action to rectify the situation. (NOHS, 2024).

What does it mean to get older? Some define age as an issue of physical health, while others simply define it by chronological years. In the United States, for example, turning 65 years old is a significant milestone, at which point citizens are eligible for federal benefits such as Social Security and Medicare. However, more recent methods of looking at the aging population consider how much life expectancy the population has remaining (United Nations, 2020). This interest in aging has led to the development of the interdisciplinary field of study known as gerontology. **Gerontology** not only includes the physical aspects of aging (the medical field focused on aging is called geriatrics), but psychosocial, economic, spiritual, and other factors as well.

In this chapter, we discuss the various concerns facing older adults and their families, and the services available to assist them. We combine a gerontological perspective, multigenerational homes, and an equity lens at the center of it all.



Figure 9.1 Older adults represent a wide range of ages, backgrounds, and abilities.

LEARNING OBJECTIVES

1. Summarize the role of developmental theory in the study of aging.
2. Identify the current issues related to the aging population.
3. Recognize the current challenges facing older adults.
4. Compare and contrast the major social programs currently serving older adults.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Ageism: a set of fixed beliefs about a specific age group that they have limits or certain capacities based on their age
- Baby boomers: the cohort of people born in the years after World War II, generally including those born between 1946 and 1964
- Beanpole family structure: the modern family structure of having fewer children in each generation, as well as each generation living longer, resulting in a chronologically long but narrow structure
- Caregiving, formal: a professional who is paid to assist with activities of daily living
- Caregiving, informal: an unpaid layperson (often a family member) who assists with a wide variety of daily needs
- Cumulative advantage or disadvantage: the processes by which the effects of early economic, educational, and other deficiencies or resources can accumulate over the life course, with these becoming magnified over the life span
- Dependency ratio: the number of citizens who are unable to work due to age or disability compared to those who can work
- Formal Caregivers: Professionals paid to provide such services (these can start as family or friend members but not if this is a profession also)
- Gerontology: the interdisciplinary study of aging, including biological, psychological, social, economic, and spiritual perspectives, among others
- Grandfamilies: where grandparents or great-grandparents provide the primary care for their grandchildren
- Informal Caregivers: Friends or family members who provide unpaid care (this can also be neighbors' support and cultural expectations)
- Life expectancy: the average number of years a person born today may expect to live
- Loneliness is the discrepancy between the social contact a person has and the contacts a person wants

- Medicaid: the joint federal- and state-sponsored program aimed at providing medical care to lower income individuals
- Medicare: the federal health care program in the United States provided to adults 65 and older as well as disabled citizens
- Multigenerational families: where more than two generations live together
- Older Americans Act: the federal legislation, originally enacted in 1965, that authorizes a majority of community services for older adults, including community centers and nutrition programs
- Stereotype embodiment theory (SET) posits that the more a person is exposed to ageist messages, the more likely they are to believe—and demonstrate—these messages
- Social Security Act: a federal program established in 1935 to provide protection against poverty to older Americans
- Silver tsunami: a term used to describe the skewing of the population toward older ages

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Figure 9.1. **Photo** by **Nappy** is in the **Public domain**.

9.2 The Aging Population

Since its creation in 1790, the U.S. Census Bureau has been tracking age in the population. Age is an important factor to analyze along with accompanying demographic figures, such as income and health. The population pyramid in figure 9.2 shows projected age distribution patterns for the next several decades. As you go from the "pyramid" shape in green (representing 2010) to the fatter "bullet" shape in dark purple (representing 2030) and on to the "rectangle" shape in lighter gray-purple (representing 2050), you can see that the population has many more people surviving into the older categories. This squaring up of the population means that the average age of the population is growing older, and the ratio of children and younger adults to older adults is decreasing.

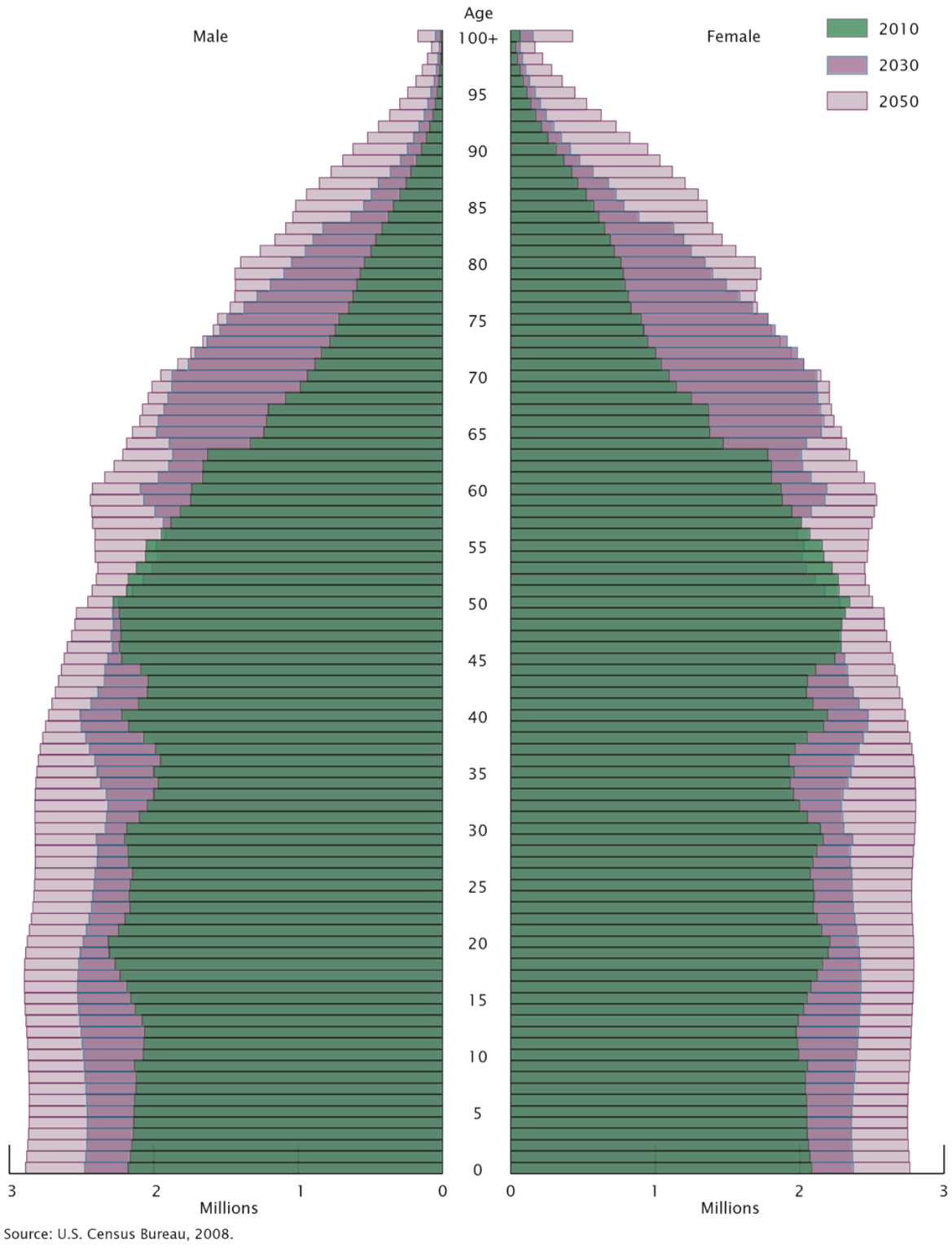


Figure 9.2 As our population ages, the population "pyramid" begins to look more like a population "rectangle."

Statisticians use data to calculate the median age of a population—that is, the number that marks the halfway point in a group's age range. In the United States, the median age is about 40 (U.S. Census Bureau, 2022). That means that about half of the people in the United States are under 40 and about half are over 40. This median age has been increasing, which indicates the population as a whole is growing older.

This demographic change has enormous implications in terms of economics, health, and social needs. This also means that many more professionals are needed who are familiar with the needs of older adults—not only geriatricians (medical professionals who focus on the health of older adults) but gerontologists, who study the other aspects impacted by aging, including economics, social services, mental health, and spirituality.

Demographic Changes Over Time

Demographically, the U.S. population over 65 years old increased from 3 million in 1900 to 33 million in 1994 (Hobbs, 1994) and to 36.8 million in 2010. This is a greater than tenfold increase in the over-65 population, compared to a mere tripling of both the total population and of the population under 65 years old (Hobbs 1994).

There are several reasons why the United States is aging so rapidly. One of these is **life expectancy**: the average number of years a person born today may expect to live. When we review Census Bureau statistics grouping Americans by age, it is clear that in the United States, at least, we are living longer. In 2010, there were about 80,000 centenarians (age one hundred or higher) in the United States alone. They make up one of the fastest-growing segments of the population (Boston University School of Medicine, 2014). People over 90 years of age now account for 4.7 percent of the older population, defined as age 65 or above. This percentage is expected to reach 10 percent by the year 2050 (U.S. Census Bureau, 2011). As of 2013, the U.S. Census Bureau reports that 14.1 percent of the total U.S. population is 65 years old or older.

It is interesting (and somewhat alarming) to note that not all people in the United States age equally. Different ethnicities and socioeconomic groups can expect different outcomes as they age. The latest data from the National Institutes of Health estimates the average life expectancy of Asian Americans at 85.7 years, 82.2 years for the Latino population, 78.9 for Whites, 75.3 for the Black population, and a mere 73.1 years for American Indian/Alaskan Natives (NIH, 2022). The major cause of this difference is the likely accumulation of inequities throughout life that impact people's health as they age. We discuss this in more detail later in the chapter.

Consequences of an Aging World

From 1950 to approximately 2010, the global population of individuals aged 65 and older increased by a range of 5 to 7 percent (Lee, 2009). This percentage is expected to increase and will have a huge impact on the **dependency ratio**: the number of citizens who are unable to work due to age or disability compared to those who can work. (Bartram & Roe, 2005).

As the population ages, family structures change. There are two major factors influencing the structure of the family. Traditionally, we refer to our ancestral chart as our family tree. Its branches get wider with every generation. However, along with living longer lives, people are having fewer children. This has changed family structure to what Vern Bengtson, a well-known gerontologist, referred to as a **beanpole family structure**. Each generation is living longer, with fewer members in each, resulting in a longer, thinner chart rather than the traditional tree shape.

This means each family has fewer members to rely on when help is needed.

As health care improves and life expectancy increases across the world, elder care will become an emerging issue. With fewer working-age citizens available to provide home care and long-term assisted care for older adults, the costs of elder care are likely to increase (Wienclaw, 2009).

Worldwide, the expectation governing the amount and type of elder care varies from culture to culture. For example, in Asia the responsibility for elder care lies firmly on the family (Yap et al., 2005). This is different from the approach in most Western countries, where older adults are considered independent and are expected to tend to their own care. Western countries are more likely to rely on **formal caregivers** (professionals paid to provide such services) rather than **informal caregivers** (friends or family members who provide unpaid care).

Within the United States, not all demographic groups treat aging the same way. While most people in the United States are reluctant to place their older relatives into out-of-home assisted care, demographically speaking, the groups least likely to do so are Latine, African Americans, and Asians (Bookman & Kimbrel, 2011). A 2018 data review (Themeer et al., 2018) showed that Black and Latine families are much less likely to use nursing homes, and that this division became bigger when socioeconomic differences were taken into account. However, it may not be just cultural or economic differences. This data may also reflect the lack of facilities with bilingual staff or culturally appropriate foods.

Globally, the United States and other developed nations are fairly well equipped to handle the demands of an increasing aging population. However, developing nations face similar increases without comparable resources. Poverty among older adults is a concern, especially among women. This trend can be seen in many developing nations due to the number of older women in those countries who are single, illiterate, and not a part of the labor force (Mujahid, 2006).

An aging population impacts society in many ways. The loss of workers will have economic impacts, and families may be stretched to provide care for older family members. The availability of at-home caregivers has decreased, as most families require two incomes to stay above the poverty line. Also, the availability of social services and assistance can vary by region. In Oregon, for example, the more populous Willamette Valley tends to have many resources available to residents. However, many areas in rural Eastern Oregon have few or no resources available. Older adults who live in rural areas, therefore, are much more vulnerable to changes in their ability to care for themselves. It is hoped that electronic resources can begin to fill some of these needs. Current research includes the role of telemedicine visits, electronic health monitoring, and even robotic pets and caregivers.

Grandparents as a Primary Resource

People in the United States, in general, are living longer, and living healthier and more active lives. Families are having fewer children, and grandchildren are more widely spaced apart by age. This creates a capacity for both more active grandparenting than in previous generations, as well as the possibility of actual parenting of grandchildren and other caregiving relationships. It is believed that the combination of families having fewer children and living longer has led to more involvement by grandparents with their grandchildren, resulting in the increase in **multigenerational families** (where more than two generations live together) and **grandfamilies** (where grandparents or great-grandparents provide the primary care for their grandchildren). Simply put, people are living long enough to see their grandchildren be

born and to be an active part of their lives. Figure 9.3 shows the percentage of grandparents who are responsible for the primary care of grandchildren.

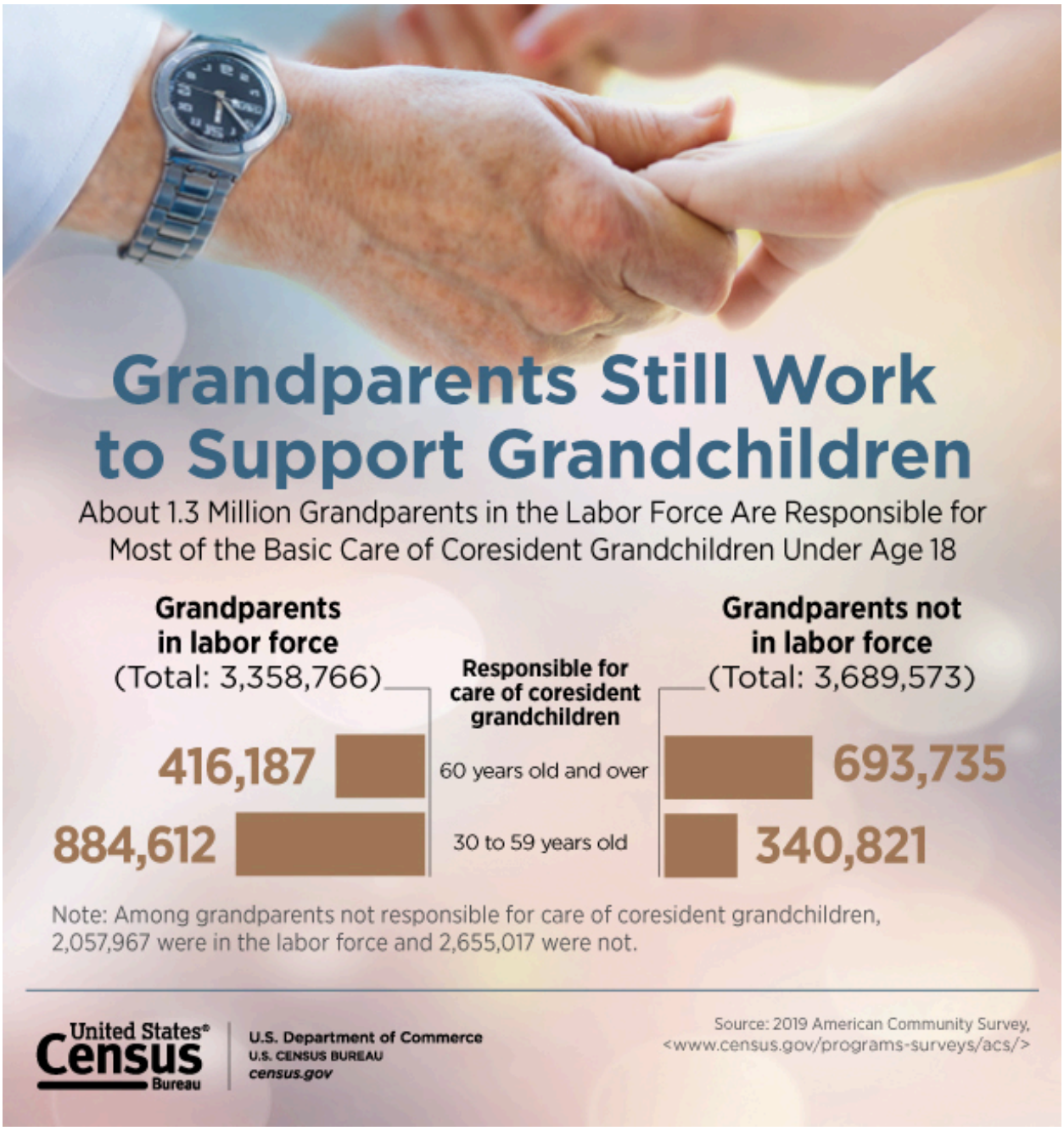


Figure 9.3 The 2020 Census Report shows that about 1.3 million grandparents are both working and caring for grandchildren.

Simultaneously, rates of single parents and divorced parents have increased. These parents may call on their own parents for financial support, childcare, shared housing, or other needs. In addition, social problems such as addiction and mass incarceration contribute to the need for more adults to be involved in parenting. Older adults, including grandparents, are more frequently involved in caregiving and supporting children and grandchildren than ever before. It is

important to note that it is not only middle class or wealthy grandparents who are helping out; poor and working class grandparents are struggling to help out their children and grandchildren.



This interactive content is not available in this version of the text. It can be accessed online here: **https://www.pbs.org/newshour/show/raising-children-for-a-second-time-grandfamilies-struggle-during-the-pandemic**

Figure 9.4 To learn more about grandfamilies struggling during the pandemic during 2021, watch the 7-minute video, **"Raising children for a second time, 'grandfamilies' struggle during the pandemic" [Streaming Video]**. **Transcript.**

Multigenerational households are on the rise after reaching a low of 12 percent in 1980. In 2016 roughly one in five adults (20 percent) lived in a multigenerational household, with an increase being attributed to the economic recession that started in 2009 (Cohn & Passel, 2018). The National Association of Realtors reports that multigenerational home purchases increased during the COVID-19 pandemic by four percentage points (Ventiera, 2020). These trends point out the connection between economic change, life expectancy, and living arrangements that affect family relationships.

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"Grandparents as Primary Resource" is by Elizabeth B. Pearce and licensed **CC BY-SA 4.0**. Edited to add current data.

Figure 9.2. "**Age and Sex Structure of the Population for the United States: 2010, 2030, and 2050**" by Grayson K. Vincent and Victoria A. Velkof, **U.S. Census Bureau**, is in the public domain.

Figure 9.3. **Grandparents Still Work to Support Grandchildren** by **U.S. Census Bureau** is in the public domain.

9.3 Care and Healing for Aging Adults in Community

As human services and social work professionals, we need to analyze and learn from the historical and global approaches to caring for and supporting the aging adult population. By doing so, we can gain valuable insights and knowledge that can help us effectively address the varied needs of our elderly clients.

We can utilize several theories to understand the different stages of aging. For instance, Erik Erikson's theory of Integrity vs. Despair as a late life stage and Gail Sheehy's New Stages of Adult Development in her book *New Passages: Mapping Your Life Across Time* comprehensively understand the psychological and emotional changes that occur as people age. For a deeper dive into Sheehy's work, watch the optional video, **"Gail Sheehy offers a roadmap to the stages of adult life" [Streaming Video]**. However, more is needed to truly understand our limited knowledge of aging with these theories alone.

It is essential to recognize that aging adults face unique challenges that require our attention. One of the most significant challenges is the increasing isolation from their families and communities that

many seniors experience. This trend is particularly evident in the United States, where individualism is highly valued. In contrast, other countries have more collectivist social structures that prioritize the community's well-being over the individual's. As providers, we must consider the cultural and social factors that contribute to the isolation of our elderly clients and work toward developing strategies that can help them remain connected to their families and communities.

Multigenerational Homes around the World

Caring for aging adults in multigenerational homes has been a longstanding tradition that reflects the importance of familial bonds and cultural heritage. In the United States, this practice has become increasingly prevalent as families take on the role of caregivers for their elderly loved ones. Unfortunately, this responsibility often comes with little support from society, government, and health care systems. Even the housing system is biased against multigenerational living, as depicted in figure 9.5. Conversely, in some countries, the social structure promotes multigenerational homes as the norm, encouraging children to live with their parents until they are married and have families, children, or their own homes. This means that some children could be living at home until the age of 35 or 40 as a standard instead of living on their own at a younger age of 18 or early 20s as many see here in the United States.

In many BIPOC families, grandparents, parents, partners, grandchildren, and cousins share the same living space, creating a unique and vibrant household. Grandparents often hold a central role in these families, serving as a cultural compass to guide essential decisions regarding stories, history, food, traditions, and significant life events. As a symbol of a community's past and future, elders are revered and respected, and caring for them is considered a shared responsibility that benefits the whole family.

In the Latine community, the grandparents' role is often particularly significant. They live with their families throughout their lives and play a vital role in decision-making, from purchasing property to naming grandchildren. Even in modern children's movies, the importance of elders is highlighted in storytelling, weaving, cooking, music, and decision-making. Caring for elders is seen as both a privilege and a responsibility, with the eldest child traditionally taking on the overall care responsibility, which is then shared among all family members.

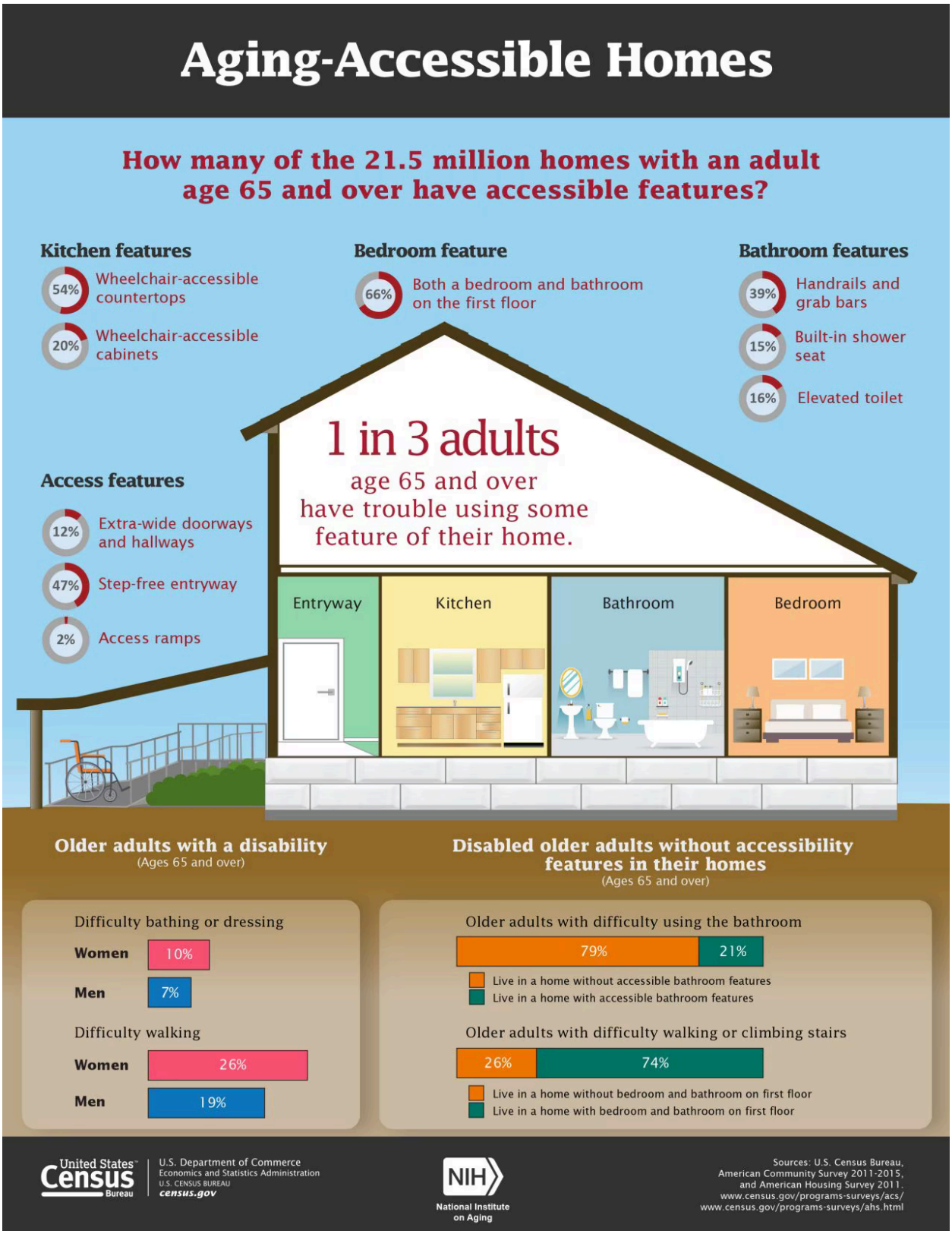


Figure 9.5 Because American culture prioritizes the nuclear-able-bodied family and segregated nursing home and assisted living care for older adults, multigenerational families face challenges in finding housing that is accessible to older adults with care needs—particularly in rural areas with older homes. **Image description.**

Research has shown that intergenerational relationships between aging adults and children promote self-esteem, friendships, and social-emotional skills. Studies in the United Kingdom, Australia, and Japan have demonstrated the positive effects of these relationships, which can also decrease isolation for the aging adult population and encourage the passage of cultural wealth. As providers, we should explore ways to structure our systems to support this system of intergenerational care, recognizing the benefits it provides to older adults and the larger community.

To learn more about intergenerational relationships, optionally read one of these articles:

- **Combining daycare for children and elderly people benefits all generations [Website]**
- **Intergenerational Programs to Promote Active Aging: The Experiences and Perspectives of Older Adults [Website]**
- **An evaluative study of the benefits of participating in intergenerational playgroups in aged care for older people [Website]**

Examples of Multigenerational Care in the United States

Upon completing my bachelor's degree in psychology, I was offered my first position as a home visitor for Head Start at the Oregon Child Development Coalition (OCDC). OCDC was created in 1971 to provide migrant farm working families with secure access to childcare following a tragic incident involving a young child. While the agency's primary mission remains the same, they have extended their support to other community needs. Their educational program is designed to foster volunteer and parent/family involvement, focusing on older adults' essential role in caring for children, much like they would in their traditional homes. To learn more about this organization, optionally watch **"We Are OCDC" [Streaming Video]**.

As I visited families' homes to discuss parenting and family care, I realized that multigenerational families were the norm. Home visits often included not just the parent and child but siblings, aunties, grandparents, and even neighbors. Adapting to the courses and curriculum was challenging until I changed my outlook and viewed the family as the client for some visits. This made assessments more transparent, manageable, colorful, and comprehensive.

In my home visiting plans, I integrated older adults' involvement in parenting as their traditions offered guidance on supporting the next generation. Therefore, many conversations I had were happening with them alongside. Some critical aspects of home visiting involve decreasing childhood injuries, educating parents on co-sleeping, healthy eating habits during pregnancy at each trimester, and developmental milestones to look for in their child as they grow, plus when to seek support if they are not meeting these milestones.

I began to understand that if I wanted to gain the trust of the parents and other family members, I needed to have the grandparents understand the purpose of my visits. Grandparents become, at times, co-facilitators of some visits, making them central to the education of their grandchildren.

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Figure 9.5. Aging-Accessible Homes by U.S. Census Bureau is in the public domain.

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9.4 Challenges Facing Older Adults and Their Families

As an individual, take a moment to think about what you do to keep yourself as youthful as possible. While not everyone will come up with an answer, a good majority of people will come up with at least one thing they do to combat aging, both physical and mental. Whether it is working out to stay fit and strong, doing mental aerobics with puzzles to keep your wits sharp, or using facial creams and/or plastic surgery to prevent or get rid of wrinkles and other visible signs of aging, many people are trying to stay young for as long as they can. While the impetus for these measures might be to prolong life as long as possible, some strategies Americans use are really more to prolong youth.

As a society, we put so much emphasis on staying young, especially physically. One article reported a study presented at the annual conference for the American Public Health Association that indicated we spend more money on medication targeting what used to be thought of as natural effects of aging, such as "mental alertness, sexual dysfunction, menopause, aging skin and hair loss," (para. 2) than we do on prescriptions designed to counteract chronic illnesses (Drevitch, 2012). Add this to the amount of money spent on over-the-counter anti-aging creams, makeup designed to cover wrinkles, and hair dye, and we have a better understanding of how society tries to prevent or avoid the aging process.

Baby boomers, those born between 1946 and 1964, are redefining how Americans look at age. Old age is no longer seen as a time of fragility and senility, but rather a time of wisdom, being active, and purposeful living (Wilson, 2014). In fact, a study conducted by the Pew Research Center found that a majority of American adults feel their life will be as satisfying or better ten years from now, including a two-thirds majority of those who are considered old-aged (Pew Research, 2013).

Ageism

Yet **ageism**, which involves discriminating against someone based on their age, is still very prevalent in the United States. We may be comfortable with our own aging, but we generally do not want to acknowledge it unless we must. Then when we do acknowledge it, it is with the belief that we will be different—that when we grow old, we will not end up like those who came before us. We will make sure we take care of ourselves, unlike those we see around us. We may not internalize the negative beliefs about getting older as much as we used to, but that does not mean as a society we are com-

pletely sold on the usefulness of the aging population.



Figure 9.6 Ageism intersects with sexism, racism, and other forms of oppression. Consider the violence in Kenneth's quote and the gaslighting in Liz's quote. Note that Joseph's economic and social privilege does not insure him against ageism.

Ageism can be easily seen in hiring practices, as Americans closer to retirement age were displaced from their jobs due to the Great Recession, between December 2007 and June 2009, and as a result had to try to find new employment. A large number of aging Americans were forced into early retirement because of stereotypes. Stereotypes that we have about old age are translated into the workplace: older workers are considered less flexible in mindset, work style, and techniques, as well as being less efficient and reliable workers due to physical ability and health (Chou, 2012). These beliefs by employers can result in unfair hiring and firing practices, extended periods of unemployment, again forced by early retirement both directly by some companies however not explicitly for their age and by an inability to secure a new job.

Although stereotypes about aging might be based on a safety concern, generalizing the behaviors and abilities of a minority percentage of the older population to everyone in this group can cause us to view the older generation as a liability. An example, think of driver's license requirements. Drivers who are 65 years old and over have a lower number of crashes and car insurance claims when compared to those under 65—especially the youngest drivers. Yet more than half of all states have specific license renewal requirements for older drivers that may include shorter renewal periods, vision tests, and road exams (IIHS & HLDI, 2015). Essentially, these regulations create an environment in which the aging population is seen as dangerous behind the wheel, when the facts tell a much different story.

American society demonstrates its bias toward youth in more than just its policies and practices. We also perpetuate stereotypes in consumerism and advertising. Products and services related to enjoying life, being active, and any kind of tech-

nology are typically marketed to younger audiences, while the products and services for taking care of one's health, dealing with chronic illnesses, and preparing to live out one's final years usually target older adults.

These practices perpetuate stereotypes and are based on both atypical experiences and an outdated understanding of old age. Defining older adults as physically weak and cognitively inept is incorrect. While some older adults may present this way, it is more the exception than it is the rule. Still, we are a long way from eliminating prejudice and discrimination.

Older adults are not universally valued. One study found that while college students did not blatantly discriminate against older people, they did not place importance on spending time with or learning from this group (Yilmaz et al., 2012). It is not only college students who feel this way. Many people in society behave as if aging adults are outlasting their usefulness to society.

It may seem easy to brush off societal messages ("I don't pay any attention to ads"; "I laugh at the cards but don't believe them"), there is a growing body of evidence that suggests that these messages are much more insidious than previously thought.

Stereotype embodiment theory (SET) posits that the more a person is exposed to ageist messages, the more likely they are to believe—and demonstrate—these messages (Bengtson & Settersten, 2016). Exposure to negative aging stereotypes is associated with a variety of negative outcomes, including physical, cognitive, and emotional outcomes.

Numerous studies (Sargent-Cox, et al., 2015; van Wijndgaarten, et al., 2019; Choi, et al., 2019) have supported the theory that the more a person is exposed to negative aging messages, the more likely they are to believe these messages. The more they believe these messages, the more likely it is that they suffer from numerous issues, such as:

- Impaired balance
- Cardiovascular disease
- Memory problems
- Loneliness

Combating negative stereotypes is not just a matter of policy; it is a matter of public health.

We must also consider how oppressive systems have contributed to ageism.

AN EXAMPLE: AGEISM IN GREETING CARDS



Figure 9.7 Here is an example of a harmful message on a birthday card that reinforces several stereotypes, including ageism and ableism.

It is easy to see with just a walk down the greeting card aisle how ingrained ageism is in American culture. This phenomenon is not only limited to the United States; however, many of these examples used are centered here. As human services providers, we understand that issues like these are not merely local, but global.

Birthdays are seen as a day to celebrate until about the age of 30, which is when the "over the hill" messages begin. Most of the cards aimed at adults have a theme of either cognitive or physical impairment, or a sense of impending death. These images and "jokes" are so prevalent that many people automatically laugh without considering the underlying message. Several organizations have begun campaigns to fight these ageist messages.

This campaign might make some people say, "We can't joke about anything anymore." But consider what this language perpetuates and how much harm it continues to cause, not just for those receiving the cards but those buying the cards. Why must we be a certain age or have a specific mental or body capacity to be considered worthy in society?

Mental Health Issues in Later Life

There are two distinct areas of mental health concerns in later life. One has to do with improved treatment for serious and persistent mental illness, while the other is related to the management of mental health along with other chronic diseases.

With improved medications and management of diseases like schizophrenia and bipolar disorder, people with these issues are able to live longer than previous generations. However, this also means that there is not a lot of research on managing these diseases in older adults. Questions such as appropriate dosage and interactions with other common medications taken by older adults are still being figured out.

Another issue is how to manage chronic mental illness along with other chronic diseases. For example, someone may have lived in a group home for their adult life, but they now also need to use a wheelchair. Are facilities that focus on mental health prepared to care for an aging population, or will the clients need to move as their care needs increase? Do our current long-term care facilities have the ability to handle mental health issues along with physical challenges? These are questions that are being posed right now.

The other focus of mental health in later life is people who develop mental illnesses later in life. This includes dementia, but depression and substance use are also major issues for older adults. Older adults are often facing multiple losses—deaths of friends and family, retirement, or changes in physical ability—that can be difficult to accommodate. Unfortunately, many medical professionals still have difficulty recognizing mental health issues in older patients. Even medical professionals sometimes say things like, "If I was in their shoes, I'd be depressed too," and "They don't have to work. Why worry about how much they drink?" It is important for family members and professionals to understand that depression and substance use are not a normal part of the aging process and can be successfully treated if recognized.

Another more recent crisis is the impact of the COVID-19 pandemic on older adults. The statistics in figure 9.8 show us that while older adults were not more vulnerable to getting COVID-19, they were much more vulnerable to having serious complications, including death.

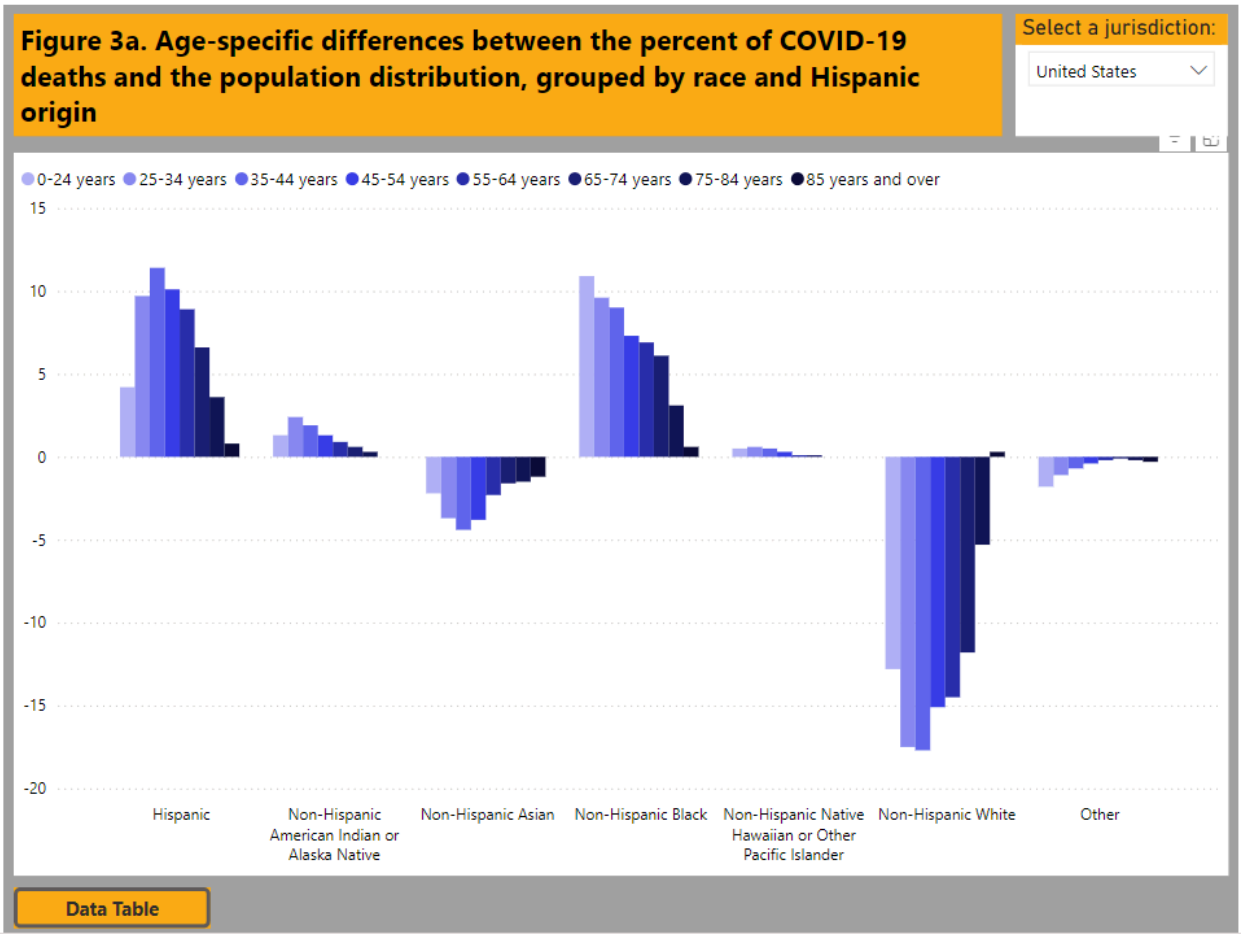


Figure 9.8 COVID-19 Mortality by Race, Ethnicity, and Age.

Many congregate living facilities (such as nursing homes and retirement communities) had outbreaks that devastated their communities. Almost all of the congregate living facilities in the United States closed their doors to visitors for a year or more. Older adults, like the person in figure 9.9, were isolated from friends and family members, only staying in contact by phone, email, or video chat. This includes multiple instances of family members having to say goodbye to dying loved ones over Zoom or FaceTime.

The Kaiser Family Foundation (Koma et al., 2020) reported that anxiety and depression increased in older adults during the COVID-19 pandemic. Anxiety and depression were worse when older adults had complicating factors, such as other chronic illness or lack of resources. Depression and anxiety were lower when older adults had a feeling that they mattered rather than feeling expendable.

However, other studies that compared results between older and younger adults showed that while rates of anxiety and depression did increase in older adults, they were actually higher in younger adults over the COVID-19 pandemic (Varma et al., 2021). Some (providers in the field) speculate that older adults who had lived through other major events displayed more resiliency to the pandemic than younger adults with less experience (Pearman et al., 2021; Waugh et al., 2022). It is important that we recognize and support these strengths, especially in times of crisis, such as a pandemic. And again, we must recognize the

diversity of experiences and reactions to the pandemic among older adults.

One study looked at the prevalence of "compassionate ageism" during the COVID-19 pandemic. Compassionate ageism involves regarding all older adults as needing and deserving of assistance without regard to the actual needs or desires of the older adult themselves. One example of this is referred to as "caremongering," the assumption that all older adults are frail and in need of care.

This type of language regarding older adults is featured in many of the laws, measures, and procedures developed during the pandemic. While the intent of these interventions is well-meaning, they neglect to acknowledge the diversity of abilities and experiences for older adults. For example, at the same time that it was thought best to protect older adults with isolation, retired doctors, nurses, and other medical professionals were being asked to return to the field to help out overburdened hospitals. There was no acknowledgement that these professionals were also older adults.



Figure 9.9 The restrictions brought on by the COVID-19 pandemic hit older adults in congregate living facilities particularly hard. This woman is pictured on her first outing after quarantine.

Loneliness as a Mental Health Issue

Loneliness is the discrepancy between the social contact a person has and the contacts a person wants (Brehm et al., 2002). It can result from social or emotional isolation. Women tend to experience loneliness due to social isolation, men from emotional isolation. Loneliness can be accompanied by impatience, desperation, depression, and a lack of self-worth.

Being alone does not always result in loneliness. For some, being alone means solitude. Solitude involves gaining self-awareness, taking care of the self, being comfortable alone, and pursuing one's interests (Brehm et al., 2002). In contrast, loneliness is perceived social isolation.

For those in late adulthood, loneliness can be especially detrimental. Novotney (2019) reviewed the research on loneliness and social isolation and found that loneliness was linked to a 40 percent increase in a risk for dementia and a 30 percent increase in the risk of stroke or coronary heart disease. This was hypothesized to be due to a rise in stress hormones, depression, and anxiety, as well as the individual lacking encouragement from others to engage in healthy behaviors. In contrast, older adults who take part in social clubs and church groups have a lower risk of death. Opportunities to reside in mixed age housing and continuing to feel like productive members of society have also been found to decrease feelings of social isolation and loneliness.



Figure 9.10 This bench (in Manchester, UK) is part of an international grassroots effort to address loneliness by providing residents a chance to interact.

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Figure 9.6. Workplace Age Discrimination Still Flourishes in America © AARP. Image included under fair use.

Figure 9.7. Images from Funny Birthday Cards and "Dying Reward – Birthday Card" © Greetings Island. Image included under fair use.

Figure 9.8. Demographic Trends of COVID-19 cases and deaths in the U.S. reported to CDC is in the public domain.

Figure 9.9. COVID-19: residents of a retirement home on their first official group outing since Mid March lock-down by Gilbert Mercier is licensed under CC BY-NC-ND 2.0.

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9.5 Programs That Assist Older Adults

As we delve deeper into this chapter, it's crucial to understand the needs of older adults and the services available to them. Given that older adults often require specialized care, it's essential to reflect on our personal experiences with them, the kind of relationship we share with them, and our cultural experiences. This includes understanding the various factors influencing their lives, such as their health status, social support systems, and living arrangements. It's also essential to consider the expectations of care they may have as they age, including medical care, assistance with activities of daily living, and emotional support.

By taking a holistic approach to understanding the needs of older adults, we can better appreciate the unique challenges and opportunities that come with aging. This knowledge can enable us to work toward meeting the needs of older adults more effectively, whether through developing specialized care programs or advocating for policy changes that support their well-being. Ultimately, by prioritizing the needs of older adults, we can create a society that is more inclusive, fair, and just for people of all ages.

Social Security

The **Social Security Act** of 1935 was aimed at solving the problem of poverty among the American elderly. It was modeled after a similar program in Germany. The original premise was fairly simple: workers would pay a portion of their earnings into a fund until retirement. A person's social security card, depicted in figure 9.11, includes an account number issued at birth. Upon retirement, these workers could then receive monthly payments to furnish a base income. Several other benefits have been added over the years, such as income benefits for those considered disabled, widows, and minor children of workers who die before retiring.

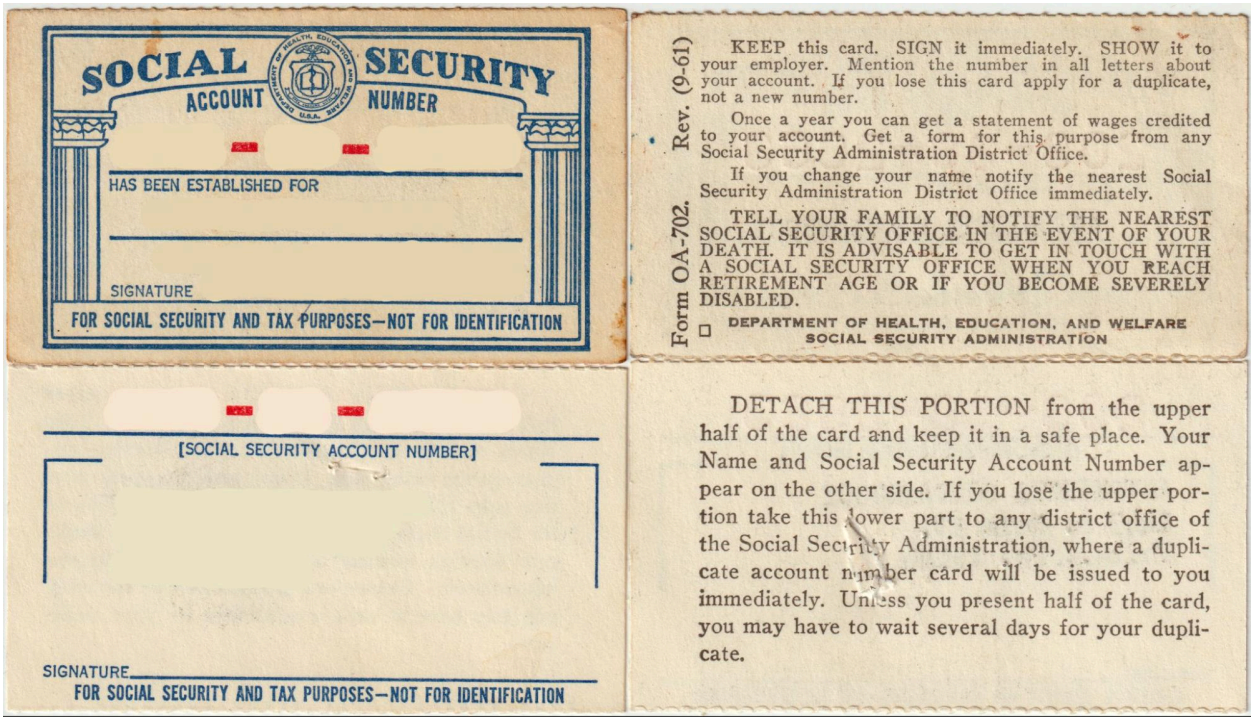


Figure 9.11 At birth, each U.S. citizen is assigned a Social Security card. If you fall into groups that are considered "deserving," Social Security provides monetary assistance including to disabled children and adults, older adults, widows, and other groups.

The money collected from workers is held in a separate fund from the regular federal budget, known as the Social Security Trust Fund. There have been many myths and false statements floating around about this fund for decades. One of the biggest concerns is the trust fund running out of money as more and more workers live longer and fewer workers enter the workforce. Most reliable sources state that the trust fund will cease breaking even and begin to spend down the balance sometime between 2035 and 2040. This does not mean that the fund will "go broke." It means that the fund, which has been collecting more money each year than it has been dispensing, will cease building a balance and will begin spending more than it brings in. This does not mean that Social Security will disappear, although this may impact the amount paid to retiring workers. Many solutions are being considered, including raising the retirement age, raising the amount taken from wages, and privatizing the entire program.

Medicare

Medicare is a healthcare program specifically for older adults and is not limited by income level. One way to remember the difference between Medicare and Medicaid is that *aid* is given to anyone who needs help because they cannot access care on their own; *care* is given to those who need regular health care assistance. Thus Medicaid is for lower-income individuals who need help covering their health needs, and Medicare is for older Americans who utilize care more often. Technically, Medicare is for anyone 65 years of age or older, people of any age who have certain disabilities, and those with permanent kidney failure, all of whom may need much more care than the general population.

Because older Americans utilize medical services more often, Medicare has become the largest contributor to health care coverage in the United States. Since it is not an insurance program for those experiencing lower income and poverty, it is

not as integral in helping those without insurance become insured. This means it has had few major structural changes after the implementation of the ACA in 2010.

Medicare is by no means perfect, as the various parts of the program are coordinated differently and can be confusing for those utilizing the benefits, specifically Parts C and D (Kronenfeld, 2011). It also does not cover treatment in long-term care facilities, which is an important concern for some who are eligible for Medicare (Austin & Wetle, 2012). However, it is still a prominent piece in the continued coverage of people who have reached retirement age and may have lost their insurance when they stopped being employed. As our older adult population grows, Medicare will continue to play an important role in how this group pays for their medical needs. To be clear, many people reach retirement age in the United States and are working well past that due to the inability to work full time because of their financial needs overall in their life.

Where policy fails, human services workers have a responsibility to intervene on behalf of all those who live in the United States yet do not have that access to affordable health care. We need to be aware of community resources available to clients who otherwise have little or no health coverage. In policy practice, we need to help evaluate the implementation and effects of the ACA, recommend and work for any needed positive changes, and assist state and local governments and agencies to ensure the law is being implemented correctly.

Medicaid

Medicaid offers a health care coverage solution for low-income individuals and families, including children, those who are pregnant, people experiencing a disability, and those older adults the government considers seniors. However, healthy women and children who are otherwise uninsured have historically made up the majority—70 percent—of those enrolled in Medicaid programs (Kongstvedt, 2009).

Medicaid is a fee-for-service coverage program that limits how much state governments pay directly to providers for specific services. Many states work with managed care organizations to provide care through a network of various providers. This is how the vast majority of Medicaid recipients are served (Centers for Medicare & Medicaid Services, n.d.). Medicaid has been expanded by the ACA to allow more Americans to utilize these programs and provide options for states to further increase eligibility requirements as they see fit.

States still have much say in how they implement these programs. However, the passing of the ACA has allowed the federal government to increase eligibility, expand coverage, and adjust minimum regulatory drivers behind the program to reduce the number of uninsured Americans who are not receiving the care they deserve or require. There is far more to be done to secure the human right to adequate health care, and as figure 9.12 indicates, policy relies on advocates to support and raise awareness.



Figure 9.12 Social action is necessary to prevent Medicaid cuts and work requirements imposed by state legislatures. It is telling that social movements use the framing Medicare for All—rather than Medicaid for All—to support efforts to publicly fund medical care in the United States.

The changes made to these programs align legislation's foundational ideas by improving quality of care and expanding treatment, especially for those who have historically received lower levels of service from health care providers. People covered under these programs may still have nominal co-payments, co-insurance requirements, deductibles, and premiums—including for prescription medication and emergency room visits—but how much they pay out-of-pocket is limited by federal mandate.

In addition to trying to increase the number of those with adequate insurance, Medicaid, similarly to the ACA, is working to reduce the actions taken by insurance companies, healthcare providers, and patient consumers that contribute to the increasing medical care costs. For instance, going to the emergency room for non-emergency purposes is one thing directly addressed by Medicaid.

Those with low income and no insurance who cannot afford to go to the doctor for what many people see as a minor health issue, such as a cold, have few options for care. Since emergency rooms cannot turn anyone away, an individual can go to the ER for antibiotics or other treatment and care that should be available at a physician's office. Medicaid charges premiums for non-emergency use of emergency rooms as a means of trying to curb this behavior and help lower costs for care overall.

Older Americans Act

The recognition of struggles faced by older Americans was the impetus for creating the **Older American Act** of 1965, which was designed to support a wide range of social services and programs for individuals aged 60 years or older. According to the Administration on Aging (n.d.):

> Congress passed the Older Americans Act (OAA) in 1965 in response to concern by policymakers about a lack of community social services for older persons. The original legislation established authority for grants to States for community planning and social service research and development projects, and personnel training in the field of aging. The law also established the Administration on Aging (AoA) to administer the newly created grant programs and to serve as the Federal focal point on matters concerning older persons. (para. 1)

Basically, the Older Americans Act, in line with the provisions of the Administration on Aging, provides services and programs focused on alleviating societal woes of older Americans that are regulated and overseen by state governmental bodies. These services and programs are offered through various social service and health care agencies, both public and private not-for-profit. While the AoA does the most to meet needs with programming and information, there are other governmental programs and policies for the older population as well.

Advocacy Groups

Advocacy groups are vital organizations that support older adults by raising targeted issues to the public's attention and addressing them through legal and other means. These groups are crucial in driving positive change and meeting seniors' needs and rights.

Advocacy groups partner with state and federal lawmakers to advocate for programs that support seniors. They focus on a wide range of issues that impact older adults, including access to affordable housing, medical care, food security, elder abuse prevention, and poverty alleviation. By raising awareness of these problems and advocating for solutions, advocacy groups can help seniors receive the support they need to lead fulfilling lives.

One of the most prominent and influential advocacy groups for seniors in the United States is AARP (formerly known as the American Association of Retired Persons). AARP advocates for various issues that impact seniors, such as prescription drug costs; dental, vision, and hearing coverage; support for informal caregivers, affordable housing; and age-friendly communities. As the nation's most prominent nonprofit, nonpartisan organization dedicated to empowering people to choose how they live as they age, AARP is a force for good in the lives of older adults.

Another essential advocacy group is the Gray Panthers, depicted in figure 9.13, a network of local chapters that takes an intergenerational approach to combating ageism and advocating for social justice issues that impact older adults. The Gray Panthers ensure that seniors are treated with respect and dignity and that their voices are heard in critical policy and program conversations. They believe civic participation and responsibility are fundamental to achieving social justice and peace.



Figure 9.13 The Gray Panthers are protesting the discretionary spending budget of the United States–which allocates far more to defense spending than social welfare.

The Diverse Elders Coalition (DEC) is another vital advocacy group that works to improve aging in our communities as racially and ethnically diverse people. The DEC is "made up of six national organizations representing a growing majority of millions of older people throughout the country: American Indian and Alaska Native Elders; Asian American, Pacific Islander, and Native Hawaiian, older adults; Black and African American older adults; Hispanic and Latinx older adults; and lesbian, gay, bisexual, and transgender (LGBT) older adults. By advocating for policy changes and programmatic solutions that respond to this demographic shift and remove barriers facing their communities, the DEC envisions a world where all older adults can live entire and active lives as they age" (Diverse Elders Coalition, n.d., para. 2).

In conclusion, advocacy groups are essential in supporting and advocating for older adults. They are critical in meeting seniors' needs and rights and driving positive change to improve their lives. The impact of advocacy groups, such as AARP, the Gray Panthers, and the Diverse Elders Coalition, cannot be overstated, and their work is crucial in creating more age-friendly communities and a better world for older adults.

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Figure 9.11. **Social Security card** by **N Giovannucci** is licensed under **CC BY-SA 4.0**.

Figure 9.13. **Gray panthers on the prowl** by **Elvert Barnes** is licensed under **CC BY 2.0**.

9.6 End of Life, Dying, and Supports

Death is something that is not an easy topic for many and taboo for others to bring into a conversation. It is usually only talked about as we are getting older, especially in the United States. Conversations around death are deemed "inappropriate," and unnecessary for many in this country, since it is "supposed" to take place later due to advances in technology and medicine. However, this also denies many people the ability to fully understand what living is because so much fear surrounds what death looks and feels like.

Many people have spiritual, religious, and even scientific ideas of what happens after we die, but we are advocating for more openness about starting conversations and supporting this topic. Cultures around the world have thousands of years of practice with open conversation around death from the very start of life, and it is not something that is seen as inappropriate to talk about or a taboo subject. These conversations are not age-restricted, since they are not connected to fear but to how the whole culture lives.

Cultures all around the world, from Mexico to Africa, have practices around death that are different and open in comparison to the United States. This section will help you as practitioners consider how this field of human services and social work intertwines with conversations to support communities around death, dying, and grief.

Death with Dignity Act

Oregon enacted the Death with Dignity Act (DWDA) on October 27, 1997. It allows terminally ill individuals to end their lives through the voluntary self-administration of lethal medications expressly prescribed by a physician for that purpose after meeting clearly defined criteria outlined in the law, including safeguards. Outcomes for the 2022 enrollees in the DWDA program are visualized in figure 9.14. You can optionally read the complete law linked at **Oregon's Death with Dignity Act [Website]**. The criteria for eligibility are as follows:

1) Must be 18 years of age or older.

2) Must be capable of making and communicating health care decisions to health care practitioners.

3) Must be diagnosed with a terminal illness that will lead to death within six months.

The attending and consulting physicians must determine whether a patient meets these requirements and report that fact to Oregon Health Authority (OHA) at the time a prescription is written. When OHA identifies any instance of noncompliance with the statutory requirements, it reports the instance to the appropriate licensing board.

In October 2021, a lawsuit was filed against the state of Oregon alleging that the residency requirement in the act violated the Privileges and Immunities Clause and the Dormant Commerce Clause of the United States Constitution. This prevented Oregon health care providers from offering medical aid to dying nonresident patients. The case was presented in the U.S. District Court for the District of Oregon, and on March 28, 2022, a settlement was reached. As per the agreement, the state would not enforce the residency requirement mentioned in the act and would introduce a legislative concept to repeal the residency requirement in several sections.

I understand that it is a sensitive topic, and it's important to note that a patient's state of residence is not collected during the DWDA prescription process. OHA only receives death certificates from other states if the deceased was an Oregon resident; therefore, if an Oregon DWDA patient dies out of state and is not an Oregon resident, it's

unlikely that OHA will be informed of the death. As a result, the out-of-state deaths reported may not represent all DWDA deaths from out-of-state residents who received a DWDA prescription from an Oregon health care provider.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2022, as of January 20, 2023

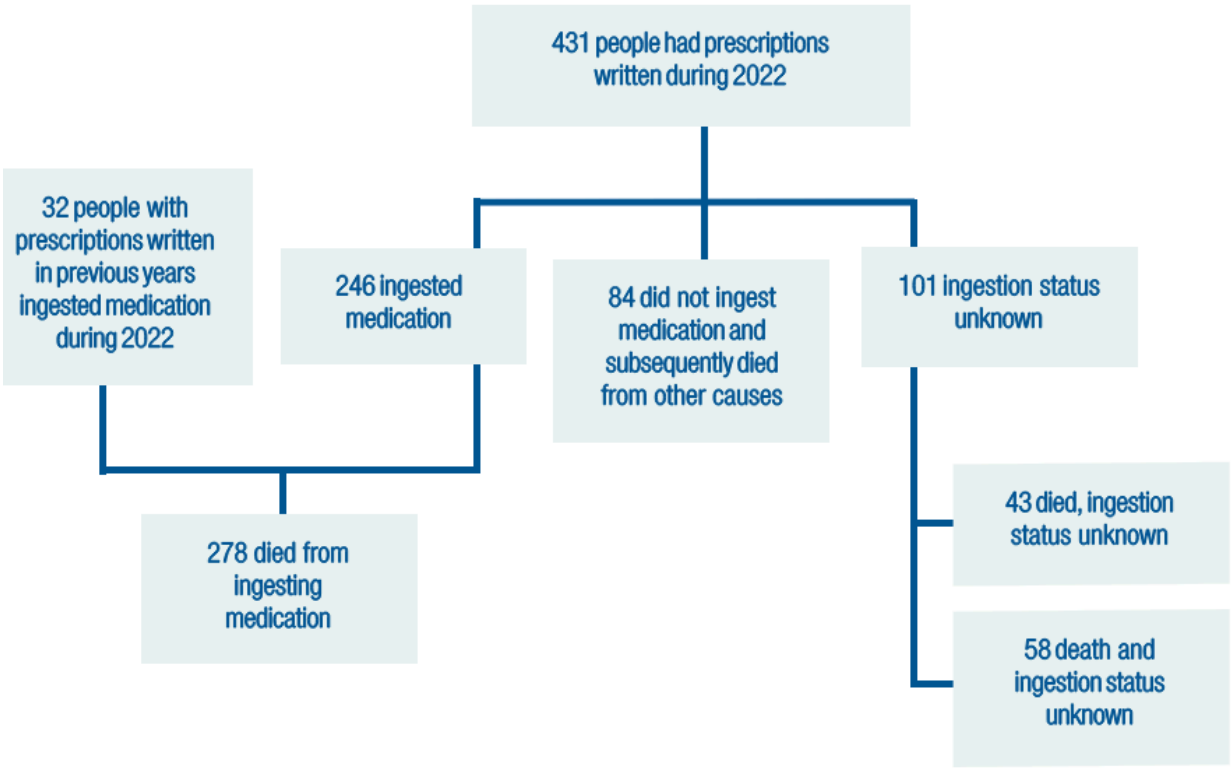


Figure 9.14 As a human service worker, it is your ethical duty to support people through each stage of this process, honor their self-determination, and support clients and their loved ones to make informed care decisions. **Image description.**

It's important to understand that the changes made to the act were to ensure that all individuals receive the care they deserve regardless of their residency. The Oregon Legislative Assembly passed House Bill 2279, removing all text in the act related to the residency requirement for patients receiving medical aid in dying. This was done in hopes that it would bring some peace of mind to those who were affected by the previous requirement.

As providers in the field, we may struggle with the idea of suicide and our own personal beliefs around it. But many people are going to need our support during times of great need, which can include moments near the end of life or when members of a client's family have decided to use something like DWDA. Understanding what this act means and how we can support clients is important both for our own growth and our clients' needs. If a client has decided they want to move forward with this, there is additional support available.

End of Life Doulas

The idea of supporting someone entering this world with a birthing doula is well known by many and used in many cultures around the world. So are end-of-life doulas. The work of end-of-life doulas is described by International End of Life Doula Association (INELDA):

> End-of-life doulas provide companionship, comfort, and guidance to those facing a terminal illness or death. Our non-medical holistic support encompasses emotional, spiritual, and practical care. We offer resources to help the dying person, along with their family and loved ones, make informed decisions in a supportive environment.
>
> A doula can become involved any time in a person's life. We offer support when people are impacted by a life changing illness, after a terminal diagnosis, when death is imminent, or even after a death—to help with light grief support. Sometimes family members or loved ones of the person dying seek support and guidance from end-of-life doulas.
>
> Doulas normalize deathcare by creating spaces to hold conversations leading to increased communication and increased spiritual and emotional well being. When individuals plan for death, they have autonomy over their decisions and are able to clearly define their end-of-life wishes with family and loved ones. While there are alternative names for end-of-life doulas like death doula, death midwife, death coach, end-of-life coach—we all seek to provide compassionate deathcare. (International End of Life Doula Association, 2023)

This is a career that many people are unaware of as being a possibility. It is a way to work with aging adults and their families with compassion. It centers their humanity and needs by combining medical, social services, cultural, and spiritual supports in a unique, client-centered way.

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Figure 9.14. **Figure 2: Summary of DWDA prescriptions written and medications ingested in 2022, as of January 20, 2023** by Public Health Division, Center for Health Statistics, is included under fair use.

9.7 Key Takeaways and Discussion Questions

As discussed in the beginning of the chapter, changes in the population's demographics will have an impact on the field of human services. Looking at aging from a professional perspective can be difficult, considering we are all subject to the aging process and have our own personal views. Understanding some of the issues related to an aging population, such as a lack of caregivers, as well as common resources, can help us approach our work with a clearer view.

Included in this section are tools for the reader to refresh and retain the knowledge. A

Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or

- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- Learn to evolve along with changes in what care will look like as the needs of older adults change.
- Multigenerational families and the shifting needs of these family structures
- Examine our own biases and fears around the aging process.
- Understand that ageism can negatively impact the health and well-being of older adults, and can impact our own attitudes and behaviors as human services providers.
- Learn about the death and dying process and other end-of-life supports.

DISCUSSION QUESTIONS

Due to changing demographics, no matter what area of human services you decide to pursue, it is likely you will be interacting with older adults. One of the biggest issues professionals face is confronting their own ageism. This is a list of activities that can help you challenge your own beliefs and bring the pervasive ageism of our culture to the forefront.

1. Go to the greeting card section of a local store. Look for examples of stereotypes of older adults. You will likely find many negative examples (being frail, being incontinent, being deaf), but you may also find some examples of compassionate ageism. Please bring a few examples to class and talk about them with classmates. Examine your biases and each classmate's intersecting identities in comparison to others.
2. Go to the health and beauty section of a local drugstore. Try to figure out the percentage of products that do not claim to have an anti-aging effect. What do these messages convey? Why do we need to prevent or cover up wrinkles, age spots, or gray hair? Now consider European beauty standards. How does it intersect with race and ethnicity? Colorism? How many are available for darker complexions in comparison to lighter skin complexions? Are there any products for lightening skin?
3. What are some of your own biases about getting older? How might this impact your work as a human services professional? You may want to consider your thoughts about gray hair, looking old, sexuality in later life, and appropriate behavior for older adults.

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CHAPTER
10

Becoming A Professional

10.1 Chapter Overview and Learning Objectives

ETHICAL STANDARDS FOR HUMAN SERVICES PROFESSIONALS

Standard 36: Human service professionals hold a commitment to lifelong learning and continually advance their knowledge and skills to serve clients more effectively (NOHS, 2015).

This chapter focuses on the transition from the world of being a student into the world of **human services** work. This transition starts when you participate in your first **internship** or volunteer position. Although some of you may not yet see yourself as a professional, you are developing connections and a reputation for who you are in the workplace. It is important to behave professionally in your fieldwork setting.

Because human services emphasizes lifelong learning, there is an implicit understanding that you do not know everything that a long-practicing professional knows. However, you should be open to learning. This chapter is focused on important traits, knowledge, and practices that will help you make decisions about your future as you transition into the world of human services work.

LEARNING OBJECTIVES

1. Apply reflective tools for career assessment.

2. Assess training, certification, degrees, and continuing education required for human services career paths.
3. Discuss the value of participating in field placements, understanding **organizational culture**, and identifying mentors.
4. Apply knowledge and skills to identify next steps in the career path, including education, internships, and career focus.

KEY TERMS

Key terms are important vocabulary for understanding the content of the chapters. They will be bolded and defined via an in-text glossary the first time that they appear in the chapter.

Key terms for this chapter are:

- Compassion fatigue: a consequence of knowing about a traumatizing event experienced or witnessed that reduces one's capacity or interest in being empathetic or bearing clients' suffering (Adams et al., 2006)
- Compassion satisfaction: the sense of fulfillment you feel for the work you do
- Continuing education credits: Continuing education requirements depend on your licensures, certification, board requirements. Some of the requirements include keeping human service providers up to date on the latest ethical, suicide prevention, and treatment trends every couple of years
- Decolonize: the acts of identifying systems of oppressive colonization, dismantling historical records that emphasize the dominant culture's story, and striving to effect power structures so that they are shared more equitably
- Degree: an academic rank conferred by a college or university after completion of a specific course of study
- Field education: a credit class in which students apply theory to practice by using what you have learned during coursework in a real-world setting with a supervisor or mentor who is invested in your growth and development
- First-generation college student: the first person in their immediate family to go to college.
- Internship: supervised, structured learning experiences in a professional setting (University of Maryland, n.d.)
- Informational Interview: an informal meeting with a professional in the field
- License: a certification conferred by the government or an educational institution that is required for certain occupations
- Mentor: an experienced individual who helps to guide a less experienced person, sometimes called a mentee, in their learning and growth
- Mindfulness: a mental state of focused attention on the present moment, accepting and acknowledging one's feelings, thoughts, and physical sensations
- Organizational culture: system of shared assumptions, values, and beliefs that show people what is appropriate and inappropriate behavior in a particular agency or workplace

- Positionality: awareness of your own social identities and how those fit with others and within a power structure
- Practicum: opportunity for students to observe and apply their knowledge in a professional setting. Typically unpaid and connected to a specific course. Practicum experiences are usually shorter than internships (SocialWork.org, n.d.)
- Profession: a paid career that involves education, formal training, and/or a formal qualification
- Restorative practices: strategies that build, strengthen, and repair relationships among individuals as well as connections within communities
- Trauma stewardship: recognizes that trauma has impacts that can be named and managed; it acknowledges that the person who is helping someone who is suffering from trauma may also suffer
- Group Supervision: Supervision groups can have 3 to 10 therapists, and options include triadic or group supervision. They can be drop-in or closed, and the requirements depend on state regulations
- Individual Supervision: Individual clinical supervisors throughout your career or even in various specialty areas, like individual trauma supervision from a trauma clinical supervisor or individual substance abuse supervision from an addictions specialist

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10.2 Finding Your Fit

An important part of finding your place in the field is understanding your own goals and values. When you know these aspects of yourself, you can find an environment that reflects them. This environment includes not just the work you do, but the agency or agencies that you work within. Develop a good grasp on your own views and make sure you are aware of the goals and values of the organizations you are considering (figure 10.1).



Figure 10.1. It is important to be thinking about your values and goals as you develop your professional identity.

Understanding Yourself

The first step in finding your fit is to have a deep understanding of what is important to you in the work that you do. You may want to find work in the field that reflects some of your personal strengths. For example, if you have an easy time establishing rapport with young people, you may decide to focus on finding positions that work with youth. In addition, you might enjoy being outdoors and find office work a bit repetitive. This could lead you to seek agencies that do field-based work with youth, such as residential treatment or wilderness-based programs.

In contrast, you may decide you want to focus on areas of growth. You may have years of experience working with small children, but now you'd like to work with a different age group. You may have become comfortable working in large bureaucracies and would like to understand more about working in a smaller community organization.

In addition to understanding your strengths and areas for growth, it is important to be realistic about your limitations. You may have obligations, such as family or spiritual practices, that limit your availability. You will want to focus on agencies that can work with your schedule. Another limitation faced by many students involves transportation. If you do not drive or do not have access to a car, you will need to focus on agencies that are near public transportation and work that does not involve home visits or traveling to other agencies. Some agencies have vehicles available for employees to use for client sessions and agency work.

Consider your preferences versus your non-negotiables. You may prefer a regular nine-to-five, Monday-through-Friday schedule, but you may not want to rule out positions that match your values and goals but require working weekends. However, you may have a religious practice that prohibits working on certain days or that has services that you feel are significant and cannot be missed. This would represent a non-negotiable. For example, you might receive a job offer upon graduation that is the exact position you are looking to secure, but with an agency that is located in a city 20 miles from your home. While you would prefer to work locally, you may decide the position itself is such a great match that an extended commute is tolerable.

Finally, you must also know how the work matches your worldview then focus on positions and organizations that match that view. This may include opinions about the field that involve macro-level policies, such as immigration or health care, or opinions that are more personal and on the micro level, such as abortion or LGBTQIA+ rights. Many of you have heard the phrase "separate the issue from the person," but can we do that? Bias is so embedded in our choices and societal expectations that we sometimes don't realize that we made our choices before we realize that we made our decisions because of their identities, not because of the issue that needs to be resolved.

Personal Values

The significance of personal values in shaping one's worldview cannot be overstated, particularly in the **human services** sector. While **social justice** forms an integral part of this field, an individual's values will significantly impact their professional identity, including the type of role and agency they choose to work with. This may require making difficult choices between competing values, such as selecting to work with an issue one is passionate about or an agency that aligns with one's diversity values. This predicament is further complicated by personal and professional values often being interwoven and difficult to distinguish.

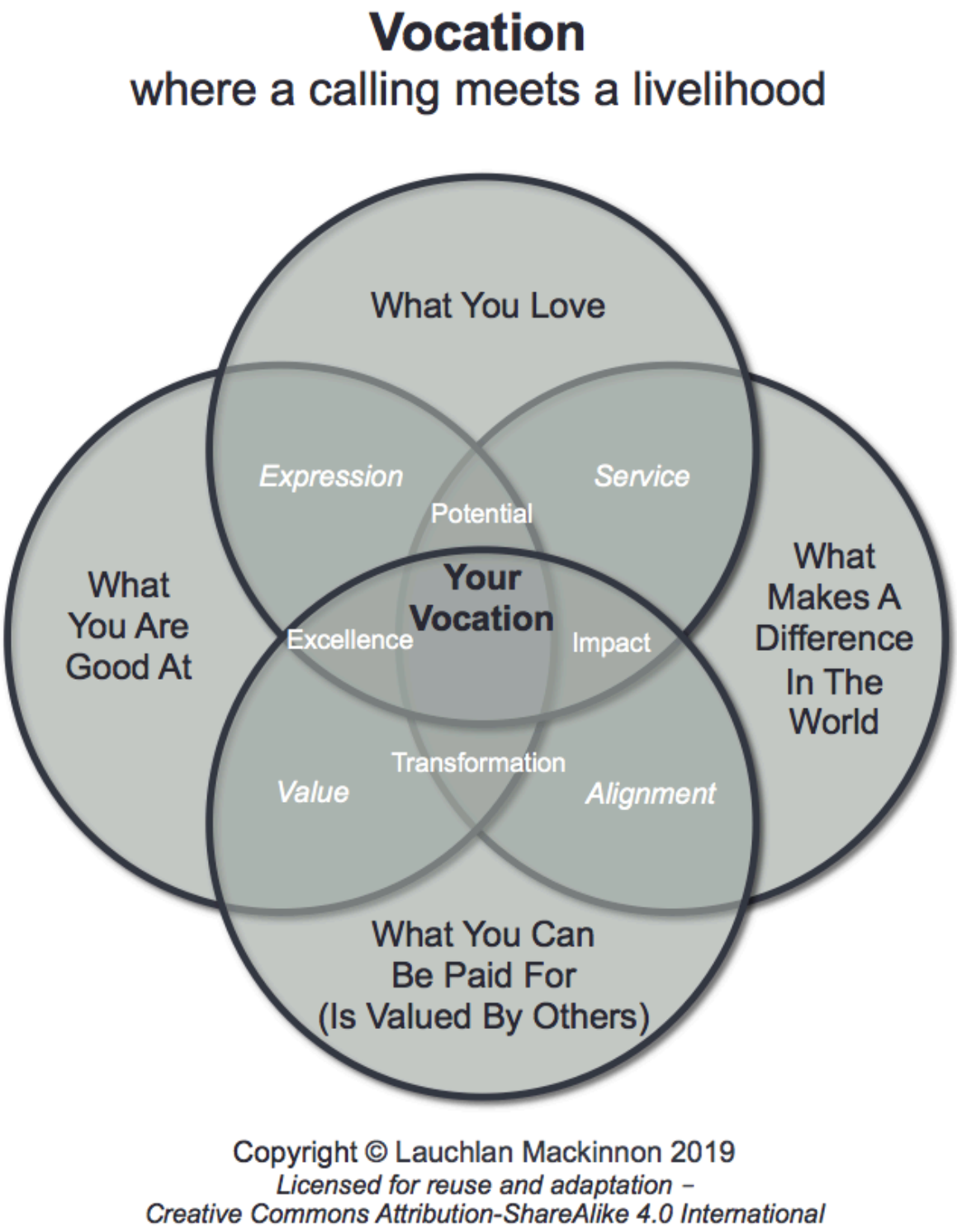


Figure 10.2. Aligning your personal and community values with your paid employment is part of a lifelong process of career development. Image description available. **Image description.**

It is imperative to consider **intersectionality** when examining personal values and their impact on individuals. These values form the basis of one's worldview and spill over into the profes-

sional domain. Therefore, it is crucial to carefully evaluate the influence of personal values and balance personal and professional values when making decisions. This balance is essential when personal values do not align with professional **standards**.

The alignment of personal values with professional standards is not just a consideration but an integral aspect of the human services field. Professionals must critically assess their values and their impact on their worldviews to make informed decisions when deciding between competing values. This alignment is a task that cannot be delayed or taken lightly, as it directly influences the quality of our work and the impact we have on our clients.

Positionality

Positionality refers to an awareness of our social identities and how those fit with others and within a power structure. It is important to engage in self-reflection and examine our identities to better understand ourselves and how others perceive us. Our privileges can greatly impact our interactions within the agency and affect how our clients and colleagues perceive us. Think about developing an awareness of the power structures within our agency and how they influence our daily interactions.

This awareness is not a solitary journey but a collaborative one. It can be nurtured through individual and group supervision, and by committing to an intersectional approach throughout our lives. This commitment involves intentional time and action while working together with BIPOC and White affinity colleagues in their affinity spaces to understand and respect their experiences.

Starting with **race** is essential, as it is one of the most significant factors and systems of oppression that we must consider when examining our positionality. It is also necessary to consider other factors, such as **gender**, sexual orientation, **religion**, and socioeconomic status, when reviewing our positionality.

By actively participating in these conversations and actions, we can foster a more inclusive and equitable workplace. It's vital to remember that this is not a one-time task, but an ongoing process that demands continuous effort and a hunger for learning and growth. This commitment to continuous improvement is what will truly make a difference in your workspace.

A Personal Story: That's Not What a Professional Looks Like

When I (Martha) first decided to apply for graduate school, I was told by a professor in my undergraduate program that I was not what a professional looked like. I should not waste my time applying for programs that don't take people who wanted to do the kind of "passion projects" that I wanted to do or had life experiences that "don't fit with what the field needs."

This would not be the last time that my version of **professionalism** would be put into question or asked to change to fit into a more "appropriate" way of acting. These ways were always centered around my appearance, how I sounded, whether my knowledge came from "the right place," or how I wanted to use my cultural experience to support my community's needs. I was often asked why I always wanted to bring up race or why I needed to ask questions about diversity, **equity**, and inclusion in every conversation. "That is not what this meeting is about," I was often told.

This would be a pattern that I would deal with in my career, and allies would be necessary. I had to find people who could understand my story so I would not be alone in the experience of being a child of immigrants trying to navigate the world

that had systemic barriers to block me from entering it.

This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=1QlM5cJGimA**

Figure 10.3. Watch **Epistemic injustice in healthcare [Streaming Video]** from the Wellcome Trust on how healthcare systems and human services replicate the same experiences I have described. Excluding oppressed groups from the definition of who is professional excludes their experiences from our theories and problematizes how they present to others. **Transcript.**

As I searched for understanding, I yearned to meet people who shared my appreciation for my parents' intelligence and strength despite their sometimes heavy accents. I longed to find individuals who recognized that my parents' accents were not a reflection of their intellectual capacity but a testament to their ability to read, dream, sing, speak, protest, pray, and create an entire world in a language that others in our new community could not.

Their accents reminded my parents of their sacrifices when they left their home country to give their daughters a chance to thrive in a foreign land where their education and skills would be valued. My parents were determined to provide a brighter future for their family, whether they were practicing nurses or civil engineers in another country. And yet they carried with them the rich cultural heritage of their homeland and a deep love for the language that defined their identity. They (the world around us) could see my parents' deep-brown skin, which was sun-kissed by Huitzilopochtli, the Nuhutl sun god, as a gift, not something that was scary.



Figure 10.4. Huītzilōpōchtli (Nahuatl sun god) is also known as "Hummingbird" or "The Turquoise Prince."

Professionalism: Ten Ways White Supremacy Lied to Us All

When asked to describe a professional, it should not include the color of someone's skin or cultural experience; that perspective only comes from one cultural experience. A professional is someone with a skill set used in a specific field. These skills could come from a formal educational setting, from your own life experience, from **internship** experiences, or from traditional cultural learning.

This does not include a specific way of dressing, which is usually one of the ways that professionalism is pushed onto students. This can limit what people think they need to look like or be in order to be considered a professional. The ideas that are being forced on many students in educational set-

tings about professionalism are centered around White supremacy **culture**. Tema Okun talks about ten ways in which this shows up (Jones & Okun, 2001; Okun, 2021):

Perfectionism: Expressing appreciation for the work of others is often overlooked. When it is expressed, it's usually directed toward those who already receive most of the credit. It's more common for people to point out someone's inadequacies or flaws rather than recognizing their positive qualities or good work. Even worse, talking about someone's shortcomings to others without addressing the person directly is prevalent.

Mistakes are not personal failures; instead, they are integral to the learning process. They should not be seen as a reflection of one's worth but as opportunities for growth and learning. It's crucial to focus on reflection and identify lessons that can enhance performance; otherwise, mistakes will not be used as stepping stones for personal development.

There's a tendency to focus on what's wrong rather than right, which makes recognizing and appreciating positive contributions difficult. This tendency causes people to feel inadequate and struggle with a harsh inner critic. They might overlook their excellent work and instead focus on their failures and mistakes.

Sense of urgency: In any organization, it's essential to prioritize inclusivity, democratic decision-making, long-term thinking, consequence evaluation, and learning from mistakes. It can be challenging to maintain this focus when there is a constant sense of urgency. In such situations, there is a risk of neglecting potential allies in favor of quick or visible outcomes.

For instance, sometimes the interests of communities of color may be overlooked to expedite success for White individuals. This urgency is further perpetuated by funding proposals that demand excessive work for inadequate compensation from funders with unrealistic expectations. To overcome these challenges, it's crucial to balance urgency and inclusivity. This can be achieved by involving all stakeholders in the decision-making process, being mindful of the long-term impact of our actions, evaluating the consequences of our choices, and being open to learning from mistakes.

Defensiveness: Although an organization may have a clear structure, there is still an opportunity to cultivate the potential of each individual and clarify power dynamics. However, some may prioritize maintaining the status quo and preventing abuse over introducing innovative or challenging ideas.

Promoting a culture of open-mindedness and encouraging constructive criticism is essential to bring about positive change. By investigating how racism manifests in the workplace, the organization can take steps toward creating a more inclusive environment. Leaders should interpret calls for change as opportunities to improve rather than personal attacks, which can empower people to effect change. A constructive approach can help the organization achieve a more positive and inclusive future.

Quantity over quality: Optimizing available resources and attaining measurable outcomes can be seen as imperative to achieving organizational goals. Quantitative measures take precedence over non-quantifiable ones. For instance, meeting attendance, newsletter distribution, or incurred expenses are prioritized over relationship quality, democratic decision-making, or conflict-resolution skills.

Processes that cannot be measured are not valued. Emotional factors are consistently ignored. The prioritizing process is in a conflict between content (such as a meeting agenda) and process (like participant engagement). Without prioritizing non-quantitative measures, decisions made during such a meeting may be disregarded or challenged, even if the agenda is accomplished.

Worship of the written word: Many organizations consider formal information documentation

through memos valuable. However, other methods of sharing information can be equally effective. While strong writing and documentation skills are highly regarded, interpersonal skills are also crucial to success.

There is only one right way: It emphasizes the importance of clearly understanding the most effective approach to a task. It also emphasizes the significance of being open to new ideas and willing to modify one's behavior. Everyone has a unique perspective, and each person's input can be valuable. We should strive to appreciate diverse viewpoints and learn from them. This approach fosters a collaborative and inclusive environment where everyone is valued and respected.

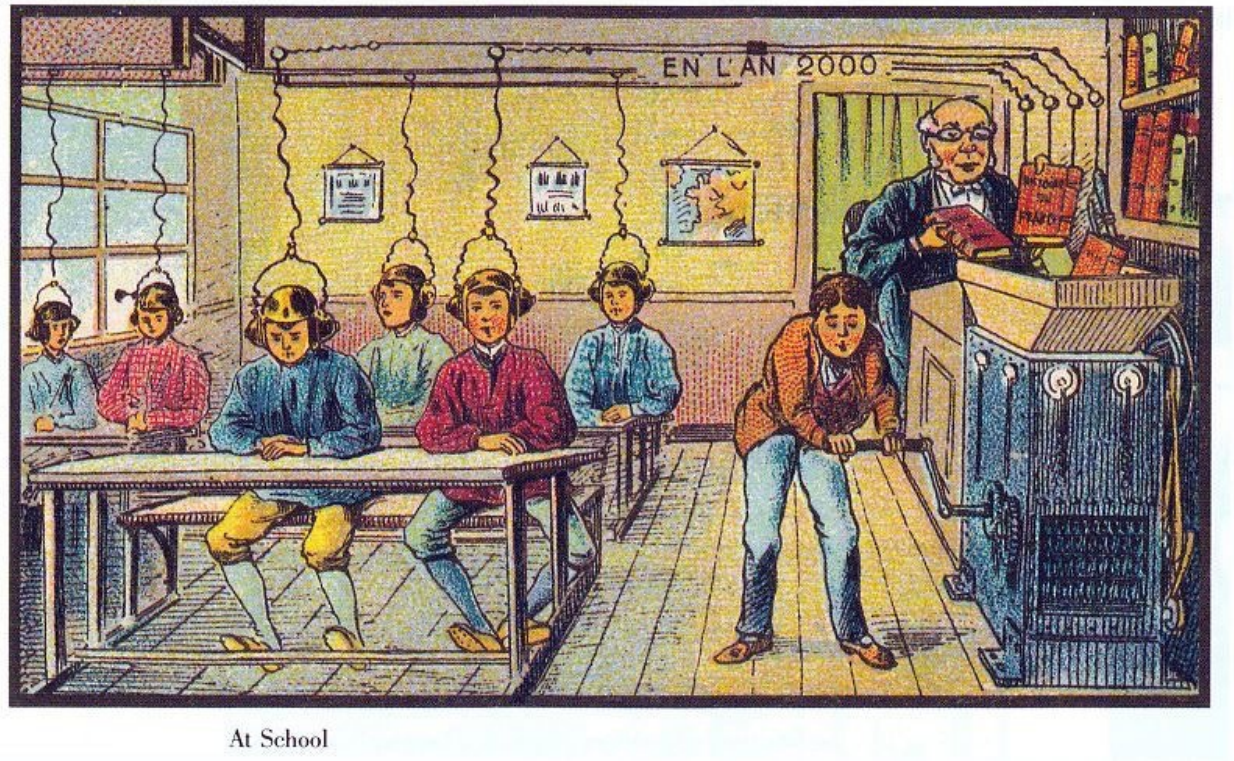


Figure 10.5. Jean-Marc Côté's vision of school in 2000, drawn in 1901, shows an older White male instructor delivering the written word–the one true way of knowing–via electronic machine into students' heads. This model of education ignores that knowledge, including Western scientific knowledge, is grounded in discovery and collaboration across diverse groups over time.

Paternalism: Effective decision-making requires transparency and consideration for all perspectives involved. Those in positions of power should recognize that their decisions can impact those without power and try to understand and incorporate their viewpoints.

On the other hand, those without power may not need to comprehend the decision-making process entirely, but they do need to be able to voice their concerns and provide feedback. We can make more informed and equitable decisions by working together and valuing diverse perspectives.

Either/or thinking: When we view things as either/or, we limit ourselves to only two options and disregard the possibility of alternative solutions. This can oversimplify complex issues and create conflict and urgency.

Instead, we should adopt a both/and approach that allows us to consider multiple perspectives and generate creative solutions. By embracing this mindset, we can avoid oversimplification and work toward finding more effective and sustain-

able solutions. Complex problems often require time and resources to solve, and we should be open to considering all possible options before deciding.

Power hoarding: Encouraging open communication and **collaboration** among team members is necessary to foster a more inclusive and effective decision-making process. Sharing power with those in leadership positions can also lead to a more balanced and constructive organizational structure. Additionally, providing team members with training and resources to develop their leadership skills can help them become more effective agents of change.

A culture of trust and respect is essential to creating an environment where team members feel secure and valued. Such an environment encourages them to share their ideas and concerns without fearing retribution. The emphasis of the significance of diversity and inclusivity, as these values can contribute to a more prosperous and sustainable organization.

Fear of open conflict: It is common for individuals in positions of authority to avoid confrontation. When a challenging matter is raised, the automatic response frequently assigns fault to the person presenting it rather than addressing it. There is a tendency to maintain a veneer of politeness, even when policies or actions are deeply painful or offensive to those impacted. This emphasis on etiquette can stifle conversations or negotiations, leaving individuals to suppress legitimate feelings of anger or frustration. Furthermore, intricate issues may be dismissed as impertinent, discourteous, or inappropriate, impeding the search for meaningful solutions.

When walking into a classroom, agency, or interview, you may be the only one who looks like you, has your stories to tell, comes from spaces that you were once not allowed in and others may not even consider asking about. You may be treated differently or not even be recognized as a professional in the space. It's frustrating, but not unusual, to hear people say, "Are you the interpreter?" "It is not professional to wear those earrings in the office." "You don't look like any instructor I have seen teach here before; can I see some ID?"

Organizations and Associations

Transitioning from a student perspective to a professional one involves commitment to the **profession** of human services itself. Being part of a **profession**—a career that requires education (formal, informal, non traditional, traditional), formal training and degrees or certifications—means that you will adhere to a code of ethical standards, commit to lifelong learning, and strive to continue the development of human services. This can include activities such as attending professional conferences, reading, discussing, or even conducting research, advocating for legislation, and belonging to a professional organization. Listed below are three common professional organizations that even students can belong to:

- **National Organization for Human Services (NOHS) [Website]**
- **National Association of Social Workers (NASW) [Website]**
- **National Council on Family Relations (NCFR) [Website]**

You can join the associations above as a student and evolve into being part of them as a professional. The cost associated with these organizations is lower for students than for professionals after being licensed or even retiring. Each organization has a code of **ethics** members abide by. As stated before, ethical codes are not the same as laws and cannot be enforced by associations in the way that laws are enforced by governments, just encouraged by the associates.

As members of these organizations, it is up to us to keep our field's values aligned. In Chapter 4, we discussed ethics and how intersectionality needs to be considered for every code we are thinking about. But what if the membership of these associations is less diverse than the clients their members serve? What can students and instructors advocate for to support the increased diversity of the field?

Consider how we look at human services recruitment, how we look at the occupations that we include in our field, and how we look at mentorship in the field. All of these questions help us build plans to continue to diversify a field that, at this time, does not reflect the communities that it supports.

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Figure 10.3. Epistemic injustice in healthcare | Wellcome by Wellcome is licensed under CC BY 3.0 Unported.

Figure 10.4. Huītzilōpōchtli by Gwendal Uguen is licensed under CC BY NC SA 2.0.

Figure 10.5. At School by Jean-Marc Côté is in the public domain.

10.3 The Value of Field Education

Field education refers to the opportunity to take what you learn in your **human services** coursework and apply your knowledge in a real-world setting. The opportunity to apply and practice your skills in the community is considered such an important part of human services education that it is a required component of all accredited human services programs. Fieldwork usually comes at the end of a **degree** or certificate program, and can be referred to by many different titles such as **internship**, **practicum**, or cooperative work experience and can differ depending on your program. Although the actual experience comes toward the end of your program, you can begin laying the groundwork for your fieldwork now.

The value of this part of education is crucial to any educational period in a student's life. Still, for students who have marginalized identities, it is a different experience, as they enter the work field with different needs and expectations. They have higher possibilities of not being seen for their full potential of skills, being discriminated against, not being mentored, being asked to do things other students would not be asked to do, or even being overlooked for positions. As current providers and professionals, it is up to us to ensure that we continue to provide feedback and help students advocate for themselves. We must pre-screenings potential sites to help reduce and mitigate some of these barriers.

Conducting Informational Interviews

One of the best ways to explore different areas in the field is to conduct **informational interviews**. An **informational interview** is an informal meeting with someone who works either at a position you are interested in or at an agency you would like to explore. It gives you a chance to meet with a professional in the field and ask them questions

about their work. You can begin these interviews as early in your program as you like, and they are a good way to get to know the local agencies and the work they do while you make contacts in the field.

Many instructors have guest speakers come to class to talk about their work and their agency. If one of these interests you, following up with an informational interview is a great way to find out more. This way, you can begin to create a list of possible sites for internships. Informational interviews can open the door to a more formal opportunity down the road.

Internships/Practicum Experiences

As mentioned above, field experience is considered such an important part of a human services curriculum that it is required in any accredited program. What this experience looks like depends on a lot of factors, including what type of certificate or degree is being offered, whether or not you are pursuing a specific specialty (such as substance use treatment), and what specific requirements exist within the college or university.

The number of hours and the length of the internship may vary, but generally a **practicum** will include specific experiences, such as shadowing employees, assisting with paperwork, attending meetings and trainings, and working one-on-one with clients.

Identifying Mentors

When making academic decisions and career plans, having a **mentor** with similar goals is helpful. A **mentor** is an experienced individual who helps to guide a mentee—the less experienced person seeking advice. A good mentor for a student engaged in academic and career planning is someone knowledgeable about the student's desired career field and who is perhaps more advanced in their career than an entry-level position. This is a person who can model the types of values and behaviors essential to a successful career.

Your college or university can connect you with a mentor through an organized mentorship program or the alumni association. If your college lacks an organized mentor program, you may be able to reach out to family friends who work in your field of interest, search online for a local professional association or organization related to your field (some associations have mentorship programs as well), or speak to the professors who teach the courses in your major. You may also find a mentor through your informational interviews.

Look for a mentor who will challenge you to grow professionally and personally, and will cause you to expand the way you look at the field as a whole. Consider your language skills, cultural experience, the kind of experience you need, the populations and communities you wish to expose yourself to, or the type of professional you would like to align yourself with. This is an opportunity to network with individuals you may not consider part of your work life now but who are in fields you want to grow into as you gain more experience.

When you're looking for a mentor to help you develop professionally and personally, several essential factors can help you find the right match.

Consider your language skills and cultural background: Finding a mentor who shares your cultural background can provide a unique perspective and benefit your professional growth. By working with someone who understands your cultural experiences and challenges, you can gain insights that may only be available from someone within your community. This can be especially important if you are part of an underrepresented group in your industry or field.

Identify the type of experience you need: Do you need specific skill development or seek broader guidance on navigating your industry or field? This can help you find a mentor with the

expertise and experience to help you achieve your goals.

Consider the populations and communities you want to work with: Finding a mentor with experience working with these groups can be especially helpful if you plan to work with underrepresented populations. They can guide you in building relationships, navigating complex cultural dynamics, and avoiding common pitfalls.

Think about the type of professional you want to work with: Do you have a particular industry or company in mind? Finding a mentor with experience in your desired field can help you achieve your career goals because they can provide you with insights and advice specific to that industry or company.

One of the benefits of finding a mentor is networking with individuals who can help you develop and grow in your field. By considering these factors, you can find a mentor who is a good match for you and can help you achieve your career goals. Remember to write in a way that is easy to understand by keeping your sentences short and direct, using everyday language, and trying to use an active voice.



This interactive content is not available in this version of the text. It can be accessed online here: **https://www.youtube.com/watch?v=3HDh4o6JpTU**

Figure 10.6. Watch **Women of Color Research Network Discusses: The Importance of Mentoring [Streaming Video]** from the NIH Working Group on Women in Biomedical Careers on goals of mentorship. Culturally responsive mentorship is important for human services workers from minoritized groups. Human service professions face the same structural inequities as other professions, despite their social justice mission. **Transcript.**

Thinking About Fieldwork

As mentioned elsewhere in this section, you can begin preparing for your fieldwork at any time during your program. Here are some examples of how students have identified possible internship opportunities:

- Katelyn was conducting an informational interview as part of a class assignment. She chose to interview the director of a local agency she was interested in. The director identified documentation skills as one of the most challenging aspects of the work. Katelyn mentioned a documentation format she was learning in one of her classes. The director asked if she had an example, and Katelyn gave her one of her recently completed assignments. The director was so impressed with Katelyn's documentation skills that she invited her back for an internship when she was ready. Katelyn reached out the following year and was accepted immediately. Having a clear example of your work in a central location is a good idea. Have both electronic and hard copies available if possible. Many would say why would you have a hard copy in a digital world? Well, not all agencies you will work in digital formats and many times you have to carry files with you in the field in hard copy formats. Knowing how to read and write in at least two different kinds of note taking styles is also recommended. DAP and SOAP notes are two different styles of formats you can use to take notes in.
- Zakir had to create a presentation about a local agency for his community resources class. He had just heard about the first recovery-based high school to open in the area, and he was excited to learn more. He researched the high school and arranged to visit and meet with the principal. During their discussion, he found out that the school was still looking for

recovery mentors to work with students on both academic issues and recovery challenges. Zakir, in recovery himself, asked whether they would be open to an intern. The following academic year, he became one of the first recovery mentors to work with their students. The high school now actively recruits mentors from the human services program each year. An important aspect of this was Zakir's personal connection to the students in this high school. A recovery mentor position could require not only knowledge of the students in need of support with recovery from substance use disorders but personal knowledge of what this is like.

- Gabriela's Introduction to Human Services instructor offered extra credit to students who attended a monthly meeting of the local information and referral services group. The meeting was once a month at 7:30 a.m. Although the early-morning meeting was a challenge, Gabriela decided to attend and introduced herself as a human services student. After the meeting, several attendees representing local agencies mentioned to her how impressed they were by her eagerness and interest. Several offered her their business cards and stated their willingness to be a resource to her in the future. She now had personal contacts at several agencies to refer to when looking for an internship site. Consistent and active networking is one of the biggest skills that agencies want to see in their providers. These are skills that they not only need in their work field but skills they would like to help reinforce in the clients they work with on a daily basis.

Be aware of opportunities in your own education to make connections. You never know when one of these connections can become a great fieldwork opportunity!

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10.4 Organizational Culture in Field Sites and Workplaces

Organizational culture refers to a system of shared assumptions, values, and beliefs that show people what is appropriate and inappropriate behavior in a particular agency or workplace

(Chatman & Eunyoung, 2003; Slocum, 2005). These values have a strong influence on employee behavior as well as on organizational performance. Organizational **culture** is expressed implicitly, explicitly, or a combination of both.

It is an advantage to experience multiple field sites before obtaining a paid or full-time job. While organizational culture may not spring to mind as the very first criteria to consider, it can make a big difference to your overall satisfaction with the workplace, and to your stress level in particular. Observe and assess varied organizational cultures in a variety of settings before choosing a job or career. Organizational culture can be expressed subtly, and knowing what it is and how to look for it takes practice.

Culture, most often associated with family and social groups, describes the arts, traditions, social institutions, values, and beliefs that are shared and passed down through generations over time. While many traditions remain the same, others are adapted and adjusted by subsequent generations. So how does this mesh with a **human services** organization and workplace?

Formal Organizational Culture

Most workplaces express their organizational culture in the form of a mission statement, a vision statement, or core values. Organizational culture can be explicitly stated (e.g., in written policies, employee manuals and training, codes of ethical conduct, website forms, and instructions for clients), or it may be obvious only through experience and observation. For example, Brown Hope, a service and advocacy organization in Portland, Oregon, states its mission on the home page of their website:

> Brown Hope is planting and nurturing seeds for racial justice and healing. We serve and mobilize communities in order to heal our collective soil from the poisons of our past and present, so our future roots can thrive.

Some organizations share other parts of their organizational culture publicly. For example, the All Because of Children (ABC) House in Albany, Oregon, states some of its values as well as its expectations of employees on its general recruitment page, as shown in figure 10.7.



Figure 10.7. The **All Because of Children House [Website]**, which serves children and families affected by child abuse and neglect, uses its recruitment page to tell us more about what the organization does, as well as what they expect from their employees.

ACTIVITY: WEB PAGE ANALYSIS

Analyze the ABC House web page, pictured above **and linked here**, by discussing the following:

1. What are some expectations of the employees? Find the specific words that describe employee traits to define and discuss.
2. What kind of atmosphere, or organizational culture, might you expect to work in at the ABC House?

Informal Organizational Culture

In contrast to the formal structures that are conveyed via written and electronic materials, there are less formal aspects of organization structure, such as the ways that employees relate with one another internally and outside of work, that may not be as explicitly communicated. Here are some examples of informal practices:

- How employees greet each other when they arrive or see each other for the first time each day
- How workers address one another (first name, last name, or with a title)

- Is the convention applied equitably across job and education levels?
- Are some people addressed by title and others by name?

- Typical ways that employees dress, even if there is not a formal dress code

- Does it vary by day of the week, job, title, or **gender**?

- How personal life overlaps with professional life

- What personal information is typically shared?
- What is kept private? Do expectations vary by job, title, **ethnicity**, gender, or **sexuality**?
- Are there workplace-based celebrations of milestone events such as birthdays, weddings, births, or deaths?
- Are there expectations or practices related to who is invited to celebrations outside of the workplace?

Shared values and social norms that are only known implicitly or are underlying assumptions will be more difficult to discern by any newcomer to the organization, which contributes to a feeling of being out of place. An organization with a culture of practicing the explicit sharing of values, beliefs, and behaviors will be a more equitable organization, one in which newcomers are more likely to feel that they belong.

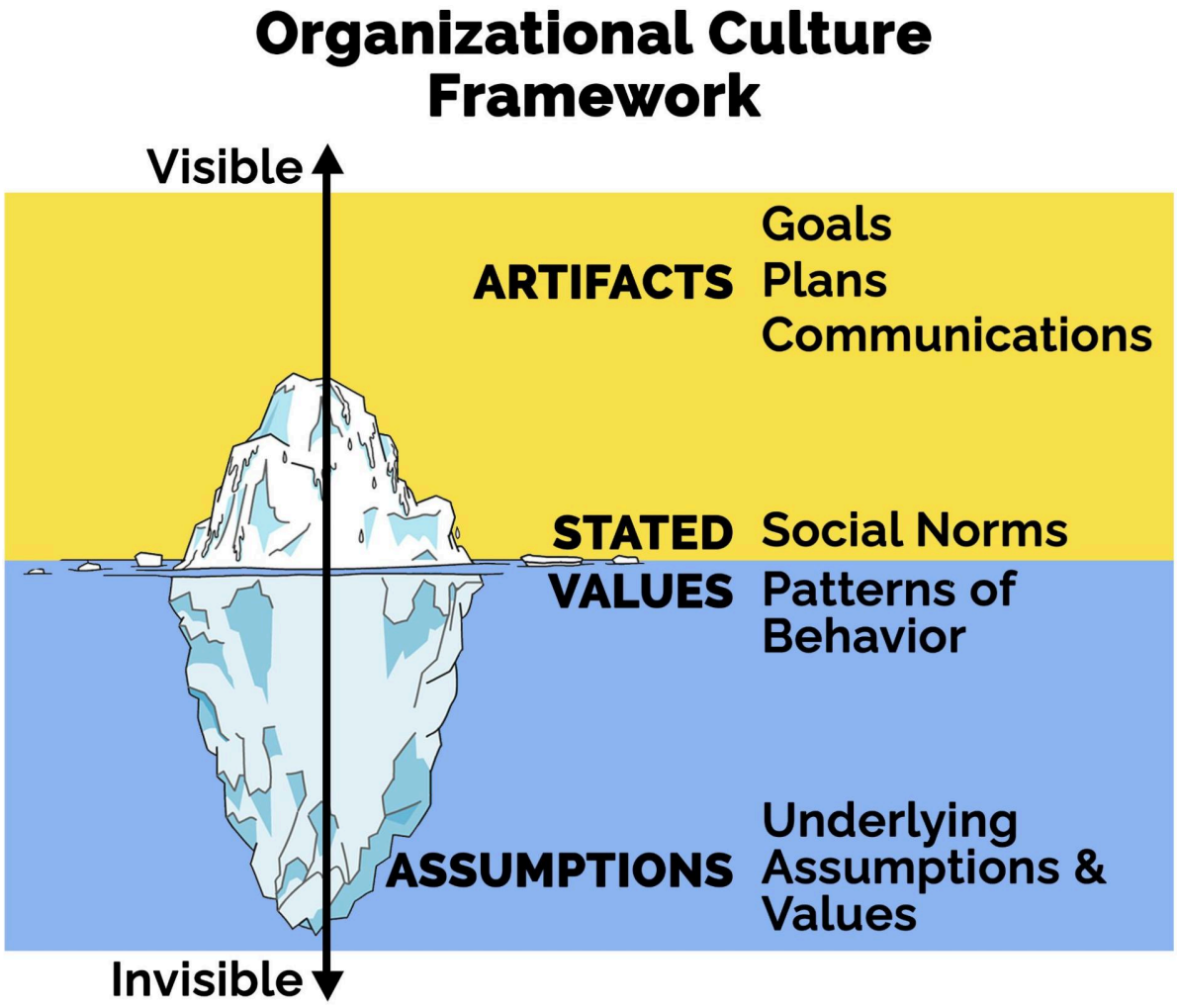
Some of these practices may be evident to you when you interview at a location, but it is more likely that they will become apparent to you over time. Keeping organizational culture in mind will help you to evaluate whether or not this is a place that you would like to work over the long term and what you want to look for in future **internship** and work settings.

Organizational Culture Framework

This framework uses three elements for another way of looking at organizational culture:

- **Artifacts**: mission, goals, plans, and communications
- **Values**: norms and behaviors
- **Underlying assumptions**: unconscious, taken-for-granted beliefs; habits of perception, thoughts, and feelings

In figure 10.8, you can see that the underlying assumptions are the foundation and source for the values, actions, and artifacts (Schein, 1985).



Based on ideas from Edgar H. Schein, *Organizational Culture and Leadership*, Jossey Bass, 1985. Graphic designed by Elizabeth Pearce and Michaela Willi Hooper, Open Oregon Educational Resources, CC BY 4.0. Iceberg image public domain via Pixabay.

Figure 10.8. This organizational culture framework shows how parts of the culture are visible and other parts are invisible. The parts that are invisible are the foundation for what is visible. Image description available. **Image description.**

One of the challenges that an organization can face is the fundamental assumptions not being congruent with the more visible aspects, especially if the organization is trying to change. The underlying assumptions need to be uncovered and exposed in order for the organization to develop, grow, and have true **congruence** with its values and artifacts.

Organizational Culture and Inclusion

How does organizational culture relate to **equity**,inclusion, diversity, and **restorative justice**? If we define equity as being sure that everyone has what they need in order to have similar opportunities, we must pay attention to the ways that any organization welcomes new people into the space and cultural structure. In addition, how

people are oriented and included in the organization will affect their ability to adapt and willingness to stay. How are they oriented to the space and entered into the community or space in general?

If people new to the organization represent diverse groups from those who have typically held power, the organizational structure needs to be set up not to just include but to value diverse thinking and perspectives. The only way that diversity, equity, and inclusion can be institutionalized is if the organizational structure and culture is dedicated to these principles as underlying assumptions, stated values, and artifacts. If it is, diverse staff will be retained, and eventually this will facilitate the decolonization and diversification of the leadership.

Let's take the example that many of you may be familiar with: the **first-generation college student**. Over the past few decades, increasing attention has been paid to acknowledging that a **first-generation college student**, the first person in their immediate family to go to college, will have different needs and strengths compared to a student whose parents, grandparents, or perhaps even siblings went to college.

These students often face different challenges than those faced by students who have family experience with college, and whose families typically support, encourage, or even require them to attend college. First-generation college students face the challenge of negotiating an environment that their parents may not be able to help them figure out, as well as the possibility that their families do not value a college education. They face challenges in learning the process and rules of college life as well as the difficulties of fitting in and developing a new social identity as a college student. If their family relationships are harmed by going to college, they need even more social support and relationship formation at the college itself (London, 1992).

The organizational culture at the college will be key to the first-generation college student's likelihood of completing a **degree**. First-generation college students benefit from engagement in extracurricular activities and connections with peers (Demetrio et al., 2017). For example, if the college staff and faculty have underlying assumptions and understand the typical challenges faced by first-generation students, they may perform a number of activities (artifacts), such as:

- fostering the transition from high school to college with one-on-one relationships
- creating community among students in classes
- providing extracurricular activities where students can build relationships with other first-generation students
- creating time and space to listen to students who are struggling with their family relationships or social identity (Ricks & Warren, 2021)

If their underlying assumptions do not align with values and artifacts that support the integration of first-generation students into campus life, then it is less likely that students will persist and graduate. For example, if staff and faculty have underlying assumptions such as, "It's tough for everyone. You can't provide special services to some students. It's not fair," this belief will affect the organization's success with implementing strategies to diversify and **decolonize** education. As discussed in **Chapter 2**, education needs to intentionally address inequities in order to actively include typically marginalized communities in leadership positions.

Another way to foster inclusion is to support the ability of each person to express themselves authentically. The next section discusses an emerging practice that some organizations are

formally adopting to support diversifying and decolonizing social services.

Another group of students impacted by many of these same concerns are those who are coming back into the field after a period of not working. This could be due to many reasons, primarily raising children, being caretakers for older adults or older children needing physical and mental health support, needing a career change, coming out of retirement, or wanting to gain some additional certification or skills for their current careers. The reasons are vast, but the support needs can be similar, such as the need for community and help to provide a transition from one identity to another. These students are sometimes called nontraditional students, but in reality a student does not look one way. We call them students.

Restorative Practices within the Workplace

Restorative Practices (RP) is an emerging social science to many White people, but it evolved from ancient practices. RP studies how to build, strengthen, and repair relationships among individuals, as well as connections within communities. The practice focuses on building connections, accountability, and commitments through participatory learning and decision-making. Specifically, restorative practices can provide some justice to people who have been harmed via systemic oppression.

RP is also connected to Restorative Justice, in **Chapter 3**. While more preventative in nature, restorative practices has emerged from Restorative Justice, which is an intentional way handling an offense and involves three stakeholders within an organization or community: the person(s) who has offended, the person(s) who were harmed, and communities of care and reconciliation (Wachtel, 2016). Restorative Justice has roots in ancient and Indigenous practices employed in a wide variety of cultures, from Native American and First Nation Canadian to African, Asian, Celtic, Hebrew, Arab, and many others (Eagle, 2001; Goldstein, 2006; Haarala, 2004; Mbambo & Skelton, 2003; Mirsky, 2004; Roujanavong, 2005; Wong, 2005).

Restorative Practices are becoming increasingly common within many professions and workplaces related to human services, including criminal legal system, education, mental health, social work, and public health. Two restorative practices used in human services-related fields include Family Group Decision-Making (FGDM) and Family Group Conferencing (FCG). These were originally envisioned as family empowerment activities, such as when the native Maori people in New Zealand started using FCGs to address their concerns about the number of children being removed from their homes by the government and court structures (Doolan, 2003). Those practices have evolved to include communities of care that foster increased social capital and connections with families.



Figure 10.9. Restorative practices enable offenders to re-enter communities they have harmed by responding to challenges and building relationships that leave all members of the community better off. Image description available. **Image description.**

Restorative practices are most effective when they are used holistically to build relationships within organizations or within communities. This means using them in a proactive way and not just when harm has occurred. Structures that support the building of connection through authentic communication and social capital that is shared by all members of the community can decrease the amount of harm that occurs (Davey, 2007).

This is a gentle reminder that these practices are not something you can do in isolation once or twice as a replacement for toxic work environments. It is a way of framing a whole systemic approach to how one functions within that system—a culture of the system.

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Figure 10.7. Webpage screenshot from **abchouse.org/careers** is included under fair use.

Figure 10.9. **What are restorative practices** by Learning Policy Institute is licensed under **CC BY NC 4.0**.

10.5 Education and Career

You may still be deciding on a career path and thinking about different options. One of the great aspects of **human services** is that your choices are abundant and varied. You can begin your career long before an associate **degree**, as we all know how important lived experience is for the work we do. Or you can choose to further your education, which will give you even more options to choose from. Below we talk about how the different degrees function and then the licensing requirements required by some fields and some agencies.

How Degrees and Licenses Function

Different areas of specialization often require different levels of education and different types of certifications. This can be very confusing to students, and even to professionals already in the field! Here we discuss some of the most common **licenses** and certifications, focusing on how these look in the State of Oregon.

One area that requires very specific education and certification is substance use treatment. Early treatment programs often relied on people in recovery to serve as counselors and case managers. This resulted in a wide variety of training, education, and approaches to the work that were confusing and sometimes contradictory. The Mental Health and Addiction Certification Board of Oregon was created in 1977 to begin developing **standards** to be utilized across the state.

In Oregon, working in substance use treatment generally requires workers to become a Certified Alcohol and Drug Counselor (CADC). There are three levels of certification (I, II, and III) that each have specific education and experience requirements. One of the concerns in the field was creating a burden on counselors without an education who had already been doing the work successfully. With this in mind, the CADC I does not require a degree, but it does require 150 hours of education in specific topics and 1,000 hours of supervised experience. After fulfilling these requirements, candidates sit for a licensing exam. The requirements increase with each level.

Another certification that has become prominent is the Qualified Mental Health Associate (QMHA). The QMHA designation came from federal funding sources that wanted to ensure that agencies getting reimbursed from the government hired qualified workers. The QMHA designation recently became a formal certification in Oregon, which requires applicants to either have a bachelor's degree or a combination of at least three years of relevant education and experience. This certification is most commonly used in agencies providing mental health services.

A relatively new certification is the Human Services-Board Certified Practitioner Credential (HS-BCP). This certification is available to those with either an associate, bachelor's, or master's degree in human services, and involves assessing the candidate's knowledge and experience in eleven core human services competencies.

The two most common licenses in Oregon are the Licensed Professional Counselor (LPC) and the Licensed Clinical Social Worker (LCSW). Both require master's degrees and have differing educa-

tion and testing requirements. Having one of these licenses allows practitioners to bill private insurance for provision of mental health services.

To become an LPC in Oregon, you must have a master's degree from an approved counseling program or a master's degree that includes a specific curriculum, such as diagnosis of mental health disorders and group dynamics. You also must have at least 1,000 hours of supervised clinical experience and pass a competency exam.

The LCSW credential requires applicants to have graduated from an accredited Master's in Social Work (MSW) program, complete 3,500 hours of post-graduate experience (2,000 of which must be direct client contact), and complete at least 100 hours of supervision with a qualified LCSW supervisor. Applicants must also pass a licensing exam. This **license** is very specific in that it only applies to those who complete an MSW program.

LINKS TO INFORMATION ON LICENSES AND CERTIFICATIONS

- Mental Health & Addiction Certification Board of Oregon (MHACBO) [Website]
- National Organization for Human Services (NOHS) [Website]
- Oregon Board of Licensed and Professional Counselors and Therapists [Website]
- Oregon Board of Licensed Social Workers [Website]

Variance in Degree and License Qualifications

Degree and license requirements can vary from state to state and from country to country. Many states have reciprocity agreements, which means that they recognize experience and credentials in other states. However, there are often additional steps you must complete to be fully credentialed or licensed in the new state. If you are planning to work in another region after graduation, it will be helpful to research their requirements ahead of time.

While the specific licensing requirements vary, all of the credentials discussed have a few common elements. All have some education or training requirement, as well as a specified amount of experience. In addition, all of these credentials have an **ethics** component, either proof of training in professional ethics or signing a code of conduct agreement.

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10.6 Key Takeaways and Discussion Questions

Included in this section are tools for the reader to refresh and retain the knowledge. A Key Takeaway serves one of three purposes:

- highlighting an especially complex aspect of the chapter;
- summarizing an overarching idea; or
- emphasizing an idea that invites the reader to think about it more deeply, to connect to life experiences, and/or additional learnings.

Discussion Questions are recommended for individual reflection or class discussion.

KEY TAKEAWAYS

- Engaging in research such as informational interviews and web page analysis will help ensure that you invest your fieldwork time in an agency that is a good fit for you.
- **Organizational culture** is both formal (artifacts, values) and informal (underlying assumptions). The most congruent agencies will have formal and informal cultures that align, but not all workplaces are congruent.
- Degrees and licenses are complicated, vary from state to state, and can change over time. It is very important that you access current local information when you are making decisions about degrees and licenses.

DISCUSSION QUESTIONS

1. How does your personal story play a role in your career? Have you seen yourself professionally? Consider **intersectionality** like the few identities below.

- **Race**
- **Gender**
- Sexual Orientation
- Legal Documentation Status
- (Dis) Ability
- LGBTQAI2S

- What are the qualifications you need for the career path you want? What degrees, licenses, certificates or other qualifications do you need?
- At this point in your education,what do you see as the next steps in your career path?

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Glossary

Absolute approach
a way of defining poverty that designates a basic subsistence income level (the absolute version of a poverty line) and anyone who falls below that line is considered poor

Acquired disability
A disability that occurs at some point after the disabled person is born. This could be something that happened to them as an infant or at any point afterward.

acute trauma
a single traumatic incident

Adolescence
the period of life following the onset of puberty, while the brain is still developing, and transitioning into adulthood

Adoption
the social, emotional, and legal process in which children who will not be raised by their birth parents become full and permanent legal members of another family

adverse childhood experiences
traumas that occur in an individual's life before they turn 18, which include neglect, abuse, and household difficulties

Ageism
a set of fixed beliefs about a specific age group, usually referring to negative beliefs about older adults.

attachment theory
a theory that highlights how attachment patterns are developed from the earliest stages of life

Baby Boomers
the cohort of people born in the years after World War II, generally including those born between 1946 and 1964.

Beanpole family structure
the modern family structure of having fewer children in each generation, as well as each generation living longer, resulting in a chronologically long but narrow structure

Bio-psycho-social-spiritual approach
the act of assessing levels of functioning within biological, psychological, social, and spiritual dimensions (and how they are connected) to help understand human behavior.

Black and Indigenous People of Color (BIPOC)
an umbrella term used to identity people of color most affected by White domination

Cannabis
a drug with active chemicals that affect central nervous and immune systems, usually dried.

Caregiving, formal
a professional who is paid to assist with activities of daily living.

Caregiving, informal
an unpaid layperson (often a family member) who assists with a wide variety of daily needs.

Central Nervous System (CNS)
the body's processing center, made up of the brain and the spinal cord.

child abuse
the intentional emotional, negligent, physical, or sexual mistreatment of a child by an adult

Child welfare
typically refers to any situation where the child's needs are paramount and their immediate protection takes priority over the other family needs

chronic trauma
a traumatic experience that is repeated over a period of time

Code of ethics
one of the distinguishing features of a profession, it sets standards and values for workers to uphold.

Collaboration
the act of working with others.

Community mental health center (CMHC)
a small institution dedicated to serving people who have mental health struggles in contrast to large institutional hospitals

Compassion fatigue
the sense of fulfillment you feel for the work you do

Compassion satisfaction
the sense of fulfillment you feel for the work you do.

complex trauma
a repeated traumatic experience that has been inflicted by a caregiver

Congenital disability
A disability that occurs before or during birth; something the disabled person has had for all their life.

Congruence
being "real"; actions in line with values and beliefs.

Cultural responsiveness
being aware that each individual you meet has their own set of beliefs, values, routines, and rituals that contribute to their culture.

Culture
shared meanings and shared experiences by members in a group, that are passed down over time with each generation

Cumulative advantage/disadvantage
the processes by which the effects of early economic, educational, and other deficiencies or resources can accumulate over the life course with these becoming magnified over the life span.

Decolonize
the acts of identifying systems of oppressive colonization, dismantling historical records that emphasize the dominant culture's story, and striving to effect power structures so that they are shared more equitably.

Degree
an academic rank conferred by a college or university after completion of a specific course of study.

Depressants
a drug that reduces functional or nervous activity, slowing down a person's ability to respond.

Developmental approach
social welfare programs are a necessary part of social and economic development

Dilemma
a situation in which one has to make a choice between two options that have competing values and are equally unfavorable.

Disability
A physical, cognitive or emotional condition that limits or prevents a person from performing tasks of daily living, carrying out work or household responsibilities, or engaging in leisure and social activities.

Ecological systems theory
emphasizes the complexity of the environments that each individual interacts with.

emotional abuse
nonphysical maltreatment of a child through verbal language, including humiliation, threatening, ignoring, and manipulating

Emotional Support Animal
Any animal that is used to provide companionship, relieve loneliness, and sometimes help with depression, anxiety, and certain phobias for individuals with mental health disabilities.. Emotional Support Animals can be any type of animal, but they have no specialized training related to disability. Other than being allowed in housing that is generally managed with a "no pets allowed" requirement, Emotional Support Animals have no legal status.

Empathy
being able to feel and relate to another's feelings.

Employee assistance program (EAP)
a benefit provided by some employers; workers can access quick, temporary mental health support

Equity
provision of what each individual needs in order to receive and obtain equal opportunities.

Ethics
moral principles.

Ethnicity
social identity based on the culture of origin, ancestry, or affiliation with a cultural group

Evidence-based practice
an approach based on scientific evidence, client values, and clinical experience.

Field education
a credit class in which students apply theory to practice by using what you have learned in coursework in a real world setting with a supervisor/mentor who is invested in the student's growth and development.

First language
the language an individual learns in early childhood

First-generation college student
the first person in their immediate family to go to college.

Foster care
a temporary placement of a child with another family while parents are resolving issues

Functional Limitation
A disability-based restriction or inability to perform an action or activity in the same way others who do not have disabilities can do.

Gender
the socially constructed perceptions of what it means to be male, female or nonbinary in the way you present to society

Generalist approach
using multiple disciplines and methods.

Gerontology
the interdisciplinary study of aging, including biological, psychological, social, economic, and spiritual perspectives among others.

Handicap
A barrier that causes people with disabilities to be unable to independently complete tasks or activities, but has no impact on people without disabilities.

Hereditary disability
A disability caused by genetic mutations that are passed down from one or both parents. The disability could be congenital or acquired.

Houselessness
(also known as "homeless"), when a person lacks a reliable place to sleep and care for themselves

Housing insecurity
conditions that might cause someone to become houseless or that are hazardous to the health of occupants of a home

Human services
a professional field focused on helping people solve their problems.

Informational Interview
an informal meeting with a professional in the field

Institutional view
social welfare programs are human rights and will always be a part of our society

Interdisciplinary approach
the use of multiple disciplines, or knowledge branches, working together to solve problems.

intergenerational trauma
a phenomenon in which the descendants of a person who has experienced a terrifying event show adverse emotional and behavioral reactions to the event that are similar to those of the person himself or herself

Internship
a credit class in which students apply theory to practice by using what you have learned in coursework in a real world setting with a supervisor/mentor who is invested in the student's growth and development.

Intersectionality
race, class, gender, sexuality, age, ability, and other aspects of identity are experienced simultaneously and the meanings of each identity overlaps with and influences the others leading to overlapping inequalities

Intervention
action taken to improve a situation or address a problem

intimate partner violence
any incident or pattern of behaviors (physical, psychological, sexual or verbal) used by one partner to maintain power and control over the relationship

Kin
People related to one another. Family

License
a certification conferred by the government or an educational institution that is required for certain occupations.

Medicaid
the joint federal and state-sponsored program aimed at providing medical care to lower income individuals.

Medical Model of Disability
The presumption that the disabled person needs to be treated and "fixed;" this model focuses on what the individual cannot do and considers disability to be "abnormal."

Medicare
the federal health care program in the United States provided to adults 65 and older as well as disabled citizens.

Mentor
an experienced individual who helps to guide a mentee, the less experienced person in their learning and growth.

Mindfulness
a mental state of focusing attention on the present moment, accepting and acknowledging one's feelings, thoughts, and physical sensations.

National Association of Social Workers (NASW)
a professional organization for social workers and those studying social work.

National Organization of Human Services (NOHS)
a professional association for human services professionals and those studying human services.

neglect
the failure to meet the basic needs of a child

Older Americans Act
the federal legislation, originally authorized in 1965, that authorizes a majority of community services for older adults, including community centers and nutrition programs.

Opioids-
a substance used to treat moderate or severe pain by binding to receptors in the central nervous system

Organizational culture
system of shared assumptions, values, and beliefs that show people what is appropriate and inappropriate behavior in a particular agency or workplace.

Origin
refers to the geographical location that a person was born and spent (at least) their early years in

Personal troubles
a problem affecting individuals that the affected individual, as well as other members of society, typically blame on the individual's own personal and moral failings

physical abuse
any act, completed or attempted, that physically hurts or injures a child, including hitting, kicking, scratching, and pulling hair

Positionality
awareness of your own social identities and how those fit with others and within a power structure.

Poverty
the state of lacking material and social resources needed to live a healthy life

Poverty gap
measures the difference between the poverty line and the actual income level of the average poor family

Poverty line
a calculation that assumes people spend about ⅓ of their budget on food; taking the most frugal diet that the Department of Agriculture has recommended as potential bases for family food budgets and multiplied it by three.

Practicum
a credit class in which students apply theory to practice by using what you have learned in coursework in a real world setting with a supervisor/mentor who is invested in the student's growth and development.

Prevention
develop strategies that fend off problems

Prevention, Intervention, and Remediation
a model that looks at three ways to help people solve problems.

Profession
a paid career that involves education, formal training and/or a formal qualification.

Professionalism
the conduct, qualities, and qualifications recognized as part of a profession.

Psychoactive
something that affects the mind, typically a drug.

Psychosocial theory
a guideline for the entire lifespan and suggests certain primary psychological and social concerns throughout life.

Public issues
see definition for social problem

Race
socially created and poorly defined categorization of people into groups on basis of real or perceived physical characteristics that has been used to oppress some groups

rape culture
a society or environment where there is a culture of disbelief and lack of support for sexual violence survivors through normalizing and trivializing sexual violence despite its prevalent occurrence

Reasonable Accommodation
A change in the usual and customary practice or activity which allows a disabled person to participate more independently in spite of the limitations their disability causes. Reasonable accommodations are most frequently found in educational and employment settings but can also include social settings. Accommodations can be made through structural changes, use of mechanical and technological devices, and reassignment of duties.

Rehabilitate
relearn or reform behaviors

Relative approach
a way of defining poverty considers a person poor when their income is much lower than the typical income in that population

Religion
shared systems of beliefs and values, symbols, feelings, actions, experiences, and a source of community unity

Remediation
the correction or reversing of actions or behaviors

Residual view
social welfare programs should exist only in times of particular need to avoid becoming crutches that people rely on.

restorative justice
an alternative approach to criminal justice that centers the survivor, taking into account what they need to experience healing. It also involves the participation of the perpetrator, requiring them to recognize the harm they did in the process of holding them accountable.

Restorative practices
strategies that build, strengthen, and repair relationships among individuals, as well as connections within communities.

Self-care
action to preserve and improve one's own physical and mental health.

Service Animal
A dog or miniature horse that has been trained to perform specific tasks in order to assist a specific disabled person to maintain independence and/or to protect them from harm or death. Service animals work with people with all types of disabilities, including sensory losses, physical mobility, seizure disorders, chronic and persistent mental illness, diabetes and more. Service animals are considered working animals, not pets, and have legal authority to accompany their human partner anywhere they go.

Sex
a biological descriptor involving chromosomes, primary, and secondary reproductive organs.

sexual abuse
maltreatment, violation, and exploitation where a perpetrator forces, coerces, or threatens a child into sexual contact for sexual gratification and/or financial benefit, including molestation, statutory rape, prostitution, pornography, exposure, incest, and other sexually exploitative activities

Sexuality
a person's emotional, romantic, erotic, physical, and spiritual attractions toward another in relation to their own sex or gender.Sexuality exists on a continuum or multiple continuums

Silver Tsunami
a term used to describe the skewing of the population toward older ages.

Social constructivism
a theory that emphasizes the shared understandings agreed to by members of a society.

Social Insurance programs
a group of programs that take into account any contributions that the beneficiary has made to the program and may be considered preventative in nature.

Social justice
viewpoints and efforts toward every person receiving and obtaining equal economic and social opportunities; removal of systemic barriers.

Social Model of Disability
The perspective that considers disability to be part of what makes the individual who they are. This model acknowledges disability-related limitations but also recognizes that disabled people have shared community, values and aspirations.

Social Problem
any condition or behavior that has negative consequences for large numbers of people and that is generally recognized as a condition or behavior that needs to be addressed. Multiple factors contribute to the complexity of social problems. Typically the solution to the problem needs to be systemic in nature; in other words, it cannot be solved by any one individual.

Social Security
a federal program established in 1935 to provide protection against poverty to older Americans.

Social welfare programs
a group of programs meant to alleviate the effects of poverty, and applicants must pass a means test in order to receive benefits.

Socialization
process through which we learn the culture of the social groups that we belong to.

Sociological imagination
the ability to understand individual experience within the context of social structures.

Spirituality
connection to something larger than you (a higher power), a quest for meaning, and a commitment to live each day in a sacred manner

Standards
Agreed upon level of quality in selected areas.

Stimulant
speed up the CNS by increasing heart rate and breathing and raising blood pressure.

Strengths-based approach
the practice of using the strengths of individuals, families, and communities to solve problems.

Sygeneristic
relates to the interaction of one or more substances or other agents, to produce a combined effect greater than the sum of the original components.

Systems theory
focuses on the bi-diorectional impacts of an individual with different aspects of society

Therapy Animal
Any animal trained and certified to provide comfort and affection to people other than their handlers or owners. Therapy animals do not focus on the needs of their handlers but instead are socialized to be petted by anyone and are often found in hospitals, nursing homes, schools and other institutions. They may also work in clinical mental health settings under the control of their handlers.

trauma
results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being

Trauma stewardship
recognizes that trauma has impacts that can be named and managed; it acknowledges that the person who is helping someone who is suffering from trauma may also suffer.

trauma-informed care
a collection of approaches that translate the science of the neurological and cognitive understanding of how trauma is processed in the brain into informed clinical practice for providing services that address the symptoms of trauma

trauma-specific practices
practices that directly treat the trauma that an individual has experienced and any co-occurring disorders that they developed as a result of this trauma

Unconditional positive regard
belief that everyone has worth and deserves our consideration.

vicarious trauma
secondary traumatic stress, which is an occupational challenge for people working in the human services field due to their continuous exposure to victims of trauma and violence.

Welfare
well-being

Whitewashing
focusing on the accomplishments of White people and groups,and excluding BIPOC strengths and accomplishments

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Self-Check Questions

Questions

Chapter 1: An Overview: Human Services

1. A healthy relationships class can help teach students how to recognize signs of dating violence and emotional abuse. What aspect of the human service model does this class address?
    1. Prevention
    2. Intervention
    3. Remediation
    4. Reentry
2. A human service worker lobbies her state government with a group of clients to expand access to Medicaid services for people diagnosed with intellectual and developmental disabilities so they may get access to assistive technology that helps them communicate with their caregivers. This is an example of addressing social problems at which level?
    1. Microsystem
    2. Mesosystem
    3. Macrosystem
    4. Exosystem
3. Evidence-based practice relies mostly on finding the appropriate scientific literature and applying it in practice.
    1. True
    2. False
4. Which of the following terms best describes how human service workers take their clients' perspectives and communicate their understanding of clients' emotions and thoughts?
    1. Sympathy
    2. Compassion
    3. Empathy
    4. Humanism

Chapter 2: Historical Context and Contemporary Focus

1. Which of the following statements is true about Jane Addams, one of the "founding mothers" of social work?
    1. She was the first Nobel Peace Prize winner.
    2. She was from a poor immigrant community and family.
    3. She assisted in the earliest conceptualizations of the child welfare system.

4. Her approach to social work integrated social activism and care work.

2. Ageism refers to which of the following?
    1. Discrimination based on old age.
    2. Stereotypes about older adults being slow, frail, or incapable.
    3. Dismissing the insight and capacity of children and adolescents.
    4. Developmental transitions that occur throughout the lifespan.
3. Which of the following terms refers to the capacity of human services to be "open to learning about other cultures while acknowledging one's own lack of competence and recognizing power dynamics that impact the relationship?"
    1. Cultural respectfulness
    2. Cultural competence
    3. Cultural humility
    4. Cultural attunement
4. Which of the following determines someone's race?
    1. Skin color
    2. Facial features
    3. Height
    4. None of the above

Chapter 3: Trauma and Support Practices

1. A natural disaster like an earthquake or tsunami is best categorized as which kind of trauma?
    1. Acute
    2. Chronic
    3. Intergenerational
    4. Systemic
2. Trauma-informed cognitive behavioral therapy (TFCBT) works with the child and non-abusive caregivers to help them identify, cope, and manage unhelpful emotions, thoughts, and behaviors. This is best classified as:
    1. Trauma-informed care
    2. Trauma-specific practices
    3. Secondary traumatic stress
    4. Trauma stewardship
3. Which of the following best summarizes restorative justice?
    1. Restorative justice started as an alternative to the criminal justice system.
    2. A collection of restorative practices proven to be effective.
    3. Involve stakeholders in an offense to identify and address harms and needs.
    4. Using Indigenous practices to address harms.
4. Which of the following best matches the definition of resilience?
    1. An inborn trait that some people have more or less of.

2. Responding positively to a crisis.
3. The willpower and determination to overcome challenges.
4. The ability to bounce back from difficult times in life.

Chapter 4: Ethical Standards

1. If a human service worker were required by law to report a client who had sought an abortion, would it pose a conflict between which two ethical standards?
    1. Responsibility to clients
    2. Responsibility to colleagues
    3. Responsibility to the public
    4. Responsibility to the profession
2. Which of the following are part of the nine NOHS ethical standards that describe responsibilities to clients?
    1. Avoid dual relationships with clients.
    2. Advocate for change to unjust laws.
    3. Honor commitments made to employers.
    4. Use a strengths-based approach.
3. If a client says they abused their child, a human service worker should consider which of the following:
    1. Laws
    2. Workplace policies
    3. Ethical responsibilities to clients
    4. National Association of Social Workers' Code of Ethics
4. If a human service worker has a conflict with her colleague at work, the ethical standards indicate they should do what first?
    1. Talk to the person directly
    2. Talk to their supervisor
    3. Consult relevant laws
    4. Monitor their actions for unethical behavior

Chapter 5: Social Safety Net Programs, Community Organizations, and Social Issues

1. To fully understand the history of the social safety net, human service workers need to study
    1. Policies from the Great Depression and before.
    2. Social movement organizations like the Black Panther Party.
    3. The most relevant policies from the past twenty years.
    4. Establish a theoretical perspective through which to view history.
2. Which of the following programs are a part of the social safety net?

1. A minimum income for people in poverty.
2. A living stipend for people with disabilities.
3. Temporary financial assistance that requires parents to work.
4. A right to adequate housing for your family.

3. What is the difference between social insurance versus social welfare policies?
    1. Social welfare policies require work to receive benefits.
    2. Social insurance programs are managed by private companies, but social welfare policies must be publicly managed.
    3. Social insurance policies require participants to contribute financially in order to benefit.
    4. Social welfare policies are designed to eliminate poverty, but social insurance policies are designed to manage poverty.
4. Which of the following programs provides health insurance to adults once they enter old age?
    1. Medicare
    2. Social Security Disability Insurance
    3. Old-Age, Survivors, and Disability Insurance
    4. Medicaid

Chapter 6: Models of Care: Medical, Public Health and Human Services

1. Which of the following statements is true about the social determinants of health?
    1. Poor lifestyle choices are beyond someone's control.
    2. Health outcomes are impacted by social conditions and individual choices.
    3. Individual choices and genetics determine health outcomes.
    4. Health outcomes are more positive in the United States than in other countries.
2. A human service worker who is leading groups for men convicted of domestic violence and sentenced to receive services that teach them anger management and healthy conflict in relationships.
    1. Prevention
    2. Intervention
    3. Remediation
    4. Presentation
3. Anyone who does not have coverage through their employer and cannot afford to purchase coverage from the Affordable Care Act marketplace is eligible to receive health insurance through Medicaid.
    1. True
    2. False
4. Which of the following best distinguishes the wellness model and medical model of healthcare?
    1. The wellness model does not address functional limitations or deficits.
    2. The medical model focuses on addressing functional limitations or deficits.
    3. The medical model focuses on long-term strategies to improve health policies in a community.
    4. The wellness model focuses on preventing illness and long-term health improvements for individuals.

Chapter 7: Mental Health

1. Which of the following definitions best matches mental wellness?
    1. Freedom from anxiety and depression
    2. Not having a mental illness
    3. Mental health
    4. An internal resource that helps us process our experiences and adapt to changes
2. Which of the following professionals are likely to be found on a multidisciplinary treatment team?
    1. Psychiatrist
    2. Social worker
    3. Police officer
    4. Judge
3. Which of the following is true about nonsuicidal self-injury?
    1. It is only associated with major depressive disorder and bipolar depressive disorder.
    2. It is mostly used to "get attention."
    3. It is often done to cope with negative emotions.
    4. It refers to "non-completed" suicide attempts.
4. According to the prevalence statistics cited in the DSM5-TR, which of the following is the most common diagnostic category among adults in the United States?
    1. Specific Phobia
    2. Eating Disorders
    3. Schizophrenia
    4. Bipolar disorder

Chapter 8: Families, Children, and Schools

1. The nuclear family was the dominant family form throughout history until recently when alternative family structures have become more common
    1. True
    2. False
2. All social services within a school must be delivered by school employees, like a nurse, school counselor, or school social worker.
    1. True
    2. False
3. Children in foster care from which groups are required to be placed with people from their culture?
    1. Native American
    2. Black or African-American
    3. Alaskan Native
    4. Refugees from other countries

4. Which term describes the social power attached to identities and indicators like race, gender, disability, class, and so forth?
    1. Socialization
    2. Internalized oppression
    3. Cognitive dissonance
    4. Social location

Chapter 9: Serving Older Adults

1. Which of the following best describes the dependency ratio in a society?
    1. How many people in poverty receive government benefits.
    2. How many people remain on anti-poverty assistance after five years.
    3. The number of citizens able to work due to age and disability versus those who can work.
    4. If government disability benefits move someone out of poverty.
2. Which of the following describes how ageist messages are internalized by older adults and make them more likely to believe and enact them in real life?
    1. Stereotype embodiment theory
    2. Baby boomer generation
    3. Activity theory
    4. Multiple loss theory
3. Which of the following are programs that primarily support older adults?
    1. Temporary Assistance for Needy Families
    2. Medicare
    3. Tricare
    4. Social Security
4. In order to be eligible for the Death with Dignity Act program, a person must be:
    1. Older than 18 years.
    2. Diagnosed with an illness that will lead to death within six months.
    3. Cannot be diagnosed with an intellectual or developmental disability.
    4. Cannot be diagnosed with major depressive disorder or another mental health disorder.

Chapter 10: Becoming A Professional

1. Tema Okun talks about 10 ways white supremacy shows up in the workplace. What are some examples?
    1. Perfectionism
    2. Worship of the written word
    3. Money-centered
    4. Embracing open conflict

2. Which of the following is a profession?
    1. Life coaching
    2. Hair braiding
    3. Family studies
    4. Human services
3. Which of the following are good sources of professional guidance?
    1. Mentors
    2. Informational interviews
    3. Intuition
    4. Supervisors
4. Which of the following are examples of informal organizational culture?
    1. Policies on providing pronouns when interacting with new people
    2. Codes of ethical conduct
    3. A client Bill of Rights posted at the entrance to the agency's building
    4. How employees typically dress

Answer Key

Chapter 1: An Overview: Human Services

1. A healthy relationships class can help teach students how to recognize signs of dating violence and emotional abuse. What aspect of the human service model does this class address?
    1. Prevention (correct)
    2. Intervention
    3. Remediation
    4. Reentry
    5. Answer feedback: Prevention programs help people avoid entering into emotionally abusive or violent relationships. Counseling could be an intervention in an abusive relationship. A human services worker may use remediation if someone abused their partner.
2. A human service worker lobbies her state government with a group of clients to expand access to Medicaid services for people diagnosed with intellectual and developmental disabilities so they may get access to assistive technology that helps them communicate with their caregivers. This is an example of addressing social problems at which level?
    1. Microsystem
    2. Mesosystem
    3. Macrosystem (correct)
    4. Exosystem
    5. Answer feedback: Lobbying for government change is an example of macro practice, as visualized in Figure 1.10. Such change would impact the meso and micro levels of practice, as new services and programs could be offered to support the needs of people with disabilities.

3. Evidence-based practice relies mostly on finding the appropriate scientific literature and applying it in practice
    1. True
    2. False (correct)
    3. Answer feedback: Evidence-based practice is not just "doing what the literature says." It begins with client assessment and centers client values. Evidence-based practices can't be implemented competently by all social workers or all social work agencies.
4. Which of the following terms best describes how human service workers take their clients' perspectives and communicate their understanding of clients' emotions and thoughts?
    1. Sympathy
    2. Compassion
    3. Empathy (correct)
    4. Humanism
    5. Answer feedback: Although these terms seem interchangeable, empathy requires professionals to step out of their own patterns of thought and try to understand things from the client's perspective. That is the first step to establishing trust in a therapeutic interaction.

Chapter 2: Historical Context and Contemporary Focus

1. Which of the following statements is true about Jane Addams, one of the "founding mothers" of social work?
    1. She was the first Nobel Peace Prize winner.
    2. She was from a poor immigrant community and family.
    3. She assisted in the earliest conceptualizations of the child welfare system. (correct)
    4. Her approach to social work integrated social activism and care work. (correct)
    5. Answer feedback: Focusing on Jane Addams' position as "founding mother" overlooks the impact of marginalized social work leaders doing similar groundbreaking work. Although less individualistic than Mary Richmond, Addams was constrained by her understanding of privilege.
2. Ageism refers to which of the following?
    1. Discrimination based on old age. (correct)
    2. Stereotypes about older adults being slow, frail, or incapable. (correct)
    3. Dismissing the insight and capacity of children and adolescents. (correct)
    4. Developmental transitions that occur throughout the lifespan.
    5. Answer feedback: Ageism is most often associated with older adults, but it refers to age-based discrimination, stereotypes, and prejudice for any age. For example, someone who is 18-21 may be stereotyped as irresponsible and lazy.
3. Which of the following terms refers to the capacity of human services to be "open to learning about other cultures while acknowledging one's own lack of competence and recognizing power dynamics that impact the relationship?"
    1. Cultural respectfulness
    2. Cultural competence

    3. Cultural humility (correct)
    4. Cultural attunement
    5. Answer feedback: Cultural humility presents the "lack of knowledge" as a core component to trust in the service relationship. Once you feel comfortable not knowing, you can sense the complexity and power dynamics that culture brings to the service relationship.
4. Which of the following determines someone's race?
    1. Skin color
    2. Facial features
    3. Height
    4. None of the above (correct)
    5. Answer feedback: There are no biological features of race. Race is a social construct from the 1800s that proposed such a link existed but it never did. Biological differences between racial groups are smaller than among people in the same racial group.

Chapter 3: Trauma and Support Practices

1. A natural disaster like an earthquake or tsunami is best categorized as which kind of trauma?
    1. Acute (correct)
    2. Chronic
    3. Intergenerational
    4. Systemic
    5. Answer feedback: Natural disasters tend to happen once, unexpectedly. They differ from other kinds of trauma listed, which happen over long periods of time.
2. Trauma-informed cognitive behavioral therapy (TFCBT) works with the child and non-abusive caregivers to help them identify, cope, and manage unhelpful emotions, thoughts, and behaviors. This is best classified as:
    1. Trauma-informed care
    2. Trauma-specific practices (correct)
    3. Secondary traumatic stress
    4. Trauma stewardship
    5. Answer feedback: While trauma-informed care and trauma stewardship are about larger, organizational efforts to address trauma, specific therapies, like TFCBT, are practices specific to addressing trauma.
3. Which of the following best summarizes restorative justice?
    1. Restorative justice started as an alternative to the criminal justice system.
    2. A collection of restorative practices proven to be effective.
    3. Involve stakeholders in an offense to identify and address harms and needs. (correct)
    4. Using Indigenous practices to address harms.
    5. Answer feedback: Restorative justice is the practice of involving everyone, especially those most harmed, as part of the process of addressing the harm and returning all parties to a better place.

Although it is currently used in the criminal justice system, its roots run deep into Indigenous practices and more modern restorative practices.

4. Which of the following best matches the definition of resilience?
    1. An inborn trait that some people have more or less of.
    2. Responding positively to a crisis.
    3. The willpower and determination to overcome challenges.
    4. The ability to bounce back from difficult times in life. (correct)
    5. Answer feedback: Resilience is often confused and misused. It means only how someone adapts after difficult and challenging life events. It is not grit, willpower, or some inborn trait. Rather, it emerges from a person's interactions with social supports.

Chapter 4: Ethical Standards

1. If a human service worker were required by law to report a client who had sought an abortion, would it pose a conflict between which two ethical standards?
    1. Responsibility to clients (correct)
    2. Responsibility to colleagues
    3. Responsibility to the public (correct)
    4. Responsibility to the profession
    5. Answer feedback: Ethical dilemmas occur when two parts of the ethical code provide conflicting guidance on how to approach a situation. This example conflicts with a worker's responsibility to clients and to the public.
2. Which of the following are part of the nine NOHS ethical standards that describe responsibilities to clients?
    1. Avoid dual relationships with clients. (correct)
    2. Advocate for change to unjust laws.
    3. Honor commitments made to employers.
    4. Use a strengths-based approach. (correct)
    5. Answer feedback: Although all of these are ethical standards, only two – dual relationships and strengths-based approach – address responsibilities to clients. Human service workers also have responsibilities to colleagues, employers, society, and other stakeholders.
3. If a client says they abused their child, a human service worker should consider which of the following:
    1. Laws (correct)
    2. Workplace policies (correct)
    3. Ethical responsibilities to clients (correct)
    4. National Association of Social Workers' Code of Ethics (correct)
    5. Answer feedback: Child abuse is one example when a worker's responsibility to maintain a client's confidentiality conflicts with their responsibilities to society. Ethical standards guide workers to consult laws and policies in making ethical decisions.

4. If a human service worker has a conflict with her colleague at work, the ethical standards indicate they should do what first?
    1. Talk to the person directly (correct)
    2. Talk to their supervisor
    3. Consult relevant laws
    4. Monitor their actions for unethical behavior
    5. Answer feedback: NOHS ethical standards are clear. If you believe someone has acted unethically or if there is interpersonal conflict, human service workers are ethically obligated to engage the person with whom they are in conflict directly.

Chapter 5: Social Safety Net Programs, Community Organizations, and Social Issues

1. To fully understand the history of the social safety net, human service workers need to study
    1. Policies from the Great Depression and before. (correct)
    2. Social movement organizations like the Black Panther Party. (correct)
    3. The most relevant policies from the past twenty years.
    4. Establish a theoretical perspective through which to view history.
    5. Answer feedback: The social safety net is important to understand both through the lens of government policy changes as well as the social movement organizations that drive social change and inspire later government action.
2. Which of the following programs are a part of the social safety net?
    1. A minimum income for people in poverty.
    2. A living stipend for people with disabilities. (correct)
    3. Temporary financial assistance that requires parents to work. (correct)
    4. A right to adequate housing for your family.
    5. Answer feedback: The social safety net includes supplemental security income (SSI) and Temporary Assistance to Needy Families (TANF), but it does not include a minimum income program or right to housing.
3. What is the difference between social insurance versus social welfare policies?
    1. Social welfare policies require work to receive benefits.
    2. Social insurance programs are managed by private companies, but social welfare policies must be publicly managed.
    3. Social insurance policies require participants to contribute financially in order to benefit. (correct)
    4. Social welfare policies are designed to eliminate poverty, but social insurance policies are designed to manage poverty.
    5. Answer feedback: Social insurance policies, like home insurance, require you to contribute financially to benefit. Social insurance policies managed by the government are often subcontracted to private companies to manage parts of the insurance program.
4. Which of the following programs provides health insurance to adults once they enter old age?
    1. Medicare (correct)

2. Social Security Disability Insurance
3. Old-Age, Survivors, and Disability Insurance
4. Medicaid
5. Answer feedback: Medicare is the name for the federal health insurance program for older adults who may also be covered by Medicaid under some circumstances. The other programs listed provide financial support but not medical insurance.

Chapter 6: Models of Care: Medical, Public Health and Human Services

1. Which of the following statements is true about the social determinants of health?
    1. Poor lifestyle choices are beyond someone's control.
    2. Health outcomes are impacted by social conditions and individual choices. (correct)
    3. Individual choices and genetics determine health outcomes.
    4. Health outcomes are more positive in the United States than in other countries.
    5. Answer feedback: The social determinants of health perspective argues that health outcomes like early death or diabetes are the result of social processes rather than the choices and genetics of individual people.
2. A human service worker who is leading groups for men convicted of domestic violence and sentenced to receive services that teach them anger management and healthy conflict in relationships.
    1. Prevention
    2. Intervention
    3. Remediation (correct)
    4. Presentation
    5. Answer feedback: Because the client is an offender sentenced to receive services, these services are best described as remediation. They attempt to teach the offender better ways to address the causes of the offense.
3. Anyone who does not have coverage through their employer and cannot afford to purchase coverage from the Affordable Care Act marketplace is eligible to receive health insurance through Medicaid.
    1. True
    2. False (correct)
    3. Answer feedback: Although forty states have expanded Medicaid to cover all people in poverty who cannot afford coverage, ten states have not.
4. Which of the following best distinguishes the wellness model and medical model of healthcare?
    1. The wellness model does not address functional limitations or deficits.
    2. The medical model focuses on addressing functional limitations or deficits. (correct)
    3. The medical model focuses on long-term strategies to improve health policies in a community.
    4. The wellness model focuses on preventing illness and long-term health improvements for individuals. (correct)
    5. Answer feedback: The medical model views addressing service needs similar to a mechanic fixing a machine's problems to restore it to proper functioning. The wellness model focuses on strengths as well as challenges, long-term prevention, and health maintenance.

Chapter 7: Mental Health

1. Which of the following definitions best matches mental wellness?
    1. Freedom from anxiety and depression
    2. Not having a mental illness
    3. Mental health
    4. An internal resource that helps us process our experiences and adapt to changes (correct)
    5. Answer feedback: Mental wellness is not the same thing as mental health or the absence of mental illness. Instead, it is an internal capability that we use to respond to life events.
2. Which of the following professionals are likely to be found on a multidisciplinary treatment team?
    1. Psychiatrist (correct)
    2. Social worker (correct)
    3. Police officer
    4. Judge
    5. Answer feedback: Psychiatrists, social workers, and other care workers are likely to be a part of a treatment team. Although treatment teams often collaborate with judges and officers in the criminal justice system, they are not a part of the client's treatment team.
3. Which of the following is true about nonsuicidal self-injury?
    1. It is only associated with major depressive disorder and bipolar depressive disorder.
    2. It is mostly used to "get attention."
    3. It is often done to cope with negative emotions. (correct)
    4. It refers to "non-completed" suicide attempts.
    5. Answer feedback: Nonsuicidal self-injury is best thought of as a release for negative and overwhelming feelings and thoughts. It is a complex issue often oversimplified into depression, attention-seeking, and confusion with suicide attempts.
4. According to the prevalence statistics cited in the DSM5-TR, which of the following is the most common diagnostic category among adults in the United States?
    1. Specific Phobia (correct)
    2. Eating Disorders
    3. Schizophrenia
    4. Bipolar disorder
    5. Answer feedback: Specific phobias are the most common diagnostic category, with about 8-12% of the population reporting a clinically significant phobia.

Chapter 8: Families, Children, and Schools

1. The nuclear family was the dominant family form throughout history until recently when alternative family structures have become more common
    1. True
    2. False (correct)

3. Answer feedback: The nuclear family is a modern construction, and the most common family structure is multigenerational.

2. All social services within a school must be delivered by school employees, like a nurse, school counselor, or school social worker.
    1. True
    2. False (correct)
    3. Answer feedback: Most school districts use a combination of school staff and specialists from community agencies to provide the services students need to succeed in the classroom.
3. Children in foster care from which groups are required to be placed with people from their culture?
    1. Native American (correct)
    2. Black or African-American
    3. Alaskan Native (correct)
    4. Refugees from other countries
    5. Answer feedback: The Indian Child Welfare Act requires Native American and Alaskan Native children who are in foster care to be placed with people from their culture.
4. Which term describes the social power attached to identities and indicators like race, gender, disability, class, and so forth?
    1. Socialization
    2. Internalized oppression
    3. Cognitive dissonance
    4. Social location (correct)
    5. Answer feedback: Social location refers to indicators like age that are vectors for power in the social world. Other terms are relevant for understanding social location.

Chapter 9: Serving Older Adults

1. Which of the following best describes the dependency ratio in a society?
    1. How many people in poverty receive government benefits.
    2. How many people remain on anti-poverty assistance after five years.
    3. The number of citizens able to work due to age and disability versus those who can work. (correct)
    4. If government disability benefits move someone out of poverty.
    5. Answer feedback: The dependency ratio refers to the share of non-workers to workers in a society. Societies with more people able to work will produce a larger economic surplus for social welfare programs than those with fewer workers.
2. Which of the following describes how ageist messages are internalized by older adults and make them more likely to believe and enact them in real life?
    1. Stereotype embodiment theory (correct)
    2. Baby boomer generation
    3. Activity theory
    4. Multiple loss theory

5. Answer feedback: Stereotype embodiment theory describes how older adults internalize ageist beliefs from society and enact them, even if they do not agree with the messages.

3. Which of the following are programs that primarily support older adults?
    1. Temporary Assistance for Needy Families
    2. Medicare (correct)
    3. Tricare
    4. Social Security (correct)
    5. Answer feedback: Social Security and Medicare are two programs that primarily help older adults.
4. In order to be eligible for the Death with Dignity Act program, a person must be:
    1. Older than 18 years. (correct)
    2. Diagnosed with an illness that will lead to death within six months. (correct)
    3. Cannot be diagnosed with an intellectual or developmental disability.
    4. Cannot be diagnosed with major depressive disorder or another mental health disorder.
    5. Answer feedback: People over 18 diagnosed with an illness that will lead to death within six months are eligible. People with mental health disorders or intellectual and developmental disabilities can still be judged capable of making end-of-life decisions for themselves.

Chapter 10: Becoming A Professional

1. Tema Okun talks about 10 ways white supremacy shows up in the workplace. What are some examples?
    1. Perfectionism (correct)
    2. Worship of the written word (correct)
    3. Money-centered
    4. Embracing open conflict
    5. Answer feedback: White supremacy culture includes perfectionism and worship of the written word. Okun identifies money only as a vector for power. Additionally, open conflict is feared in white supremacist environments, as it threatens current power relationships.
2. Which of the following is a profession?
    1. Life coaching
    2. Hair braiding
    3. Family studies
    4. Human services (correct)
    5. Answer feedback: Human services is a profession because it has a code of ethics. It requires formal training and lifelong learning.
3. Which of the following are good sources of professional guidance?
    1. Mentors (correct)
    2. Informational interviews (correct)
    3. Intuition
    4. Supervisors (correct)

5. Answer feedback: Mentors, informational interviews, and supervisors are excellent sources of professional development, helping you gain information about yourself, your practice, and your opportunities.

4. Which of the following are examples of informal organizational culture?
    1. Policies on providing pronouns when interacting with new people
    2. Codes of ethical conduct
    3. A client Bill of Rights posted at the entrance to the agency's building
    4. How employees typically dress (correct)
    5. Answer feedback: Informal organizational culture is more about norms and what is not written down. Written policies, posters, and codes of conduct are examples of formal organizational culture.

Image Descriptions

Image description for Figure 1.6

Six concentric circles, showing the ecological systems by level of generality with the individual in the middle. Each circle is also connected to the next largest and next smallest circle with two-headed arrows, indicating a bidirectional relationship between all levels.

Inner circle

A Black girl with pigtails. Her attributes include:

- Attachment
- Racial-ethnic identity
- Internal working model

Second circle

Attributes of this girl's microsystem include:

- Mentors
- Spiritual community
- Teachers
- Social media
- Health providers
- Parents
- Peers

Third circle

The mesosystem is visualized with two arrows showing the connections among the elements of the microsystem.

Fourth circle

Attributes of this girl's exosystem include:

- Neighbors
- Foster care system
- Physical and mental health systems
- Parent's workplace
- Extended family & fictive kin
- School system
- Juvenile justice system
- Mass media

Fifth circle

Attributes of this girl's macrosystem include:

- Systemic racism
- Cultural strengths
- Colorism
- Public policy

Sixth circle

Attributes of this girl's chronosystem include:

- Black Lives Matter Movement
- Historical & intergenerational trauma

Return to Figure 1.6

Image description for Figure 1.8

The words Strengths-Based Approach are in a large bubble centered in the middle. Ten smaller bubbles are around it, some connected to one another by a line.The following bubbles are violet, and more related to external resources:

- Connections, connected to Community, Resources, Support, and Family
- Community, connected to Connections and Resources
- Resources, connected to Community and Resilience
- Support, connected to Family and Connections
- Family, connected to Support and Connections

The following bubbles are teal, and more connected to internal resources:

- Resilience, connected to Client's Awareness, Resources, and Client's Strengths
- Client's Awareness, connected to Resilience and Client's Strengths
- Client's Strengths, connected to Insight, Self-Knowledge, Resilience, and Client's Awareness
- Insight, connected to Self-Knowledge and Client's Strengths
- Self-Knowledge, connected to Client's Strengths and Insights

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Return to Figure 1.8

Image description for Figure 1.10

System Level	Characteristics of this Level
Macro: Large Systems	• Address social problems • Focus on root causes and prevention • Work with government and nonprofit agencies on county, state, or national efforts
Meso/Mezzo: Communities	• Collaborate directly with communities or agencies to develop programs or plans • Projects have school, community, or neighborhood impact
Micro: Individual	• Carework • Counseling • Coaching • Work with individuals or families to solve life problems

Return to Figure 1.10

Image description for Figure 2.2

This poster features a large hand-drawn portrait of Dr. E. Franklin Frazier, Sociologist. Dr. Frazier has dark skin, a small mustache, round wire-rimmed glasses, and warmth in his eyes. Three small penciled illustrations accompany the portrait:

- The first illustration shows the sociologist teaching in a math classroom and reads: "Dr. Frazier's natural curiosity about people and their problems led him into the field of sociology. He began his career as a teacher of mathematics, history, and English!"
- The second illustration features the sociologist visiting the home of a family with dark skin and reads: "Recogized authority on the Negro Family, his sociologist writings have created a deeper understanding of Negros, both in this country and in South America."
- The third illustration shows the sociologist surrounded by stacks and stacks of papers and reads: "As head of the department of sociology at Howard University, President of the D.C. Chapter and member of the Executive Committee of the American Sociological Society, Resident Fellow, Library of Congress, Dr. Frazier is a very busy man!"

Return to Figure 2.2

Image description for Figure 2.3

The following questions are excerpted from the 2020 U.S. Census form:

NOTE: Please answer BOTH Question 8 about Hispanic origin and Question 9 about race. For this census, Hispanic origins are not races.

8. Is Person 1 of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin Yes, Mexican, Mexican Am., Chicano
- Yes, Puerto Rican
- Yes, Cuban
- Yes, another Hispanic, Latino, or Spanish origin – Print, for example, Salvadoran, Dominican, Colombian, Guatemalan, Spaniard, Ecuadorian, etc.

9. What is Person 1's race? Mark one or more boxes AND print origins.

- White (Print, for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.)
- Black or African Am. (Print, for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.)
- American Indian or Alaska Native (Print name of enrolled or principal tribe(s), for example, Navajo Nation, Blackfeet Tribe, Mayan, Aztec, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, etc.)

- Chinese
- Filipino
- Asian Indian
- Other Asian (Print, for example, Pakistani, Cambodian, Hmong, etc.)
- Vietnamese
- Korean
- Japanese
- Native Hawaiian
- Samoan
- Chamorro
- Other Pacific Islander (Print, for example, Tongan, Figian, Marshallese, etc.)
- Some other race

"Excerpt from Census 2020 form" from **United States Census 2020** by U.S. Department Of Commerce, Economics and Statistics Administration, U.S. Census Bureau. Public Domain.

Return to Figure 2.3

Image description for Figure 2.4

The Gender Unicorn infographic features a smiling cartoon unicorn with five icons on or around its body. A rainbow icon sits in a thought bubble above its head, representing Gender Identity. Two overlapping hearts on its chest represent Physical Attraction (yellow) and Emotional Attraction (red). Where its legs meet is a double helix, representing Sex Assigned at Birth. A silhouette of dots outlines its body, representing Gender Expression. Each of these icons is annotated with additional information to show a spectrum of identities and desires.

"Gender Identity" (rainbow icon) includes three arrows. One points to female/woman/girl, one points to male/man/boy, and one points to other genders.

"Gender expression" (dots) includes three arrows. One points to feminine, one points to masculine, one points to other.

"Sex Assigned at Birth" (double helix) includes three dots. One dot is female, one dot is male, one is other/intersex.

"Physically Attracted To" (yellow heart) includes three arrows. One points to women, one to men, and one to other gender(s).

"Emotionally Attracted To" (red heart) includes three arrows. One points to women, one to men, and one to other gender(s).

"Gender Unicorn Image Description" by Veronica Vold for **Open Oregon Educational Resources** is licensed **CC BY 4.0** and is based on "The Gender Unicorn" by Trans Student Educational Resources, 2015. http://www.transstudent.org/gender.

Return to Figure 2.4

Image description for Figure 2.5

The poster of the Medical Model Understanding of Disability. The illustration is of a fair skinned man sitting in a wheelchair. The wheelchair has five large yellow tags tied to it with the following text:

- Cannot Work Full Time
- Legs Don't Work
- Can't Climb Stairs
- Has Special Needs
- Needs Medication

Under the illustration is the text – What's the problem? = the disabled person.

Return to Figure 2.5

Image description for Figure 2.6

The illustration's title is Social Model of Understanding of Disability. The illustration is of a dark-skinned person with hair to their shoulders standing with a cane in one hand and the other hand on their hip. There are four horizontal lines in front of the person representing barriers. There are four signs on the bars.

- Physical & Environmental Barrier
- Institutional & Organizational Barrier
- Attitudinal Barrier
- Information & Communication Barrier

Under the illustration is the text: What's the problem? = the barriers in society.

Return to Figure 2.6

Image description for Figure 2.7

The illustration's title is The People in Jessica's Life. It consists of four concentric circles. The innermost circle is the Circle of Intimacy, which includes images and text for mother, father, Uncle Rav, and brother. The next circle is the Circle of Friendship and contains images and text for Friend Orla, Family friends Tom and Lily, Aunt May, and Cousin Gina. The third circle is the Circle of Participation. It contains images and text for work friend Pam. The outermost circle is the Circle of Exchange. The circle contains images and text for Lyn Key – Worker, Ann – Social Worker, Joe Centre Manager, Massage Therapist – Noleen, Physio – Lisa, Nicola, and Sans – G.P. Outside of the circle is a young woman in a wheelchair.

Return to Figure 2.7

Image description for Figure 3.4

A concept map titled 'Trauma Informed Care' is followed by the text: Trauma Informed Care (TIC), which recognizes that traumatic experiences terrify, overwhelm, and violate the individual. TIC is a commitment not to repeat these experiences and, in whatever way possible, to restore a sense of safety, power and worth.

Under the paragraph is a box containing the text 'The foundations of Trauma Informed Care' with two red arrows pointing down to two boxes.

The left box contains the text 'Commitment to Trauma Awareness'.

The right box contains the text "Understanding the Impact of Historical Trauma and Oppression'.

Under the two boxes is the text 'Agencies Demonstrate Trauma Informed Care with Policies, Procedures and Practices that:'

Under the text are three red arrows pointing down to three boxes with text.

Left box:

Create Safe Context through:

- Physical safety
- Trustworthiness
- Clear and consistent boundaries
- Transparency
- Predictability
- Choice

Middle box:

Restore Power through:

- Choice
- Empowerment
- Strengths perspective
- Skill building

Right box:

Build Self-Worth through:

- Relationship
- Respect
- Compassion
- Acceptance and Nonjudgment
- Mutuality

- Collaboration

Image credit: Trauma informed Oregon, 2014
Return to Figure 3.4

Image description for Figure 3.5

This figure contains an illustration of a Venn Diagram titled 'Types and Degrees of Restorative Justice Practice.' There are three overlapping circles: Victim Reparation, Communities of Care, and Offender Responsibility.

There are three gray non-overlapping sections representing partly restorative practices.

1. Victim reparation

- victim services
- crime compensation

1. Communities of Care Reconciliation

- contains offender family services
- family-centered social work

1. Offender Responsibility

- related community service
- youth aid panels
- reparative boards
- victim sensitivity

There are three blue overlapping sections of two practices that represent mostly restorative practices.

1. Victim Reparation and Communities of Care Reconciliation

- Victim support circles

1. Victim Reparation and Offender Responsibility

- Victim restitution
- Victim-offender mediation

1. Offender Responsibility and Communities of Care Reconciliation

- Victimless conferences
- Positive discipline
- Therapeutic communities

The center section is where all three sections overlap and represents fully restorative Justice.

- Peace circles
- Family group conferencing
- Community conferencing

Return to Figure 3.5

Image description for Figure 3.8

This figure contains a comic strip with four panels titled Self-Destructive Self-Care.

In the first panel, a young person with dark skin wearing a hat, hoodie, and jeans is walking down the street. There are two thought bubbles. The first says, "I can't believe I spent so much money today on (living expense)." The second says, "I need something to cheer myself up."

The second panel shows the young person at a restaurant counter with money in his hand. There is a speech bubble that says, "I'll have the special, heavy on the whipped cream."

The third panel shows the young person drinking a milkshake with whipped cream and a cherry.

The fourth panel shows the young person drinking the milkshake with his eyes narrowed and the thought bubble says, "shoot…"

By Mark Pragides is under the fourth panel.

Return to Figure 3.8

Image description for Figure 3.9

This figure contains an illustration with the title Mind Full, or Mindful?

The illustration is a simple line drawing of two people, an adult, and a child, holding hands. There is a yellow sun and four plants with purple flowers and green stems. The adult's thought bubble is chaotic and full of things such as a pointing finger, a car, money, a to-do list, papers, people raising their hands, and a tablet. The child's thought bubble is serene and only contains the outside scene of the four flowers and the sun.

Return to Figure 3.9

Image description for Figure 4.8

Three part image labeled "systemic barriers."

In the first image, "equality" is represented by three people trying to watch a concert. Each person is standing on the same size box. The caption reads "In the first image, it is assumed that everyone benefits from the same support. They are being treated equally."

In the second image, "equity" shows each person having a box or boxes that help that person see the concert on the stage. The caption reads "Individuals are given different support to make it possible for them to have equal access to the orchestra. They are being treated equitably.

In the third image, "inclusion" shows the people on the stage making music with the orchestra. The caption reads "All three can see the orchestra and participate without any support because the cause of inequality was addressed. The systemic barrier has been removed."

Return to Figure 4.8

Image description for Figure 8.8

Family: Targeted prevention programs and services to stabilize family and prevent removal.

Kinship placement: Family setting; targeted prevention, programs services to support reunification or adoption.

Resource placements: family setting; trauma informed programs and services to support reunification or permanency.

Therapeutic resource placements: Family setting with trauma informed treatment and services for complex health problems prioritizing family engagement or permanency.

Residential treatment: Congregate setting with trauma informed treatment and services for complex health problems, prioritizing family engagement or less restrictive permanency.

Return to Figure 8.8

Image description for Figure 9.5

Aging-Accessible Homes

How many of the 21.5 million homes with an adult age 65 and over have accessible features?

1 in 3 adults age 65 and older have trouble using some feature of their home.

Kitchen features

- 54% Wheelchair-accessible countertops
- 20% Wheelchair-accessible cabinets

Bedroom features

- 66% Both a bedroom and a bathroom on the first floor

Bathroom features

- 39% Handrails and grab bars
- 15% Built-in shower seat
- 10% Elevated toilet

Access features

- 12% Extra-wide hallways and doorways
- 47% Step-free entry
- 2% Access ramps

Older adults with a disability (ages 65 and over)

- Difficulty bathing or dressing

- 10% Women
- 7% Men

- Difficulty walking

- 26% Women
- 19% Men

Disabled older adults without accessibility features in their homes (ages 65 and over)

- Older adults with difficulty using the bathroom

- 79% Live in a home without accessible bathroom features
- 21% Live in a home with accessible bathroom features

- Older adults with difficulty walking or climbing stairs

- 26% Live in a home without bedroom and bathroom on first floor
- 74% Live in a home with bedroom and bathroom on first floor

Return to Figure 9.5

Image description for Figure 9.14

Summary of DWDA prescriptions written and medications ingested in 2022, as of January 20, 2023

- 431 people had prescriptions written during 2022

- 84 did not ingest medication and subsequently died from other causes
- 246 ingested medication

- 32 people with prescriptions written in previous years ingested medication during 2022
- 278 died from ingesting medication

- 101 ingestion status unknown

- 43 died, ingestion status unknown
- 58 death and ingestion status unknown

Return to Figure 9.14

Image description for Figure 10.2

The four circles in the Vocation Model Venn diagram are:

- What you are good at
- What you love
- What makes a difference in the world
- What you can be paid for (is valued by others)

The intersection between any two adjacent circles in the diagram defines something that is worth knowing and developing, namely (respectively):

- Your **Expression** – the work you can do and would love to do. This is your "zone of genius" and full expression.
- How you can be of **Service** to make a difference in the world
- The **Value** you can create and deliver
- How to **Align** making a difference with getting paid.

The next level of the diagram is the inner intersections:

- **Potential**

- **Impact**
- **Transformation**
- **Excellence**

In the center of the diagram is your Vocation.

Image description adapted from "A Bit of Background ..." by Lauchlan Mackinnon and included under fair use.

Return to Figure 10.2

Image description for Figure 10.8

An iceberg is represented half above water and half below water. An arrow through the iceberg pointing both up and down is labeled visible (upwards) and invisible (Downwards). Above water are Artifacts (Goals, Plans, and Communications). Stated values are half above water and half below water. These include social norms (visualized above water) and Patterns of Behavior (visualized below water). Assumptions are underwater and include Underlying Assumptions and Values.

Based on ideas from Edgar H. Schein, Organizational Culture and Leadership, Jossey Bass, 1985. Graphic designed by Elizabeth Pearce and Michaela Willi Hooper, Open Oregon Educational Resources, CC BY 4.0. Iceberg illustration adapted from MoteOo on Pixabay is CC0.

Return to Figure 10.8

Image description for Figure 10.9

Enabling reentry

- Restorative counseling
- Intervention and reentry circles

Responding to challenges

- Conflict mediation
- Repair conversations
- Healing or problem-solving circles
- Support for making amends

Building relationships

- Community circles in classes and advisories
- Conflict resolution training for all

- Calming areas
- Counseling

Return to Figure 10.9

Transcripts

Transcript for Figure 1.11, Brené Brown on Empathy vs Sympathy

[Music.]

[Brené Brown]: So what is empathy and why is it very different than sympathy? Empathy fuels connection, sympathy drives disconnection. Empathy, it's a very interesting concept. Teresa Wiseman is a nursing scholar who studied diverse professions where empathy is relevant and came up with four qualities of empathy: perspective-taking, the ability to take the perspective of another person or recognize their perspective as their truth; staying out of judgment, not easy when you enjoy it as much as most of us do; recognizing emotion in other people; and then communicating that.

Empathy is feeling with people, and to me, I always think of empathy as this kind of sacred space. When someone's in kind of a deep hole and they shout out from the bottom and they say, "I'm stuck, it's dark, I'm overwhelmed," and then we look and we say, "Hey, come down. I know what it's like down here, and you're not alone." Sympathy is, "Oh, it's bad. Uh-huh. No, you want a sandwich?"

It is a vulnerable choice because in order to connect with you, I have to connect with something in myself that knows that feeling. Rarely, if ever, does an empathic response begin with, "At least I had a…" and we do it all the time because, you know, someone just shared something incredibly painful and we're trying to silver lining it. I don't think that's a verb, but I'm using it as one. We're trying to put a little lining around it. So, "I had a miscarriage; at least you know you can get pregnant." "I think my marriage is falling apart; at least you have a marriage." "John's getting kicked out of school; at least Sarah is an A student."

But one of the things we do sometimes in the face of very difficult conversations is we try to make things better. If I share something with you that's very difficult, I'd rather you say, "I don't even know what to say right now. I'm just so glad you told me," because the truth is, rarely can a response make something better. What makes something better is connection.

[Music.]

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Transcript for Figure 2.9, The Origin of Race in the U.S.

[Danielle Bainbridge, host]: Did you know that race was not always considered a biological or genetic category? So how did we come to understand it that way today?

We all have a working definition of race. Whether you kinda understand it, hate it, claim to not see it, or study it (hint hint, cough cough: that's me), it still plays a role in all of our daily lives. From the way that people interact, to the places they live and stereotypes they face, race is still a determining factor in our social structures, both inside and outside of the U.S. But full disclosure, I do a lot of U.S. history so this is a U.S. specific video about race, since these histories operate differently across various contexts.

Ok, so let's get started by asking: What were some of the earliest definitions of "race"? Well, before we started thinking of race along the lines of biology, genetics, or phenotype (aka physical appearance) did you know that it was largely considered a category of kinship or group affiliation?

In the 16th century, we started to see the use of the word race in English, but it isn't attributed to physical traits or behavior. It meant, quite literally, that you were all members of the same household, group, or shared a common ancestor. But, when did "race" shift to being less about kinship groups, to sounding more complicated than the lyrics to "I'm my own grandpa"? Well we can see that starting in the colonial era.

And that brings us to our second question: Why did we see the shift in the idea of race in the 17th and 18th century? The answer to this question is firmly rooted in two things: the rise of global capitalism that was backed by slavery and colonialism, and a period of theorizations in Europe known as the Enlightenment.

When the Spanish began the colonization of the Caribbean, and later Latin America, after 1492, they looked to Native populations to mine silver and gold under brutal working conditions. They set about enslaving, attacking, and murdering those who didn't comply. Thousands of Native people died as a result of overwork, genocide, or because they were exposed to new diseases brought over with the Spanish settlers.

And when England established its first successful long-term colonies in North America in Virginia in 1607, they looked to mirror this pattern of enslavement with Native people, while also seeking copious amounts of silver and gold. But they had limited success with this route because: 1) Virginia wasn't exactly rich in gold and 2) Native populations were able to resist the efforts of early settlers through fighting back, or escaping and blending into adjacent Native groups. English settlers still wanted to make money off of this venture so they began to look to alternative ways of making Virginia profitable, and that came in the form of tobacco. But a major problem with growing tobacco is that it requires a ton of labor, and the laborers needed the agricultural skills to turn the crop into cash. Because they had already met with sustained resistance from Native populations, English settlers looked to other potential labor sources: enslaved Africans and indentured British laborers.

There are some important distinctions to make between these two groups. First, indenture was a contractual agreement with fixed terms that varied widely. Some indentured servants were brought to the colonies against their will either as a punishment or because they were children. Terms of these contracts were often very exploitative. But many came willingly in exchange for their passage to the new colonies. Many of these indentured servants finished the terms of their contracts and began lives as property owners.

Enslavement of Africans was an entirely different category of labor from indenture. Because 1) Slavery was for life, not for a fixed term or number of years. 2) Slaves were not considered human. 3) It was not a contract, because it takes two consenting humans to enter into a contract. And 4) Slave laws were enacted codifying hereditary slavery, meaning that if you were enslaved and had children, then those children would also remain in slavery.

With the expansion of this system there was understandably some resistance, even from Europeans. So in order to continue to justify slavery we start to see the pseudoscience of "race" emerge that connected physical features, behavior, and legal rights, right around the 18th century when colonial use of slaves was expanding. Anthropologist Audrey Smedley notes that "scientific" ideas about physical appearance and racial difference in the 18th century were largely "folk" ideas used to justify already existent social norms.

So as a result of a desire to perpetuate systems of exploitation, more and more distinctions were made about the supposed differences amongst races, primarily the differences of black people from their white counterparts. This evolution of race became more concretized after social structures of slavery were in place and not before and was solidified by the Enlightenment.

Which brings us to our third question: How did the Enlightenment impact definitions of race? The Enlightenment was a period of primarily European thought and ideological development that saw the emergence of some key concepts that tie back into today's discussion. First: there was a push in scientific communities to categorize the natural world using "reason" and creating elaborate hierarchical systems that emphasized the similarities between different species and subgroups and the inherent differences amongst others. And race was fitted into this same mold.

As European theorists looked to classify the world into "scientific" groupings, physical markers that were already established social norms through enslavement and genocide were ways that they sought to "prove" that this was the "natural" order and not a social construction. For example, Thomas Jefferson, who was a proponent of concepts like individual liberty and freedom for white men or those he considered his peers, also made claims that black slaves required less sleep than their European counterparts to justify excruciatingly long and inhumane work hours. And Samuel Cartwright, who falsely claimed that "drapetomania" was a mental defect that caused enslaved black people to run away from slavery, as if wanting to escape a lifetime of enslavement was…illogical?

The Enlightenment formulation of History also played a crucial role in the development of social ideologies of race. Kang, Hegel, and other philosophers of their day claimed that certain racial groups stood outside of history or had no history, and this included all groups that they considered non-white or outside of European ideals of modernity. This meant that groups that were devoid of history and culture were inherently less valuable and therefore subordinate to other races. They were cast as the natural sacrifices of supposed "progress."

These assumptions were also codified into law in the 18th and 19th century. The first naturalization laws of the United States in 1790, limited naturalized citizenship to "free white persons" and excluded other groups. Children born of enslaved mothers were said to inherit the legal statuses of their mother, effectively keeping them in bondage perpetually. And Native Americans were often denied legal property rights, which helped to expedite the process of Westward expansion across the North American continent. And "anti-miscegenation" laws were drafted in order to assure that people from different racial backgrounds did not intermarry or have children in order to protect ideals of racial purity. But these racial categorizations did not always neatly align with skin tone.

In his book Whiteness of a Different Color: European Immigrants and the Alchemy of Race, historian Matthew Jacobson notes that in the U.S. "White" or "Caucasian" was not always considered a unified race composed of anyone of European descent.

Whiteness was often considered exclusive to Anglo-Saxon descendants, while other European groups were broken into different ethnic categories such as "Celt," "Slavs," "Iberics," and "Hebrews," which were considered separate races from the 1840s to the early 20th century.

But in the 1920s, when there was a stemming of migration from Europe, these different races were subsumed into one category called "whiteness" to shore up a cultural majority against other racial groups and immigrants. And this persisted throughout the 20th century.

So how does it all add up? Well, race started as a marker of kinship. But then we see it shift to become less about familial inheritance and more focused on physical indicators due to the rise of Enlightenment reasoning and labor exploitation.

But where does that leave us today? Well, in the past several decades scholars have noted both an uptick in identifying with your ethnic history, for example pride in your country or culture of origin, instead of just being "white" or "black." But we've also seen a revival of outdated theories of race being biologically determined and attached to certain traits, like considering all people of one physical type as prone to certain behaviors. But regardless of how people identify themselves, race continues to be a complex topic of discussion and debate.

With that final thought in mind: Do you have any other historical points to add to the evolution of "race"? And how has race been used in both positive and negative contexts throughout history?

Definitely be sure to check out the works cited this week, since there was a LOT of material and ground to cover and this was only just the surface! Well that's it for this week. Drop them below, like, share, and subscribe and we'll see you next week!

[Hey guys, thanks for all of your comments last week on "what would happen if Islamic armies had won at the Battle of Tours?" Here's what some of you had to say: Rachel on Facebook speculates that European architecture would have been much different and perhaps the influence of Moorish architecture would have spread past Portugal and Spain and into France. Thanks for watching, Rachel! PoseidonXIII on YouTube (who is a person, and I'm assuming not an aquatic God?) says that he's really digging the new format of the episodes and enjoying the hypothetical questions. Thanks for watching from under the sea, Poseidon!

And our last shoutout is actually from our American Revolution episode, I wanted to say "hi" to Mr. Miller's class in North Carolina, I heard you were finishing up your unit on the American Revolution and used our video in class. That's super awesome! Stay curious and thanks for watching. So that's it for now, and we'll see you next week!]

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Transcript for Figure 3.7, The Non-Violent Communication Model.

Styles of communication

There are two styles of communication, violent and nonviolent — and a whole spectrum in between.

Violent communication

Violent communication is coercive, manipulative and hurts. It includes making generalizations and a use of language that induces fear, shame or guilt. It is often ineffective since it diverts our attention away from clarifying our actual needs and distracts us from solving the actual conflict.

Nonviolent communication

Nonviolent Communication is based on the idea that we all share universal human desires such as the need for trust, safety, and appreciation. It allows us to empathize and think clearly. And as a result, reach a better and more honest understanding of each other.

Four steps of nonviolent communication

Nonviolent Communication follows 4 steps: observation, feeling, needs and requests. To understand how it works, let's imagine a college student being late for class. Old Jay, her former teacher, would usually have just said, "And here she comes again, late Ann." In class he then would give her a hard time and after – as his form of punishment – a bunch of senseless assignments. Then, both would often feel bad for the rest of the day. New Jay, who's her current teacher, learned about Nonviolent Communication and knows that it begins with a clear observation.

Observation

During observation he tries noticing concrete facts – things that happen at that very moment. New Jay jots down that Ann arrived 20 minutes late and that his pulse is up – possibly a sign of stress. Note that sharing observations should not be combined with evaluating them, because then others can hear criticism and naturally resist.

Feelings

When focusing on his feelings, New Jay connects with his heart and can learn to understand various underlying emotions. This is important because what seems to be anger, might in fact be sadness. During this step it is essential to distinguish feelings from thoughts. After class, New Jay shares his observation and explains to Ann that he feels disrespected when someone is late for his class.

Needs

Knowing his needs is important because it allows him to enrich his life, and feel at peace. If we disregard our needs or don't live up to our values, we experience stress and frustration.

Understanding that we all have universal human needs is perhaps the most important step in the process. New Jay tells Ann that they should find a way to respect each other's values and desires.

Request

Lastly there is the Request, which clarifies what future New Jay wants for himself and this relationship. Clear requests are hence crucial to a transformative communication. When we ask for concrete actions, we often find creative ways to ensure that everyone's needs are met. New Jay asks Ann not to come to class at all, if she happens to run later than 1 minute.

Marshall Rosenberg

Marshall Rosenberg, who developed the model, liked to show the differences between the communication styles with two animals. The Jackal was a symbol of aggression, dominance and violent communica-

tion. The Giraffe with his long neck and big heart represents a clear-sighted and compassionate speaker and nonviolent communication style. "All violence," Rosenberg wrote, "is the result of people tricking themselves into believing that their pain derives from other people and that consequently those people deserve to be punished."

What are your thoughts on this model? Share your thoughts in the comments below

and check the description for more details, and interesting links about the topic.

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Transcript for Figure 3.10, Beyond the Cliff | Laura van Dernoot Lipsky

[Laura van Dernoot Lipsky]: Eighteen years ago, I found myself standing on top of a very tall cliff having what I would only come to recognize many years later as a near psychotic break. It would be fair for you to ask if I had always been that on edge and the answer is no. But, as many of you, I imagine, can relate, how I found myself on top of that cliff on that particular day was by way of a very long road. Like so many others, my childhood was filled with a lot of love and many challenges. Life came into particularly sharp focus for me when I was 10 years old. My mom, who was the healthiest person any of us knew, went into a doctor's appointment for what everyone thought would be diagnosed with pneumonia at the worst, and returned home having been told she had a very rare form of lung cancer, they gave her three months to live; she lived for three years, much of that time with one lung.

So she died when I was 13, and the sun rose and set with my mom and I entered into my adolescence feeling if continuing to live wasn't going to be impossible, it was going to be highly improbable. So I navigated high school with a lot of over achieving; I spent my days getting straight A's and working three jobs, and I spent my nights planning on how I could end my life without causing my older brother who had always been my protector and my role model too much pain.

I did make it through high school and then I landed in college and I found myself sitting in one of those very large lecture halls. And my professor at the time, Professor Richard Applebaum, was talking to us about suffering on this one particular morning and particularly he was talking about homelessness, and he was talking about it in a way that allowed time to stand still for me. He was building on what so many traditions have taught us for the beginning of time really that in life it is said there's equal measure of brutality and beauty of pain and pleasure of annihilating moments and of sublime moments. And yet

there was a way he was talking about it, this whole conversation about equanimity that was completely new to me. Because during those three years when my brother and I were taking care of our mom, we were surrounded by a number of very, very loving people and kind people who gave us a lot of support for appearing to be stoic, for seeming to be strong, and for holding it all together.

And what Professor Applebaum was talking about on that morning is when one is engaged in suffering, there is so much more to it than holding it all together. So what I knew was I wanted more of whatever he had going on. So I went up to him after class, asked how I could help. He scribbled on a piece of paper the name and number of our local homeless shelter's director. And that's when I started volunteering at age 18, spending the nights regularly volunteering in a homeless shelter. I went on to work with all forms of trauma and always within this kind of larger backdrop of systematic oppression and liberation theory. And what I knew was I was so grateful that I had found something that made sense to me and that I felt passionate about.

What I had no idea and wouldn't know for years to come was to what degree having borne witness to the suffering of my mom, and then the subsequent years of bearing witness to so much suffering with so many people, to what degree that was taking a toll on me. And this is something that wise people have passed down for a long time and we know more and more about now because of the advances in neuroscience and the wonderful research that many of my colleagues have done. But at the time, I had no idea about this cumulative toll. So one of the ways that the toll can show up is for those of you who are doing work.

There are folks who do work and as a result of the work you do, you might be exposed to things, either because of the content of what you're doing, but what a lot of my colleagues say is like, look, the work itself is the least of my concern. It's all my colleagues who put me over the edge, right? So sometimes the toll is because of the work. Sometimes the toll is because of the caretaking we do in our lives.

Here she's saying, I feel like I need you less and less, Mom, now that I can make myself feel guilty all on my own.

So much of the toll we feel is because many, many, many of you are caretaking in your personal lives. You're caretaking those around you, you're at home tending for folks who are returning from wars, folks who are ill, people who are in need in the community.

Sometimes the toll we feel is because of the suffering of other living beings. This is Chris Jordan's wonderful work.

And sometimes it's because of what's going on ecologically on the planet itself. This is the work of Vance Friedenberg. He's one of the leading scientists looking at the sixth mass extinction.

But what we know is that when humans are exposed to suffering, hardship, crisis, trauma of humans, other living beings, or the planet itself, there's a cumulative toll. And there's a toll on us individually. There's a toll on your immediate relationships. There's a toll organizationally for those of you who have this exposure in your work.

Institutionally, systemically, we see it in movements we're a part of. We're seeing it throughout all of our communities and society as a whole.

She's saying, speaking personally, I haven't had my day and I've never met any dog who has.

The other piece of this that's very important, at least when I do this work, is it's always held in a larger context of systematic oppression. You know this so well, but a reminder that the degree to which you're impacted by the lives you're living and the work you're doing is intimately tied to the fact that we're in a society with so much supremacy. And if we're in a society where there's no oppression, there's no racism,

sexism, homophobia, heterosexism, ageism, ableism, classism, and xenophobia, so much of the suffering we are tending to wouldn't exist and the remaining bits that exist in life, we would all be affected by that so differently.

I have no doubt that all of you have so much more insight and personal awareness than I did back in the day, and that, for those of you who know what this toll is and when you feel this toll, either because of what's going on in your personal lives or on the job, that you're able to identify it. But I was not at all able to identify it. So it was about 10 years into my career when a critical mass of people started kind of getting up in my face doing that, hey, Laura, you're tripping. You should take some time off. And I'm sure somebody said something earlier than 10 years in, but I was very stubborn and successfully ignored them.

But 10 years in is when there was a critical mass of people up in my grill really begging me to look at this. And what some of you will appreciate is that, a number of those people were clients I was serving, which you can imagine is always so disconcerting, you know, survivors of domestic violence living in a shelter who can't go anywhere, begging me not to come to work. So people were doing their due diligence, right? But at the time, I was so arrogant. I was incredibly cocky and I was entirely self-righteous. I was doing God's work. You could either step up and help me do God's work or you could step off, but I was definitely not gonna have a conversation with you about how I was affected by my job.

And like many of you possibly, I was raised in a number of traditions that implicitly and explicitly communicated: if you care enough about what you're doing, if you are down with your cause enough, if it matters enough to you, you're going to suck it up. So this whole conversation about how to sustain wasn't something I was engaging in. But finally, the pressure mounted, I caved. I didn't take any significant time off, but compromised – we took a short trip, went to visit our family who lived in the Caribbean. So on a particular day, we head out as a family on this hike and we get halfway through our hike and we summit where we wanted to summit, and there we are standing on the top of these cliffs, right?

So the family's gathered around; tiny Caribbean island, standing on the top of these cliffs, looking out. The first thing I remember thinking was, this is so beautiful. The second thing I immediately thought was, I wonder how many people have killed themselves by jumping off of these cliffs, right? And at the time, I worked at Harborview Hospital, which you know is the level one trauma center for the whole Northwest. So it wasn't my own suicidality at play anymore. It was because of the years of bearing witness to other suffering that naturally, instinctually, one starts triaging, of course, right? So you start thinking, where would the helicopter land? Does the helicopter land on the cliff and would you belay down to the person on the beach? Would the helicopter actually land on the beach?

Is there a Level One Trauma Center in the Caribbean, you ask yourself? Do they fly you to Miami? Would they stop you in customs? You know, you kind of go through the whole thing, right? So I said this out loud because I was merely presuming, I was just giving voice to inevitably what was going to come up in a family conversation because who stands on top of a cliff? And doesn't wonder where the nearest Level One Trauma Center is? But apparently in my family, nobody was thinking that. So, it got even quieter than it had been; really long, very uncomfortable pause happened, and ultimately it was my stepfather-in-law who said, 'Are you sure all this trauma work hasn't gotten to you?' And honestly, this was the first moment I had any insight into, you know, check it out.

There are people who can go on a hike and not wonder where the nearest level one trauma center is. But I'll tell you, it wasn't me; it wasn't anybody I was hanging out with, right? Because one of the things about this toll is it's slow-moving. It is very hard to gauge over time individually and collectively if we are

being affected by what we're exposed to. And also, what happens is we get very isolated. So this was one of those moments that maybe you've had where kind of everything starts flooding in, right? And then I was like, whoa, well, if this is the case, maybe it's also the case that there's people who still date out there in the world and those people who date aren't doing background checks on everybody they date, right?

Maybe there's people who can go to a playground. It's just a lovely place for children. You're not worried about, like, head injuries or Amber Alerts, right? But this is what happens that over time what you're exposed to affects your entire worldview. There are so many ways that we can be affected individually and collectively by exposure to vicarious trauma, compassion fatigue, secondary trauma. Many people call it many different things. But this exposure affects all of us so differently. What I have found through the privilege of getting to work with everyone from zookeepers to judges, school teachers to nurses, ecologists to activists is that it is breathtaking the commonalities of how one is affected, right? So some of the ways we find you feel like you're not doing enough, right?

So here they're saying we just haven't been flapping them hard enough. So this is where you feel like you're not doing enough. You constantly feel like you should be doing more, right? Another one could be morale. So they're saying I see you've done time, so working in a cubicle shouldn't be a problem. So I work with organizations nationally, internationally, and one of the things we find so much is the morale, the very, very quickly eroding morale. Here he's saying I bark at everything. You can't go wrong that way. So hypervigilance, many people can relate to a sense of hypervigilance. This is where you lose your ability to flow in really fluidly in between your sympathetic and your parasympathatic nervous system. You become kind of in hyperarousal.

I had a colleague say to me, she was a child support enforcement officer, and she said to me, 'I can tell you which one of my son's friends are going to grow up to not pay their child support.' And her son was five years old, right? Here he's saying no, not there, please. That's where I'm going to put my head. So exhaustion is something many people can relate to, and not the exhaustion before you work out, but this is an exhaustion where you are tired in your soul, you are tired in your spirit, you are tired throughout your bone marrow. All of your ancestors were tired people. There is the avoidance.

He's saying no Thursdays out, how about never? Is never good for you?

This is where the best part of your day at work is where you don't have to do your job. And then there's the avoidance in our personal lives.

She's saying it's too late, Roger, they've seen us. Cynicism, many of you can relate to.

They're saying, but she'll come down eventually, and she'll come down hard.

So what many of you might be able to relate to is not the pure cynicism, but the cynical humor. And then anger and resentment.

She's saying it's a new antidepressant. Instead of swallowing it, you throw it at anyone who appears to be having a good time.

And here he's saying, 'I can cure your back problem, but there's a risk you'll be left with nothing to talk about.'

So the other thing we see here is the externalizing that happens when more and more people are asked to do more with fewer resources. We see this whole seduction to externalizing. So this is where you start saying to yourself, 'You know, I would actually be fine taking care of my loved ones if I could have different loved ones to take care of.' Or people say, 'I would love coming to my job every day if my immediate supervisor would just retire.' And then there's blind spots that we have.

So one of the things that we notice a lot that people have is blind spots. I'll share the story to illustrate it. This is a water bottle. It says the Oregon Coalition Against Domestic and Sexual Violence. It's one of approximately over 100 water bottles I have in my home that have been gifted to me like incredible programs that many of you are involved with.

And every water bottle I have in my home has something stenciled on the side like this, which has domestic violence, sexual assault, HIV/AIDS, infant mortality, flood, hurricane, tornado, tsunami, death, destruction. And I'm just thinking this is great. I have water bottles. Every day is Earth Day here. This is fantastic. But what it also means is these are the water bottles that go with my kids to swim meets, basketball tournaments, soccer games. And I'm not thinking anything of it. But then I was unpacking my child's lunch some time ago and I noticed that at school she found the provisions to kind of hack over the word sexual, right? So she's not exactly old enough to know what sexual violence is.

She's definitely old enough to know you're not sitting at the lunch table at school with a water bottle that says domestic and sexual violence on it, right? I don't know why, but I decided to tell this story at a very large conference of police officers. And when the break came, a police officer came up to me two centimeters from my face, $20 in her hand, and said, 'Go get your kid a proper water bottle.' I feel like you know things have gone very wrong in life when you've got the cops giving you cash, instructing you on parenting, right? And then dogma and self-righteousness, okay? So here he's saying, 'Your mother and I are separating because I want what's best for the country and your mother doesn't.' And then addictions, which many of us can relate to.

She's saying, 'Of course I drink during the day. I'm way too tired to drink at night.'

And numbing. So here he's saying, could we have the dosage? I still have feelings.

One of the things I want to say to us about numbing, it is incredibly seductive with the volume and the intensity of suffering on the planet today. It is incredibly tempting and seductive to become numb. And what I want to offer to you is how critical it is that we continue to strive to cultivate our capacity to be present. One of the reasons we want so much to be present is we remind ourselves, with everything that's out of our control every single day, one of the things that remains in our control at any given time is your ability to bring your exquisite quality of presence to what you are doing and to how you are being.

That presence we know can interrupt the systematic oppression which is causing so much harm and can transform the trauma that is arising. It is very easy to get in that place of, 'You have no idea what my life would be like if you lived here,' or 'If you did my job,' or 'If you saw what I saw,' and that's when we call on our ancestors and that's when we call on so many people who have come before us who remind us that when they could not change anything external, they were able to shift everything as a result of where they put their focus.

And again, I don't know any of you personally, but the assumption I'm going to make is none of us would go up against any of these folks, right? You're not going to, oh Desmond, I know things got rough for you in South Africa, what with apartheid and all, but here in Washington State, we got a few things going on, right? Here he's saying this is the barn where we keep our feelings. If a feeling comes to you, bring it here and lock it up. The other reason I want to, bring us back to presence, is I want to remind you that while I know we have so many different life circumstances, I believe we have a shared ethic of doing no harm. If you are numb, you will not be able to gauge whether or not you're doing harm.

And if we believe in what Chief Sealth talks about with the web of life, or what Martin Luther King talked about with the single garment of destiny, you all know so well that there are so many parts of this web that are profoundly compromised. And many of you are bringing heart and soul to tremendous sac-

rifice to tend to parts of this web that are compromised. If the way you're doing that out there means in any way you are neglecting your immediate part of the web, cutting off circulation to your immediate part of the web, lighting your immediate part of the web on fire, it is not ethical practice, it's not integrity-based practice, it's not sustainable. The other piece with numbing out, and what we've learned from so many people who've come before us and in so many traditions, is you don't get to selectively numb.

So if you're going to numb out your sorrow, you're also going to numb out any possible happiness you can have. If you are going to numb out the heartbreak, you're going to numb out any ability to survive noticing what is beautiful. And the other thing is your mind and body and spirit will keep trying to bring itself back to a full range of feelings of that whole equanimity and that spaciousness. Which means that's why, you know, you can work on coalition after coalition of peace building and then you get in the lunch line or on the freeway and you don't let anybody merge in front of you. Right? And we defend that. We say how I conduct myself on that freeway or when I'm getting my food at lunch has nothing to do with the other work I'm doing.

Howard Thurman reminds us, don't ask yourself what the world needs. Ask yourself what makes you come alive and then go and do that. Because what the world needs is people who have come alive. So we remember that with the magnitude of suffering at play on the planet right now, we are in desperate need of folks who have the wherewithal and who have the courage to be present. We know from that place of presence it is possible to aspire to do no harm. It is possible to transform whatever trauma arises. And it is possible to continue to work to dismantle the systematic oppression which is causing such a legacy of suffering. From that place of presence we know that it is possible to metabolize whatever arises in life. The waves of life which will continue to present to us what they present. There is a way to metabolize that and integrate it so that over time, you find that it contributes to your awakening. That the longer we get to walk on this planet, we find we have deeper compassion, vaster humility, and we are able to come up and out of the narrow places. And from that place of cultivated presence, we remember that it is possible to create and to sustain an ability to be truly transformative. Thank you.

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Transcript for Figure 6.3, 2019 Income, Poverty and Health Insurance – Health Insurance Presentation

[Music.]

[Sharon Stern, Assistant Division Chief, Employment Characteristics]: Health insurance coverage is an important measure of our nation's overall well-being. Whether it's illness, injury, or preventative needs,

health insurance provides greater access to medical care, protection from high unexpected costs, and more economic stability.

Each year, the Census Bureau provides data on health insurance coverage. We look at who is and isn't covered, where they live, and what type of insurance they have. Policymakers use this information to make data-driven decisions.

[Larissa Makita, Branch Chief, Health and Disability Statistics]: This is Larissa Makita, Health and Disability Statistics Branch Chief, and I'm here to present today's findings.

The health insurance estimates released today come from two surveys. The Current Population Survey Annual Social and Economic Supplement (or CPS ASEC) asks people about their health insurance coverage at any time in the previous calendar year. The national level results presented today come from this survey. Today's CPS ASEC health insurance estimates are based on the updated processing system. These health insurance estimates should only be compared directly to estimates based on this updated processing system.

State level estimates released today come from the American Community Survey, which asks people about their coverage at the time of the interview. Due to its larger sample size, the American Community Survey is the recommended source of health insurance statistics for smaller populations and levels of geography.

Let me begin by summarizing the main findings this year. An estimated 8.5 percent of the population, or about 27.5 million people, did not have health insurance coverage at any point in 2018. Between 2017 and 2018, the uninsured rate increased 0.5 percentage points, and the number of uninsured people increased by 1.9 million. This represents the first year-to-year increase in the uninsured rate in the CPS ASEC since 2008 to 2009. The percentage of people uninsured at the time of their interview decreased in three states and increased in eight states between 2017 and 2018. In 2018, most people (91.5 percent) had health insurance coverage at some point during the calendar year, with more people having private health insurance (67.3 percent) than public coverage (34.4 percent).

Looking at private coverage more closely, employer-based insurance was the most common subtype of coverage overall, covering 55.1 percent of the population. Ten point eight percent of people purchased their coverage directly. The updated processing system allows us for the first time to distinguish whether this coverage was through a state or federal health insurance marketplace, such as healthcare.gov. In 2018, 3.3 percent of people, or 30.8 percent of people with direct purchase insurance, obtained their coverage through the marketplace. In 2018, 34.4 percent of people had public coverage, which includes Medicare, Medicaid, and VA and CHAMPVA coverage.

Over time, changes in the rate of health insurance coverage and the distribution of coverage types may reflect economic trends, shifts in the demographic composition of the population, and policy changes that affect access to care. The percentage of people covered by any type of health insurance decreased half a percentage point between 2017 and 2018. This decrease was primarily driven by a change in public coverage. Between 2017 and 2018, the percentage of people with private coverage did not statistically change, and the percentage of people with public coverage decreased 0.4 percentage points. Among public coverage, Medicaid coverage decreased 0.7 percentage points, while Medicare coverage moved in the opposite direction, increasing by 0.4 percentage points. This increase was partly due to growth in the number of people aged 65 and over, and not a change in Medicare coverage for adults in this age range.

Age is strongly associated with the likelihood that a person has health insurance. In 2018, adults aged 65 and over had the lowest uninsured rate (0.9 percent), followed by children under the age of 19 (5.5

percent), and adults aged 19 to 64 (11.7 percent). Between 2017 and 2018, the uninsured rate increased for adults aged 35 to 44 and 45 to 64, as well as for children aged 0 to 18. Indeed, in 2018, 5.5 percent of children under the age of 19 did not have health insurance coverage, a 0.6 percentage point increase from 2017. For many selected characteristics, the percentage of children without health insurance coverage was significantly higher in 2018 than in 2017. However, the change was not uniform across groups. For example, the uninsured rate did not change for children in families with income of less than 400 percent of poverty; however, it increased 0.7 percentage points for children living in families at or above 400 percent of poverty. In both years, the rate of uninsured declined as the income-to-poverty ratio increased.

The updated processing system allows us to report more detailed information than previously available, including sub-annual or within-year health insurance coverage. Among the 296.2 million people covered at any point during 2018, most (96.4 percent) had health insurance coverage for all 12 months, while 3.6 percent had coverage for one to 11 months. That is, most people with coverage during 2018 had coverage throughout the entire calendar year. Most people with private coverage and with public coverage also had their coverage for all of 2018. The larger sample size of the American Community Survey allows us to observe the uninsured rate, as well as changes in the uninsured rate, at the state level.

This map shows the uninsured rate by state in 2018. Lighter colors represent lower uninsured rates, and darker colors represent higher uninsured rates. Six states and the District of Columbia are in the lightest shade of blue, with less than five percent of people uninsured at the time of interview. Six states in the darkest shade have an uninsured rate of 12 percent or higher. This map presents the change in uninsured rates between 2017 and 2018. The percentage of people without health insurance coverage decreased in three states and increased in eight states. Statistically significant decreases ranged from 0.3 to 1.8 percentage points, and all increases were one percentage point or less.

More information is available in our reports online. We have a number of tables and figures on our website, in addition to an America Counts story that looks at changes in coverage for children, and a Research Matters blog that highlights a new measure of health insurance coverage: coverage at the time of interview, which we include in our report for the first time this year. Additional data products based on the American Community Survey will be available on September 26th.

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Transcript for Figure 8.2, Where Does the Nuclear Family Come From?

[Danielle Bainbridge, host]: We're all pretty familiar with the image of the American nuclear family with two parents, a couple of kids, and a loyal canine companion, but when did we start thinking of the nuclear family as the most natural one?

With Thanksgiving coming up, we thought it would be fun to talk about family. It's safe to say that most of us know more than a few families that don't fit into the typical nuclear family mold. Yet despite this diversity, if asked to describe a prototype of the American family, a lot of us will still recall images more reminiscent of Leave It to Beaver than anything we've witnessed in real life. But if all of us can imagine or know families of all shapes, sizes, and styles, then why does the expression "nuclear families" still get lobbied around to represent some sort of idealized unit?

Before we dive into the incongruous history of the family structure with the same name as the center of an atom, we should ask ourselves what is the history of family structures before the idea of the nuclear family became the shorthand for normal?

This answer varies based on time period, region, and culture. Kinship, or the recognition of relationships between people within the same community or biological family, plays a huge role in how we define our family structure. Yes, everyone all over the world has a biological ancestry, but who and what we call our familiar relations is not that cut and dry.

In the Iroquois system, your father's brothers were also your father, and your mother's sisters were also your mother. In the Kaw nation kinship system, your mother's brother's daughter, who we would call your cousin, is also called your mother. In the matrilineal Maggio culture in northern China, women freely chose their partners, and who your biological father is, is not considered very important at all. Frequently, your biological father wouldn't even live with you, and your mother's brothers often fill in the role of the father figure. Plus, all of this is frequently even more complicated by language barriers. So if you think your family structure is weird, trust me, it's not.

In terms of European history from the 1500s until the dawn of the Industrial Revolution, it was common for peasant families in northern and central Europe to live in two-generational households, consisting of the parents as the older generation in charge of the family and the children as the second generation.

That was also because kids were a big part of the economic structure of the household, working with their parents to sustain the family's livelihood. At any given point in time, only less than 10% of these peasant families lived intergenerationally, in part because a lot of the grandparents didn't live long enough to make this a reality. By the end of the Middle Ages, most families in those regions were in the traditional nuclear format, owing in part to the influence of the Christian Church, which sanctioned monogamy. By contrast, in the same periods in eastern and southern Europe, intergenerational living was much more common, with several generations of the family all living within the same household.

Not everyone thought the nuclear family was ideal. In the 19th century, researchers who were studying family structures theorized that nuclear families they observed in manufacturing regions of Western Europe and in England might not be the best, since once children left to form their own families, it left elder parents alone. There are also other structures that were practiced, such as conjugal families, or families that were connected through marriage, and consanguineous families that are connected by their common bloodline.

Another big part of how families were defined centered on the question of marriage. Although there are more contemporary notions that marriage is about love, fidelity, building a life together, and making huge centerpieces out of mason jars, that wasn't always the case. Marriage is an ancient custom dating back thousands of years, and evidence shows that marriage customs have varied as widely as family structures. According to Stephanie Coontz, author of Marriage, a History, a lot of those marriages were more about family connections than love. What marriage had in common was that it really wasn't about the

relationship between the man and the woman; it was a way of getting in-laws, making alliances, and expanding the family labor force. How romantic.

And marriage includes a laundry list of options, like arranged marriages, where families choose their children's spouse, or polygamy, where there are multiple marriages within one defined group. That includes both polygyny, or one man with multiple wives, and polyandry, or one woman with multiple husbands. Although polygyny is the more commonly known practice, accounts of polyandry exist in approximately 53 societies around the world, such as Tibet.

Although religious marriages have a long history, as centuries have passed, the state has played a larger and larger role in regulating marriage practices, so a marriage can have a religious ceremony, a civil ceremony, or a combination of both. It wasn't until the last 250 years or so that the idea that marriages should be love matches started gaining traction.

We've established that families have lots of different shapes, sizes, and customs. So that brings us to our next question: when did the nuclear family become shorthand for the American household?

The use of the specific phrase "nuclear family" in English can be dated back to the 1920s, but as the evidence shows, the concept or form of the nuclear family wasn't exactly new. But in the 1950s U.S., the Cold War was accompanied by an economic boom, the growth of suburban developments on the outskirts of major cities, and a growth in the middle class and a population surge, all of which encouraged the nuclear family.

But it wasn't inherently a natural development. PSAs and how-to videos broadcast across the country were specifically designed to teach families how to behave appropriately and what to do if they were going to achieve this stylized ideal. But these realities were marked heavily by divisions of class and race, as the civil rights movement of the 1950s and 60s was occurring simultaneously. So even though in the 1960s some historians and sociologists interested in family structures were concluding that nuclear families were the only widely spread version of the family, the contemporary reality for many American families differed greatly from the ones presented in popular media.

If even the Brady Bunch was blended, then that leads us to asking our final question: is the nuclear family really the most popular form in the U.S.? And if not, what kind of families are out there?

Let's look at the data. According to the U.S. Census Bureau, in 2012, 66% of households were family households, down from 81% in 1970. In those same years, married couples with children under 18 dropped from 40% to 20%. Black and Latino children were more likely to live in single-parent households, and households with only one person jumped from 17% to 27%. So it seems that while married couples with kids still describe a substantial number of families in the U.S., that number is shifting every day.

In the last hundred years, marriages and families have continued to evolve, at least in regards to the types of unions becoming legally recognized and visible in the popular consciousness. The political and legal system of a region can determine the types of marriages recognized by law, which in turn impacts the type of families that are visible.

In 1967, the Supreme Court case of Loving v. Virginia struck down all laws prohibiting interracial marriage in the United States. In 2015, Obergefell v. Hodges ruled that laws against same-sex marriage in the U.S. were unconstitutional. But families also exist outside of legal and state recognition, and that's not a new phenomenon. In ancient Greece, alumni was the term for children who were fostered by another family, and there is legal precedent for adoption dating back to the Code of Hammurabi in the 18th cen-

tury BC. Today, there are over a quarter of a million adoptions worldwide every year. So clearly, blood ties, marriage, and children aren't the only ways that family can be defined.

How does it all add up? Marriages, families, and kinship groups have been going strong for thousands of years in almost every configuration that we can think of, and that includes the nuclear family. While the image of the nuclear family is often held up as the ideal and only form a family can take, whether or not that's true seems to vary by social group and region. As we gear up for the holidays and think about passing various side dishes to members of our own family with both joy and maybe a little bit of caution, it's important to remember whatever form, shape, or size it takes, we have the power to define what family should look like for ourselves.

So what do you think? Any funny family stories to share? Drop them below with all of your questions, and we'll see you next week.

[Last week, we did an episode on why women give birth lying down, and Krystal Murray on Facebook had a really great question. She says, "I can't remember the exact dates, but some doctors also started smear campaigns against midwives to try to get women to give birth in hospitals." This is a really awesome question. There were ads running around the early and mid-20th century to encourage women to switch to hospitals. Although the content of the ads and how they represented midwives varied, some were interested in disparaging midwives as unsafe, while others I've seen were health department videos focused on standardizing midwifery as a practice since they provided vital services to women who were far away from hospitals. I'll drop some of these examples and links in the works cited since time period is really important to the answer for this question on how midwives are represented in popular media. Thanks for watching and thanks for the great question.]

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Transcript for Figure 8.6, Three-Minute Legal Talks: United States Supreme Court case Brackeen v. Haaland

[Music.]

[Stacey Lara]: My name is Stacey Lara and I'm an assistant teaching professor at the University of Washington School of Law.

[Interviewer]: Can you give a brief overview of the Indian Child Welfare Act?

[Stacey Lara]: The Indian Child Welfare Act was passed in 1978 in response to the really egregious and tragic practice of unnecessary removal of Indian children from their families and their communities. The Indian Child Welfare Act was put in place to address this reality and in its passage create certain protections for Indian children to remain in their homes.

These include notice, so tribes getting notice when one of their children have been removed from their family's home. It sets higher standards for service provisions. So, child welfare agencies or someone looking to a third party looking to adopt a child needs to make active efforts to keep the family intact before removal and to try and return that child home as soon as possible. It also creates higher standards of proof and creates a remedy in that it allows for the invalidation of a termination of parental rights if the law is not complied with.

[Interviewer]: What are the issues concerning Brackeen v. Haaland?

[Stacey Lara]: So, this case presents three primary issues to the Supreme Court. The first is whether ICWA unconstitutionally discriminates on the basis of race by requiring state proceedings to give preference in its placement of Indian children with that child's extended family, other members of the tribe or Indian families rather than non-Indian adoptive parents.

The second is whether ICWA in its implementing regulations constitutionally commandeers states or otherwise exceed Congress's authority.

And then the third is whether the authority that ICWA confers upon individual Indian tribes violates the Nondelegation Doctrine.

[Interviewer]: What are the arguments for both sides of the case?

[Stacey Lara]: Well, under the equal protection argument it involves placement preferences that are a component of ICWA. The Brackeen argument is that because ICWA applies to Indian children, it's a race-based classification. Many states are taking the position that ICWA is not about race. It doesn't apply because it's not based on racial identification. Tribal membership or enrollment is determined by the tribes themselves and it is a political designation, and that was established under Morton v. Mancari.

On anticommandeering, that doctrine, the Brackeen argument is that ICWA requires state agencies to spend money and resources and in doing that it commandeers state governments, which would be a violation of anticommandeering. The response is that ICWA sets minimum legal burdens and that if Congress has the power to pass a law, it also has the power to require state judges to comply with and enforce it.

And then with respect to the Nondelegation Doctrine, the Brackeen position is that Congress improperly delegates placement preferences to tribes, this response being that tribes are not administrative agencies. They're not private persons. They're separate sovereigns that have a sovereign-to-sovereign relationship with the United States government, and therefore that the delegation doctrine doesn't apply.

[Interviewer]: Can you explain what the decision might mean for federal Indian law and tribal sovereignty?

[Stacey Lara]: One commentator has said that this case could have revolutionary and catastrophic consequences. And I absolutely agree with that. There are hundreds of treaties that the federal government has made with Indian nations that are in effect. And whether or not these can stand based on whether or not this law is considered unconstitutional, really remains to be seen. If Congress can't distinguish between tribal members and nonmembers, that has the real potential to impact future litigation involving native tribes. It could impact gaming revenue, gaming rights, mineral rights, tribal recognition – really undermining native sovereignty, which has been in place since the very first days of this country.

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Transcript for Figure 9.4, Raising children for a second time, 'grandfamilies' struggle during the pandemic

[Judy Woodruff]: It's an important change in parenting here in the U.S. More and more older adults are raising kids for the second time around, because of illness, incarceration, addiction, or any number of reasons.

Stephanie Sy reports on grandparents who are caring for their grandchildren and what they're up against in the pandemic.

[Stephanie Sy]: Joanne Clough brought up two kids on her own. She never imagined that she'd have another child to raise at the age of 64, a very lively one.

[Joanne Clough]: It's just not something you economically plan for. I'm a single grandmother rolling the rock back up the hill.

[Stephanie Sy]: How old are you, Carter?

[Child]: Four.

[Stephanie Sy]: There's no way you're 4. You look like you're 5.

Carter's mother, Emily, Joanne's oldest daughter, died of a fentanyl overdose in 2016.

[Joanne Clough]: I every day grieve Emily's loss of Carter, because she will do something cute or — and I just think, over my God, Emily, I can't believe you're missing this. You know, I just can't believe you're missing this.

[Stephanie Sy]: The opioid epidemic has contributed to the growing number of grandparents raising grandchildren, says gerontologist Megan Dolbin-MacNab.

[Megan Dolbin-Macnab]: There is a priority within the child welfare system to place children with relatives whenever that's possible. And that's due to the fact that it's helpful to maintain those connections.

[Stephanie Sy]: It also saves the system money, a cost that is often borne by grandparents who can't afford it; 19 percent of grandfamilies live in poverty.

[Megan Dolbin-Macnab]: Many of them are on limited. For many grandparents, the addition of those expenses really kind of overwhelm the resources that they have.

[Stephanie Sy]: Lisa Lennon was making it work with a cleaning business that allowed her to support her grandkids, 12-year-old Luke and little Jackson, still in diapers. But since the pandemic, she's lost most of her clients.

[Lisa Lennon]: You barely keep your head above the water, and that doesn't feel very good. It doesn't allow me to feel like I can provide everything Jackson needs, everything Luke needs, and also survive.

[Stephanie Sy]: Behind on rent, she's worried about getting evicted.

How are you doing with food?

[Lisa Lennon]: We get food from the church. And we run short toward the end of the month, but we stretch it out and make it work.

[Stephanie Sy]: Since the start of the pandemic, almost 40 percent of grandfamilies say they struggle to pay for housing. A third have trouble accessing food.

[Lisa Lennon]: I was strong and confident in my ability to care for the children, and myself, for that matter. But this is — at this point, I think, psychologically, I feel knocked down, just based on not being able to sustain myself and having to ask others for help, because I'm used to helping everyone else.

So, I'm not used to that.

[Lisa Banks]: I wish I had someone's sofa that I could lay on for two hours and just cry my eyeballs out.

[Stephanie Sy]: Having a good cry would be a luxury these days, says Lisa Banks. She's got three grandchildren at home doing virtual school.

[Lisa Banks]: I'm trying to spread myself thin amongst three kids, which is difficult. A lot of the work, I don't understand because I have been out of school so long and things have changed so much.

[Stephanie Sy]: And with no school lunch, the dishes and the bills are piling up.

[Lisa Banks]: It's like, I'm hungry, I'm hungry, I'm hungry. You hear it all day, so it's breakfast, it's snack, it's lunch, it's snack, it's dinner, it's snack. You're spending it more in utilities because they're using more electricity. Everything goes up.

[Rhea Kelsall]: Any of this stuff here, you can take as much as you want.

[Stephanie Sy]: Banks recently found some help through a local nonprofit group called Gratitude 4 Grandparents. Every Sunday, founder Rhea Kelsall distributes donated food and essentials from her basement.

[Rhea Kelsall]: So many of the families had part-time jobs that lost their jobs. They have less income now than they had prior to the pandemic.

Gratitude 4 Grandparents is here for them.

[Stephanie Sy]: Kelsall herself can relate. She and her fiance are raising two grandchildren between them, also because of substance addiction.

[Rhea Kelsall]: Carl's (ph) my fiance's biological grandson. And his dad is deceased from an overdose.

I do sometimes think that the big G had a plan, because we understand what the other one is going through.

[Stephanie Sy]: And they have gone through a lot. The latest hurdle, the pandemic forced Kelsall to close the daycare she was running.

[Rhea Kelsall]: Totally lost my income, and now we're on his fixed income.

[Stephanie Sy]: Kelsall, like most grandparents, is raising the kids outside of the foster care system.

[Rhea Kelsall]: They're your blood. You want to take them home and take care of them and love them and everything else. It is not even a consideration.

[Stephanie Sy]: But without legal custody or guardianship, it can be tough to tap into government support services.

[Megan Dolbin-Macnab]: There can be eligibility requirements that push some grandparents out. And many of them really struggle.

And I think, with the pandemic, particularly for grandparents who may — who might have been laid off or are not getting income from other family members that maybe they're used to, it can be very devastating.

[Stephanie Sy]: Nonprofits like Kelsall's are trying to fill the need, which includes emotional support.

We joined the group's monthly Zoom meeting.

I wanted to see if I could see a show of hands.

I asked who thought the pandemic had compounded the challenges they faced.

[Woman]: Me.

[Stephanie Sy]: Not surprisingly, every hand went up.

[Kim Elia]: Never did I think I would be this short of breath.

[Stephanie Sy]: Sixty-year-old grandmother Kim Elia was recovering from COVID-19.

[Kim Elia]: My oxygen was at 86, and I was truly afraid to die because of what would happen to Brooklyn.

[Stephanie Sy]: Brooklyn is the 11-year-old grandchild she's raised since she was a baby.

[Kim Elia]: It was absolutely mind-numbing, the fear that I had.

[Stephanie Sy]: With the cloud of COVID, there's worry.

[Paul Anderson]: I wake up thinking about these kids and I go to sleep thinking about them.

[Stephanie Sy]: With the shadow of the past, there's worry.

[Barb Anderson]: They have experienced a great deal of trauma in their lives. And, I mean, what they need, they can't have, their mother.

[Stephanie Sy]: The grandkids' mental health weighs on Paul and Barb Anderson.

[Barb Anderson]: This thing of the kids going to school on the computer and not having a social life just exacerbates the problem, I think.

[Stephanie Sy]: As heavy as the burden may sometimes be, the children, say Lisa Lennon, are also what lift her up.

[Lisa Lennon]: They're my inspiration and reason to wake up these days.

[Stephanie Sy]: On good days and bad days, says Lisa Banks.

[Lisa Banks]: You go through those moments, you go through those stresses, you cry, you fight, you argue, whatever it takes, but you're still there at the end.

[Stephanie Sy]: And that's what really matters.

For the "PBS NewsHour," I'm Stephanie Sy.

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Transcript for Figure 10.3, Epistemic injustice in healthcare

[Professor Havi Carel, Professor of Philosophy, University of Bristol (UK)]: Maybe we can't cure people or entirely remove symptoms, but we do have the ability to give people the sense that they're being listened to and that their opinions and needs are being taken seriously.

I'm Havi Carel. I'm the principal investigator on a discovery award called EPIC which is epistemic injustice in healthcare.

Epistemic injustice. It's a philosophical concept developed in order to capture the way in which we can be discriminated against when our credibility is unfairly reduced when we speak. Because you are from this ethnic group, or because you are a woman, or because of how you dress or because of your socioeconomic status. So it's an injustice done to somebody in their capacity as a speaker, as a knower. And of course, It's particularly significant within healthcare because these contributions from patients are sometimes overlooked or ignored or not acted upon. And this, of course, could have dire consequences for the quality of the clinical care that they receive. The EPIC team includes researchers from philosophy, psychiatry, psychology, law, history, and qualitative health research. The project aims to identify, describe, document, analyze and ultimately ameliorate the phenomenon of epistemic injustice in healthcare.

So EPIC will address four existing problems in the field.

The first is, it's conceptually under-described and what EPIC will do is fill theoretical gaps in our understanding of epistemic injustice in healthcare.

Second, it's empirically untested, and this will be the first large scale project to use six case studies to describe and understand and document epistemic injustice in real healthcare domains.

The third is that EPIC will develop some amelioration and ways to address and reduce the risk of epistemic injustice in healthcare.

And finally, EPIC will try and bring the concept of epistemic injustice into contact with the broader healthcare discourse. For me, the most important outcome of the project would be to develop concrete and applicable tools for both health professionals and patients to reduce epistemic injustice within healthcare.

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Transcript for Figure 10.6, Women of Color Research Network Discusses: The Importance of Mentoring

[Donna Ginther, PhD, Director of the Center for Science Technology & Economic Policy at the University of Kansas]: I think mentoring lets people know that they're not alone, that there are other people like them having the same experiences. It lets them know how to go through and manage their career.

Careers aren't always linear. My career zigged and zagged and then I finally ended up where I am at now, and I think that people need to be able to take control of their career and make it work for them. And they're more likely to stay in a research career if they can tailor it to meet their needs.

[Hannah Valantine, MD, Senior Associate Dean at Stanford School of Medicine]: There's a pillar of mentoring but I want to call it sponsorship because mentoring without the sponsorship, which is actually

advocating for the individual and really getting them launched into, you know, awards helping – getting them into positions that they can be invited to write opinion pieces and papers and getting them into leadership positions, that's actual sponsorship as opposed to mentorship and I think that is critical.

[Belinda Seto, PhD, Deputy Director of the National Institute of Biomedical Imaging and Bioengineering]: Mentoring is the most gratifying part of my job as a deputy director of this institute. Don't be deterred or discouraged that these are so-called bigshots in their field, including the Nobel Laureates.

In my own career I've found out that those who are most successful in science, in their professions, are also, likewise, the most generous.

[Ginther]: I think it's really important to have somebody who's been there, done that and can say, give you a reality check about what you're doing, if it makes sense or not.

So I think that's why I keep always coming back to mentoring and its role and sort of having a career that you own that's not the linear "Oh, I went to graduate school and then made it to dean." You've got to make it your own, you've got to own it because nobody is going to tell you what you're doing is great. People don't congratulate you on being successful. What happens is, you have to find the rewards in your work.

[Shirley Malcom, PhD, Head of Education and Human Resources at the American Association for the Advancement of Science]: I tell people, I had to become something I had never seen. What right did I have to believe that I could ever move into the sciences, or to be able to achieve at any level, or to obtain a Ph.D, or to, or to, or to….

It's like because they're like each step moving from one place to another place to another place. Everywhere along that pathway, in a way you need affirmation. You need support and help, but you also need affirmation that you're good enough. You are, in a way, given permission to enter this space and if you're not given that permission it's harder to take that, to use your own agency in order to take that space.

[Valantine]: My overarching goal is that we can, very quickly, get to 50 percent of women in leadership positions, meaning at full professor level, and that's what we need to have in order to change this situation. So I'm calling it 50-50 by 2020 as my big goal, stretch goal, for the next 7 years.

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Acknowledgments

One of the most rewarding aspects of writing in the open education world is the opportunity to involve students in the process. I sincerely appreciate the students who have been part of this book's journey since its inception in September 2020. Their unique insights have been instrumental in shaping this book, and their contributions have been invaluable. As they continue their paths in university education and the helping professions, their distinct perspectives and experiences will undoubtedly make a significant impact. You, the students, are the inspiration behind this book, and I thank you for your intellect, support, and unique contributions that have made this a richer resource for all future students.

Kelichi Wright, MEd, LCPC, LPC; Kortney A. Carr, LCSW, LSCSW; and Becci A. Akin, PhD, all associated with the School of Social Welfare at the University of Kansas, have contributed to the unique feature of this text. Their seminal work "**The Whitewashing of Social Work History: How Dismantling Racism in Social Work Education Begins With an Equitable History of the Profession**" appeared in the openly licensed **Advances in Social Work** peer-reviewed journal in 2021. This made it possible to adapt their wisdom and expertise to the human services profession for an introductory textbook. To my knowledge, this perspective does not appear in any introductory textbook; this adaptation has the potential to make an equity-focused contribution to the foundational understanding of beginning students. As a Native author, I have also had experience in the education system, which is also an experience that many students have had. They have not seen themselves reflected in their textbooks, as their stories have been whitewashed to fit a narrative to support an educational system that many students are not being supported in, and textbooks are not feeling up to date or that they enhance learning anymore. With these books, we hope to begin to change this story, and your contributions have been instrumental in this transformative process.

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just how we looked at teaching but teaching materials including textbooks and access to those books. Intersectionality was crucial for those conversations. We know the demographics of the communities that we serve, the demographics of the students in our programs, the demographics of the providers, and the demographics of the educators in higher education, and we know that all of this needs to change. All of this needs to be considered when writing this book. I thank them for their dedication, continued critical thinking, and desire for a more equal educational and accessible experience for all students.

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About the Authors

Elizabeth B. Pearce, Linn-Benton Community College

Elizabeth aka Liz (she/her) is a faculty member who teaches Human Development and Family Studies (HDFS) classes at Linn-Benton Community College (LBCC). She has served as Department Chair, Faculty Fellow in Technology and Teaching, and as the Difference, Power, and Oppression Faculty Lead. Previously she directed the Family Resource Center, a full-time child care and parent cooperative for LBCC student and staff families. This textbook, mostly original work, originated in collaboration with LBCC students.

Her passion is creating opportunities and resources for transformative learning through open pedagogy in the community college classroom. She has presented locally, regionally, and nationally on this topic. She also leads and mentors faculty in equity-based teaching, active learning, technology use, and open pedagogy.

Liz earned a Bachelor of Arts in Child Study at Tufts University and a Master of Education degree in Administration, Planning, and Social Policy at the Harvard Graduate School of Education. She has completed post-graduate coursework in child/family development, life course theory, educational policy, and sociology at Wheelock College (now Boston University) and Oregon State University. She is the author of *Introduction to Human Services* and a contributor to *Human Services Practicum: An Equity Lens* also published by Open Oregon Educational Resources.

Martha A. Ochoa-Leyva, Portland Community College

Martha A. Ochoa-Leyva (She/Ella) was born in what is now called Mexico and is part of the Nahuas people. She immigrated to Oregon with her parents and two sisters in the early 90's. Her indigenous roots are an essential part of her teaching and who she is overall in education and her social justice formation. She is a part-faculty member at Portland Community College (PCC) and the author of Introduction to Human Services: An Equity Lens. She teaches in the Child and Families Studies Department and mentors BIPOC students as part of how she gives back to her community. Martha earned a Bachelor of Science in Psychology with a minor in Legal Studies at Western Oregon University. She earned her Master of Arts in Clinical Mental Health Counseling from George Fox University. Her current work includes founding the Child and Families Studies Department at PCC, being an Oregon Infant Mental Health Association Board member, and leading trauma-informed equity-centered workshops for school district leadership teams.

Contributing Authors

Yvonne M. Smith LCSW, Clackamas Community College; Nora Karena, Unaffiliated; Alexandra Olsen, Umpqua Community College; and Terese Jones, Linn-Benton Community College, all contributed significantly to the foundations and writing of this textbook.

Openly Licensed Works

This new textbook benefitted from several other openly licensed works, and we would like to acknowledge them here.

Scholars from the School of Social Welfare at the University of Kansas

Scholars Kelichi Wright, MEd, LCPC, LPC; Kortney A. Carr, LCSW, LSCSW; and Becci A. Akin, PhD, all associated with the School of Social Welfare at the University of Kansas, wrote an article for the openly licensed peer-reviewed journal **Advances in Social Work**. Their seminal work "**The Whitewashing of Social Work History: How Dismantling Racism in Social Work Education Begins With an Equitable History of the Profession**" was published in 2021. Adapting their work is just the beginning. In future editions of this textbook, we will strive to more fully incorporate our understanding of how whitewashing currently affects the human services profession.

Social Work & Social Welfare: Modern Practice in a Diverse World

Authors Mick Cullen, LCSW, CADC, MA, professor and chair of the social work/human services department at College of Lake County in Grayslake, Illinois, and Matthew Cullen, LICSW, LCSW, M.Ed., a counselor at Green River College in Auburn, Washington recently updated their text.

Ferris State University Department of Social Work

Ferris State University created an openly licensed text, *Introduction to Social Work at Ferris State University* in 2017.

From Dr. Jessica Gladden: "This book was written by MSW students as their final project for their Capstone class. Students were each assigned a chapter of the book to write to show that they had achieved competency as a Master's level social worker. Chapters were assigned based on student interest and experience in certain areas of the

field." In addition, Ferris State had a team of editors: Dr. Jessica Gladden, Professor Danette Crozier, Dr. Kathryn Woods, Dr. Janet Vizina-Roubal, and Professor Michael Berghoef.

DePaul University

Leonard A. Jason, Olya Glantsman, Jack F. O'Brien, and Kaitlyn N. Ramian are the lead authors of *The Introduction to Community Psychology* text. Individual contributing authors are credited for their work in their work used in this text.

Saylor Academy

Saylor Academy is a nonprofit initiative that has been working since 2008 to offer free and open online courses to all who want to learn. The authors of the text *Social Problems: Continuity and Change* are anonymous.

Publisher's Message to Instructors

This book is published by Open Oregon Educational Resources. It is part of our Targeted Pathways project, which used statewide data to target disciplines and courses in which to develop high-quality, openly licensed materials with an equity lens.

Targeted Pathways textbooks were developed in partnership with **Chemeketa Press**, which offers training in textbook development best practices and coaching to faculty authors. Chemeketa Press is the academic publishing arm of Chemeketa Community College in Salem, Oregon.

The contents of this book were partially developed under a grant from the Governor's Emergency Education Relief fund and a grant from the Fund for the Improvement of Postsecondary Education, (FIPSE), U.S. Department of Education. However, those contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the Federal Government. It is also supported by funding from Oregon's Higher Education Coordinating Commission.

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Instructor Resources

Author Message to Instructors

As the proud daughter of Native Mexican immigrants, and being one myself, this unique perspective has significantly influenced not only how I perceive the world but also the education system and access to it. This personal connection means that, as educators, we reach different students, and I kept that in mind when writing this book. My personal experiences have shaped my understanding of what would have supported my educational journey, how I could have been engaged differently, and who was not represented in books. These insights have led me to see myself not just as part of oppressed communities in history but also as part of powerful communities that created and uplifted whole societies throughout history.

This won't be the first or the last textbook you'll encounter. However, I hope this book encourages you to contemplate the numerous textbooks used in education, many of which may have contained historical inaccuracies or perpetuated harmful racist stereotypes – an experience I've personally encountered. Therefore, I intentionally prioritized diversity, equity, inclusion, and justice in this book, using them as the guiding principles for my writing. I highlight some lesser-known historical figures and groups and clear up some misunderstandings and misinformation that have been widely accepted as fact for many because only a few people from marginalized communities have had the opportunity to have their voices have platforms such as these uplifted. Yet, here I am with this opportunity I never thought I would have. I am trying to amplify the voices of diverse communities. In contrast, giving tools that can be used by students and educators alike, not just in learning settings, but being able to transfer those tools to community work, practicum settings, or internship work is essential. Some of these tools ranged from tools to examine bias in the media to a skills assessment that helps guide conversations around recommended skills for human services providers and how, both as educators and as providers in the field, we can encourage skill building for students starting from inside the classroom and encourage that natural skills that many of them have.

It's important to note that I, like many of us, am not exempt from faults or errors. However, my journey continues to be influenced by the same systems I strive to change, which is a testament to the potential for change. It's crucial to start somewhere. This marks the beginning of a transformation in how we approach textbooks and the authors we recognize for their contributions. I wanted this textbook to be different from those I used as a student, the ones I read myself as an educator trying to find something more accurate for my courses with more engaging content and resources that were more relevant to the current day and age and that had historically accurate information but could find nothing that met all of those points, especially at a price point that was accessible to students.

We need books to evolve with us and authors who are practitioners and as diverse as the communities we serve, which needs to be added to what is currently available. The urgency and importance of this evolution cannot be overstated. Sharing current resources in the field and parts of myself will encourage others to be educators and challenge the status quo. Your role in this transformation is crucial. Your

actions, voice, and commitment to diversity, inclusion, equity, justice, and education reform will drive this change forward and even move toward decolonizing education altogether.

Integrated Openly Licensed Course Materials

This book includes openly licensed course materials that fully integrate with the open textbook. Anyone can retain, revise, remix, reuse, and redistribute them. Best of all, future instructors can build on existing learning pathways that are aligned with textbook and chapter learning outcomes.

You can access openly licensed course materials in two ways:

- **Introduction to Human Services Instructor Course Packs**: A collection of aligned and accessible course materials shared by pilot instructors teaching at multiple Oregon institutions. Instructors designed each course pack with an equity lens in consultation with an instructional designer. In most cases, each course pack was revised with feedback from Oregon students and an advisory board of workforce members. Each course pack includes a complete course map, an instructor guide, and ancillary materials including weekly assignment prompts, rubrics, and suggested activities.
- **Intro to Human Services OER Commons Group**: An ongoing repository of instructor-created course materials that integrate with the open textbook. Materials may include syllabi, assessments and assignments, lesson plans, activities, and entire course shells. Please note: not all OERC resources are reviewed for digital accessibility.

You are welcome to contribute your own openly licensed course materials that align with this textbook to the OERCommons Group. Thank you for building a more inclusive future for students and future educators!

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Manuscript Development Process

This book went through an extensive pre-production process before it was launched in order to be accountable to the project's equity lens; revise drafts for quality; and incorporate feedback from scholars, practitioners, and students in the discipline.

Outline peer reviewers

- Tasha Galardi, Oregon State University
- Andrew Garland-Forshee, Portland Community College
- Sally Guyer, Portland Community College
- Alexander Jardon, Umpqua Community College
- Martha Ochoa-Leyva, Portland Community College
- Lisa Wormley, Central Oregon Community College

Manuscript peer reviewers

- Tasha Galardi, Oregon State University
- Andrew Garland-Forshee, Portland Community College
- Katelynn Jarrells, Brightpoint Community College
- Scott Nolan, Bristol Community College

Workforce advisory board members

- Melissa Cannon, Western Oregon University
- Ryan Catarius, ABC House Trauma Counseling Program
- Rudyane Rivera-Lindstrom, Oregon Higher Education Coordinating Commission

Pilot Instructors

- Andrew Garland-Forshee, Portland Community College
- Denise Hughes-Tafen, Linn-Benton Community College
- Sonya James, Linn-Benton Community College
- Heather Leonard, University of Oregon
- Alexandra Olsen, Umpqua Community College
- Yvonne Smith, Clackamas Community College

Open Oregon Educational Resources

- Phoebe Daurio, Program Manager, Open Oregon Educational Resources
- Erin Wells, Grant Project Manager, Open Oregon Educational Resources
- Michelle Culley, Grant Project Manager and Instructional Designer, Open Oregon Educational Resources
- Melissa Williams, Interim Grant Project Manager, Linn-Benton Community College
- Stephanie Hubbard, Program Assistant, Open Oregon Educational Resources
- McKenzie Gentry, Program Assistant, Open Oregon Educational Resources
- Taylor Wynia, Program Assistant, Open Oregon Educational Resources
- Jennifer Gardner, Program Assistant, Open Oregon Educational Resources
- Beth Lyons, Interim Program Assistant, Linn-Benton Community College
- Veronica Vold, Open Education Instructional Designer, Open Oregon Educational Resources
- Amy Hofer, Statewide Open Education Program Director, Open Oregon Educational Resources
- Abbey Gaterud, Director, Chemeketa Press
- Stephanie Lenox, Instructional Editor, Chemeketa Press
- Melinda Crouchley, Publishing Assistant, Chemeketa Press
- Elizabeth Pearce, Human Studies/Family Development Lead
- Heather Blicher, Equity Consultant and Instructional Designer
- Valencia Scott, Equity Consultant
- Jen Awwad, Instructional Designer
- Kirsten Hostetler, Instructional Designer
- Colin Stapp, Instructional Designer
- Casey Twining, Instructional Designer
- Jessica George, Instructional Designer
- Michaela Willi Hooper, Research Consultant and Multimedia Developer
- Jonathan Poritz, Instructional Technologist
- Matt DeCarlo, OER Development Consultant
- Chandra Lewis, Senior Research Associate, RMC Research Corporation
- Ben Skillman, Research Associate, RMC Research Corporation
- Debbie Berne, Book and Theme Design
- Lisa Berman, Cover Design
- Petra Bitterli-Stoschitzky, Pressbooks Theme Developer, Von Gunten & Co. AG

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Additional Resources

Google Doc Version of This Book

Link to view-only Google Doc version of this book – make a copy to start editing! **Introduction to Human Services: An Equity Lens 2e**

Note: minor post-production changes might not be reflected in the Google Doc. Check the web book for the most current version of this textbook.

Detailed Outline

The following detailed outline lists the sequence of topics and sub-topics covered in each chapter. We hope that reviewing this sequence will help future educators who may wish to adapt parts of the textbook for a specific course or project. Please note that the Pressbooks Table of Contents offers a high-level outline of this sequence, whereas this detailed outline shows each subtopic. Content can also be located by keyword by searching this book (upper right).

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