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Social Functioning: A Sociological Common Base for Social Work Practice

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This article describes the experience of a social work mental health agency with Social Role Theory (SRT), that is an organizing concept for the delivery of its assessment and treatment program. SRT has been called the process variable of the program, meaning how services are delivered. Social functioning, a concept taken from SRT, is a treatment outcome. The overall purposes of the article are to describe the contribution of sociology to social work practice, and to advance the argument that social functioning is a common base for social work practice generally.

Keywords: *social functioning; sociology; social work practice*

Introduction

The purpose of this article is twofold: to describe the contribution of sociology to social work practice, and to renew the argument for social functioning as a common base for social work practice as proposed by Bartlett (1970). The social work program referenced herein, for which social functioning is a treatment outcome, is titled Community Treatment and Rehabilitation (CT&R) (Blakely & Dziadosz, 2003).

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Sociology, Social Role Theory, and Social Work

Social Role Theory (SRT) has a history in the literature of sociology similar to that of social functioning in social work practice. Social functioning, a concept in SRT, has enabled CT&R clinicians to focus on the here and now of a client's social role behaviors in social positions, with a view toward changing behavior to a normative status that produces acceptance and/or positive feedback from observers. The results have been an increase in a client's self-esteem, and the psychiatric condition not being a major factor in how the client lives her/his life.

The social science of sociology has made a significant contribution to social work practice. The application of Social Role Theory (SRT) from sociology, and the major concept of social functioning taken from that theory, may further the significance of these contributions to social work practice. Social Role Theory is the process variable for CT&R, meaning that it is the theory base for the delivery of a program that leads to adaptation and social functioning. Adaptation is defined as successful management of the symptoms of the psychiatric condition and appropriate responses to the expectations of others in the social environment. Social functioning is defined as normative behavior in a social situation. The designation of behaviors that are characteristic of adaptation or appropriate social functioning are not imposed on clients by clinicians. Rather, clinical interventions are designed to help clients discover these behaviors for themselves.

Literature Review

It is recognized that CT&R may not be the only program for which SRT and social functioning are employed. However, an Internet search did not produce any results that indicated other agencies are using SRT as an organizing principle for an assessment and treatment program. Social Role Theory is the title of a section in Turner (1996) but it mainly concerned social positions and social role behaviors as major concepts with no reference to adaptation and social functioning. Other theories were described such as psycho-dynamic, ecological, problem solving, feminist, psychoanalytic, object relations, strengths based, and psychosocial, although these were viewed as

approaches to assessment and treatment and not as organizing principles. No information was located about the use of adaptation or social functioning as major concepts for a program. A strengths-based approach and psychosocial theory share some characteristics similar to the way SRT has been used in CT&R. Turner's work on psychosocial therapy (1978) has content theoretically related to our application of SRT.

The particular way the concepts of adaptation and social functioning have been used within CT&R may be of interest to administrators and planners at other social work agencies as their use in CT&R has been successful in helping persons with a psychiatric condition achieve a measure of recovery.

An article by Cornell (2006) that traced the theory of the person-in-situation paradigm and pointed to new directions for social work practice is helpful in clarifying the use of SRT in CT&R. She identified Jane Addams and Mary Richmond, early leaders in the development of social work as a profession, as proposing the dual focus of the person and the environment as a major social work practice concept.

Environment as a factor was diminished by the introduction of Freud's psychoanalytic theory. Hamilton (1951), a major contributor to social work literature, aligned with the diagnostic school of practice at first but later reaffirmed the significance of the environment. She was the first to use the phrase "person-in-situation" (p. 3), an idea that fits nicely with the way SRT has been implemented in CT&R as successful adaptation and positive social functioning may be achieved through finding the best "fit" between the person and the environment.

Three branches of sociology and the views of each on social role theory are considered for CT&R: functional and structural functional, symbolic interaction, and social cognitive (Biddle, 1986). Functionalists view roles as behavioral expectations placed on individuals by the society in which they live. People are socialized into its basic values and norms and know by unspoken consensus the distinction between appropriate and inappropriate behaviors for various roles. Structural functionalism places emphasis on social structures as meeting the basic needs of the society. Interactions among these structures constrain individual response and social role behaviors. The similarity in the functionalist and structural functionalist views

has brought most sociologists to refer to themselves simply as functionalists (Wallace & Wolf, 1999).

Parsons (1951), a leading functionalist, viewed status and role as structural elements of the social system. Status, or social position, is considered a structure in the system and role behaviors are what the individual does in a position.

Symbolic interaction is a different view of role behavior. Rather than being socialized into a set of shared values and norms, the view is that role behavior is a response to interactions with others thereby contributing to the construction of the social world rather than being formed by it (Blumer, 1969). Symbolic interaction theory proposes that a person's view of her/himself is based on observations of others. "People see themselves through the eyes of others" (Cook & Douglas, 1998). It follows that social role behavior in social positions is a response to others' expectations.

Long ago Cooley (1922), a major contributor to symbolic interaction theory, developed his "looking glass self" through the observation that individuals behave in response to other's expectations. CT&R clinicians try to impart this concept to clients by helping them become aware of the behavior expectations of others, and how normative behavior that conforms to those expectations contributes to internalizing a more positive self that reinforces further normative behavior.

George Herbert Mead (1934), another contributor to symbolic interaction theory, viewed the person of the self as an "I" and a "me." The "I" is the active part of the person, a response to the attitudes of others. The "me" is the attitudes of others incorporated into the self that gives direction to the behavior of the "I." The "I" is the novel answer to the attitudes of others. The "I" and the "me" constitute the personality in social experience.

This thinking has a direct impact on the concepts of adaptation and social functioning. The "me" of the self is the sum of the incorporated attitudes of others as perceived in social intercourse. This is the core of successful adaptation. The "I" acts out social role behaviors on the basis of the adaptation which, when successful, leads to positive social functioning that is incorporated into the "me" that becomes the foundation for additional behaviors of the "I." This forms a positive

feedback loop that strengthens adaptation and positive social functioning.

The continued training of the CT&R clinicians will incorporate this thinking as it is a summation of the clinical experience, especially in the context of transference, as the clinician is very responsible for the interpretation of social reality to clients who have a serious psychiatric condition.

Lundgren's (2004) review of research on the association between the judgments of others and the self-appraisal of individuals, and the expression or rejection of feedback, suggested that knowledge of relationships and the emotions of the participants in the interaction also are important variables in the analysis of role behaviors. The significance of the relationship between the clinician and the client is continuously emphasized during clinical training and supervision.

Bandura (1986) contributed significantly to social cognitive theory. He thought that people are proactive in their behaviors rather than reactive, proposing that social functioning depends on individuals interpreting the results of their behaviors and altering them to fit the interpretation.

Functionalism, symbolic interaction, and social cognitive theory contributed to CT&R. The synthesis of the functional view that people are socialized into the values and norms of a society with the views of symbolic interaction theory and social cognitive theory was helpful in gaining a better understanding of the adaptation and social functioning patterns of clients and in formulating interventions.

Individuals have many social positions, or statuses, with accompanying norms for associated social role behaviors. Thomas and Feldman (1964) defined position or status as a category of individuals, and role as a set of expectations about how the rights and duties of a position should be carried out. People acculturated in the same culture learn the social role behavior expectations of most social positions and understand the rules and norms that govern these behaviors. It is on this basis that people notice non-normative behaviors and often react negatively to them, such as is the case with some people who have a psychiatric condition. CT&R clinicians are expected to help clients understand this idea so the clients' adaptation to the challenges of the psychiatric condition, and the

expectations of others, can be increased. Improving adaptation leads to improving social functioning.

Social functioning is generally considered to be a subset of social role theory. It also is a social work practice concept. Boehm (1958) first proposed social functioning as a central focus for social work practice, viewing it in terms of role performance. Bartlett (1970) furthered the proposal. She viewed social functioning as having an overarching concern in all social work fields and methods as well as agency service systems. She pointed out that most social workers would emphasize two central ideas if asked to describe their profession: "1) it is a helping profession and, 2) it is concerned with the social functioning of people" (p. 86). This view is a central point in advancing the argument that social functioning is a common base for social work practice. Hollis (1972) recommended more focus on the "social" in the psychosocial paradigm. These significant contributions to social work have remained constant throughout the history of the profession.

Hyundi (1976) described social functioning as a contemporary application of social role theory. Newbrough (1976) defined social functioning as "the ability of a person to do what is appropriate in any social setting" (p. 19). These ideas were used in the agency's definition of social functioning as normative behavior in a social situation.

The National Association of Social Workers (NASW) Commission on Practice (1958) included in the "Working Definition of Practice" that the social work method is carried out through the relationship with a client that facilitates change in the reciprocal relationship of the client to the environment. This also is social functioning. NASW (1973) defined social work as "the professional activity of helping individuals, groups, or communities to enhance or restore their capacity for social functioning and to create societal conditions favorable to these goals." These references underscore the designation of social functioning as an outcome for a social agency's service delivery system, and also underscore the link between sociology and social work practice. The practice definition infers the concept of social functioning while the definition of social work states it directly.

Davis' (1996) ideas, presented in a major social work text

(Turner, 1996), were part of the beginning training of agency clinicians in the application of Social Role Theory. Davis discussed achieved and ascribed social positions and the social role behaviors related to these positions. The distinction between social position and social role as a set of behaviors associated with a position has been essential to the definition of normative social functioning as an outcome of CT&R.

The assessment of social functioning has become a significant feature of the Diagnostic and Statistical Manual (2000). Axis V, the Global Assessment of Functioning (GAF) Scale, requires clinicians to rate the level of social functioning of mental health clients. The DSM IV has significantly broadened the consideration of social functioning as a variable in social work and other helping professions. This implies a strong supportive link with sociology as a theory base for clinical assessment and diagnosis.

Bartlett's (1970) ideas have contributed significantly to the development of CT&R in which adaptation is defined as managing the psychiatric condition and social functioning is defined as normative behavior in social situations. She identified "coping" as a "relative mastery of tasks," and "task" as a response to a life situation (p. 96). Helping clients with adaptation to inner impulses and instincts and to the demands of the environment is coping. The client's achievement of treatment objectives demonstrates mastery of a task that also is appropriate social functioning.

The combination of the words social and functioning suggests a meaning of the words as successfully carrying out social role behaviors related to individual desired or preferred social positions.

Clinician Training

Initially, CT&R clinicians were trained on Social Role Theory with a focus on social positions and related social roles. This turned out to be too abstract and not sufficiently related to the social position in our society of mental patient and the general negative perception of this social position and related social role behaviors.

The training is being modified. There is a shift from a

principal focus on social positions and social role behaviors to adaptation and social functioning. The expected outcome is that clients will change social role behaviors from non-normative, characteristic of the social position of mental patient, to normative social role behaviors characteristic of positive social positions. It is important for clinicians to develop and implement an integrated knowledge base of the functional, symbolic interaction, and social cognitive theories that concern social positions and social roles. They can then help clients to gain self-awareness about learned behavioral responses and modify them so adaptation and social functioning are improved.

Recovery is conceptualized as achieving a level of adaptation and social functioning at which the psychiatric condition is not a major factor in how a client lives. This conceptualization has a base in sociology as it involves clients adapting to the psychiatric condition in a way that observers see more normative social role behaviors that are less disruptive to social intercourse.

The Social Role Theory approach with clients who are long-term chronically ill and stabilized at a lower level of social functioning is sometimes not as successful. However, the focus on behavior change to achieve adaptation and social functioning is one that lends itself to suggestion and direction about appropriate and/or inappropriate social role behaviors. This often is more successful considering the cognitive deficits of chronic mental illness. It also is easy to teach to both clients and clinicians.

Improvements in psychotropic medications have helped many clients by diminishing symptoms and clarifying thinking so that through the clinical relationship clients can learn normative behaviors and deal more effectively with the psychiatric condition and its social consequences. Helping clients understand that they are persons who have a psychiatric condition and are not "mental patients" helps them gain an awareness of controlling non-normative behaviors. Normative social role behaviors in their various social positions produces more positive acceptance and feedback from others that reinforces appropriate role behaviors and restores self-esteem.

The integrated social role theory training clinicians receive is that social role behaviors relate to the values and norms

of the society, the observations of others, and the accurate interpretation of the effects of behaviors on others. Agency clinical staff use this knowledge in developing interventions that assist clients with improving adaptation and social functioning. Meeting the behavioral expectations of others helps clients to live more comfortably within the system of their interpersonal relationships. This also is consonant with the agency's definition of social functioning.

Social Role Theory and Client Assessment and Treatment

CT&R, as an assessment and treatment program, is concerned with persons whose adaptation and normative social functioning are affected by a serious psychiatric condition. The Psychosocial Assessment of each client, using Social Role Theory, is based on the strengths and weaknesses in the client's adaptation and social functioning in designated social role behaviors. The strengths are used to encourage the client's change in behaviors and the weaknesses become targets for behavioral change. The latter are incorporated into an Achievement Plan that is a guide for treatment that includes a behavioral objective, necessary behavior changes, and client and clinician tasks. Examples of this process may be clarifying.

Therese has a diagnosis of schizoaffective disorder. She is a 37-year-old, single mother of one child, who works with her fiancée in home maintenance repair. Her stepsister is the guardian for her son. Adaptation to her psychiatric condition is difficult as she is ashamed about it, ruminates on it, and blames ineffective behaviors on it. She is easily stressed, decompensates as a result, and her social functioning deteriorates. Her strengths are her relationship with her son and her stepsister. She accepts her mother's disability as age-related and frequently visits her in a nursing home. Since her stepsister became her son's guardian, she has been relieved of the stress of providing for her son. She accepts her psychiatric condition and is medication compliant. Her stability has increased with her new relationship with her fiancée and sharing in his business. Her weaknesses are a negative sense of self, periodic instability related to a lack of understanding of the symptoms

of her psychiatric condition, and ineffective coping strategies when symptoms interfere with her social functioning.

Therese's treatment and rehabilitation objective is to form stable relationships that are personally valued and advance social functioning. Targets for behavioral change are to develop a more positive and assertive sense of self, take steps to recognize symptoms and how they affect her relationships, and to continue to develop ways of coping with her symptoms so her social functioning improves. Therese is meeting regularly with her clinician and has made progress in achieving these targets. She also is meeting with her psychiatrist regarding medication to improve the level of her adaptation.

Gail has a diagnosis of bipolar disorder with hypomanic episodes. She is a 54-year-old, single, female. Her developmental history was difficult. For example, she was psychologically abused by her parents who punished her for inappropriate behavior by abandoning her in some woods in the country. She also was taunted once by classmates who threw burrs at her during a class field trip. She experienced her first psychiatric breakdown at age 18 and has been hospitalized several times since.

Her strengths are loyalty and support for her parents and her friends, successful management of her anxiousness, positive social interaction, and friendship with her sister, acceptance of her psychiatric condition, and medication compliance. Her weaknesses are low self-esteem, fear of abandonment by her parents, rumination about their death, feelings of disapproval by others, a history of self-harm, and apprehension about her sister's real feelings about her.

Her treatment and rehabilitation objective is to utilize her free time in ways that are personally valued and advance social functioning. Her targets for behavioral change are to develop a greater sense of self-esteem based on real accomplishments, to recognize patterns of behavior that tend to exacerbate symptoms, to gain further understanding of her psychiatric condition and healthier coping mechanisms for managing symptoms, and to seek volunteer activities through the agency's club house program. Gail has kept regular appointments with her clinician and has made excellent progress toward achieving her behavior change targets and her treatment and

rehabilitation objective.

Outcome Measurement

Outcome measurement of social functioning, as related to the achievement of targets for behavioral change and reaching a state of psychiatric well-being, occurs with every client. A state of psychiatric well-being exists when the client has met the treatment and rehabilitation objectives. This pre-established list of 21 objectives also forms a measuring instrument called the Psychiatric Well-Being scale (PWB). (See Appendix A for examples of PWB scale items.)

Treatment and rehabilitation objectives are selected from the established list and included in an Achievement Plan (AP) that is a guide for treatment. The selection of an objective is based on the client's statement of a personally valued outcome and the clinician's judgment about which objective will most likely lead to a state of psychiatric well being. At the beginning of the treatment program the clinician also rates the client's ability to perform the behavior of the objective on a one to seven scale, with seven high. There is a rating scale that is specific and integral to each item. The rating on each item measures an extent to which the psychiatric condition affects social functioning.

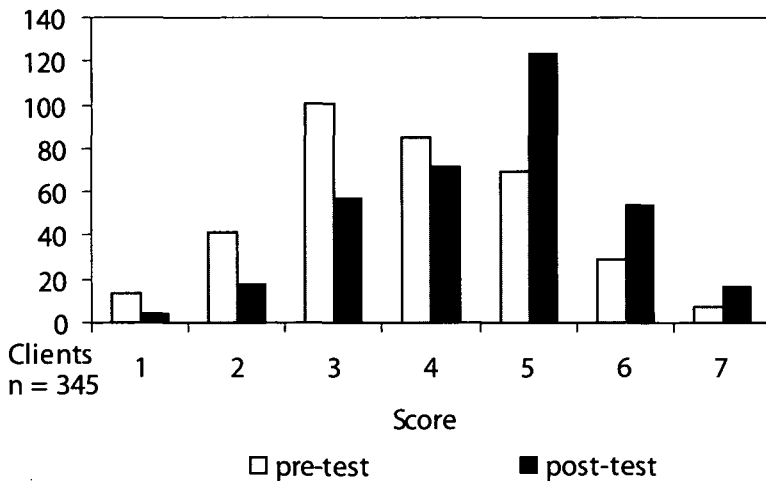
Continued ratings occur at reviews of the AP. The differences in ratings indicate the level of improvement in the behavior of an objective. These numbers are accumulated and used to evaluate the client's progress, the clinician's performance, the performance of a treatment team, and the overall quality of the agency's service delivery.

Table 1 contains an example of the rating results of clinicians' pre- and post-test rating for all the clients of a single team of clinicians for the sixth treatment and rehabilitation objective on the list. This objective appears in the Appendix. Similar data are collected for all treatment and rehabilitation objectives and may be broken down to reflect the performance of a single clinician, a team, or the total agency as an evaluation of service delivery.

The rating scores of the 21 scale items for a group of 386 clients also were totaled. The average score improved by 7.8%

over a three month period, from an average of 108.6 to 117.0 ($p < .001$). These data support the existence of improvement for the entire client group over the period of the measurement. The differences between the pre- and post-test scores are not large numerically but all the clients have a serious psychiatric condition so even a small positive incremental change is significant.

Figure 1. Pre-Post Frequency of Clients for Scale 6



A Critical Issue

There is a critical social issue that relates to the social position of mental patient. Eligibility rules to obtain and continue treatment set by the mental health system frequently require people in this position to be disabled. For example, in order to afford medication that is necessary in maintaining Psychiatric Well Being, positive social functioning, or recovery, as outcomes of CT&R, a client usually will be required to maintain eligibility to receive Medicaid. This eligibility requires the client to be both poor and disabled. This means recovery from a serious psychiatric condition, in the sense of a normative life style including employment, family, home ownership, etc. may be thwarted just because of a policy decision.

If a person were to recover sufficiently to maintain employment or otherwise obtain enough resources to be ineligible for Medicaid, it could mean that mental health services, especially medication and short-term counseling that are important in recovery, might no longer be available. This is a critical issue as most serious psychiatric conditions are chronic and may require medication and some psychosocial services for a lifetime. Changes in some mental health policies have to be made if real recovery is to be sustainable.

The potential for recovery will increase for those clients who achieve normative social functioning and escape the social position of mental patient. This is the primary reason for establishing social functioning as an organizing concept for Community Treatment and Rehabilitation.

Conclusion

Evidence of the contribution of sociology theory to social work practice, particularly social role and social functioning, at one mental health agency has been described. Social role theory has been an organizing concept, and social functioning an operational variable, for Community Treatment and Rehabilitation (CT&R). Focusing on adaptation and social functioning to achieve normative social role behavior has been helpful to persons with a serious psychiatric condition in achieving a level of recovery, meaning that the condition is not a major factor in clients' lives.

This combination of sociological concepts has contributed to the development of a clinically cohesive organization of the social work assessment and treatment program. It has provided structure for the agency's service delivery system. It also has become a shared set of concepts about clinical services that clinicians are able to use to communicate with each other about how to improve the delivery system. It also has been a helpful construct in generating a measurement of effectiveness, in the performance evaluation of clinicians and teams, and in determining program deficits and successes.

It also is on the basis of these factors that the administrative staff of this one agency concurs with Bartlett that social functioning, as a concept in Social Role Theory, is a good candidate for the selection of a common base for social work practice.

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Appendix A

There are 21 items in this list of treatment and rehabilitation objectives. Objectives are selected serially for each Achievement Plan. The clinician rates the client's level of performance of the objective using the numbered scale of each at the beginning of the implementation of the Achievement Plan and at each of the Plan's reviews.

Examples of Scale Items

1. *Symptoms are at a level that does not affect social functioning.*

A person with a serious mental illness is not likely to be totally symptom free all of the time. What is important is that symptoms interfere as little as possible with a person's life. Whether symptoms have an impact may vary considerably from person to person. Some people may have what some would consider serious and ongoing symptoms but are little bothered by them. Others may have nearly no tolerance for symptoms. This means that interventions intended to increase tolerance of symptoms may be as effective as those intended to directly reduce symptoms. This scale is meant to assess the

impact of symptoms, not the symptoms themselves.

- 1) Symptoms interfere to the extent that they are the dominant feature and determinant in the client's life.
- 2) Symptoms interfere with social functioning on an ongoing and significant basis. This is serious but not debilitating.
- 3) Symptoms interfere with desired social functioning; interference may be episodic and serious or ongoing and moderate, requiring intervention at the time in either case.
- 4) Symptoms sometimes interfere with desired social functioning. Interference is episodic and moderate or ongoing and tolerable but unpleasant. Additional intervention may be indicated with episodic occurrence.
- 5) Symptoms occasionally interfere with desired social functioning and the interference is either episodic at widely spaced intervals or ongoing but well tolerated.
- 6) Symptoms' interference with desired social functioning and other aspects of a person's life are exceptional events of short duration not requiring additional intervention.
- 7) Symptoms never interfere with desired social functioning or other aspects of a person's life.

2. The frequency and duration of periods of symptom exacerbation are at a level that does not affect social functioning.

Relapse and remission are typical of a serious, chronic illness and are to be expected with a mental illness as well. Symptom exacerbation may occur for a variety of reasons some of which may become known and anticipated, and some of which may remain unknown. Symptom exacerbation may sometimes be cyclical, and so may be predictable even if the cause remains unknown. The objective is to minimize the occurrence of relapses that interfere with functioning that is related to a desired social position.

- 1) Symptoms return regularly and frequently and seriously limit social functioning.
- 2) Symptoms return regularly, possibly frequently, and always at least moderately affect social functioning when they do recur. Symptoms have a debilitating

impact less than half the time.

3) Symptoms return periodically, they may be frequent, but they usually have only a small impact on functioning. Debilitating symptoms are infrequent.

4) Symptoms return sometimes. They are not regular or frequent, and when they occur they almost always have only a minimal impact on social functioning. Debilitating symptoms are rare.

5) Symptoms return sometimes, but when they do they almost always have little or no impact on social functioning. Occasionally they will have a moderate impact.

6) Symptoms may reoccur but they never have more than a minimal impact on social functioning

7) Symptom exacerbation has no impact on social functioning.

6. Recognizes stressors that affect symptoms and responds in a manner that advances social functioning.

A client who understands how stressors may increase symptoms, and who also knows what type of events or situations have that effect, can learn to proactively manage his or her illness by avoiding stressors, preparing for them ahead of time, or being prepared if a stressor takes him or her off guard. This scale is not a measure of the frequency or severity of stressors. It is intended to measure the client's management of his or her environment and response to it so as to effectively manage the illness.

1) The client sees no relationship between psychosocial stressors and the development of symptoms.

2) The client has some recognition that psychosocial stressors may increase symptoms but takes no action to do anything to either minimize stressors or learn adaptive strategies. This inaction may be for a variety of reasons including hopelessness, resistance, or powerlessness over the situation.

3) The client generally understands that there are some things that can make his or her discomfort or symptoms worse and is interested in learning what to do about it. He or she does not usually anticipate a problem, but will, sometimes, attempt to use adaptive skills when stress does occur.

- 4) The client generally knows what situations or events can exacerbate symptoms. He or she has willingly learned adaptive strategies. He or she will sometimes anticipate stressors and will either avoid them or make an effort to prepare an adaptive strategy. More often than not, he or she will use adaptive strategies when stressed.
- 5) The client knows the stressors that exacerbate symptoms and usually recognizes them when they occur. He or she will usually anticipate a stressor and either avoid it or will actively work to prepare an adaptive strategy. He or she will routinely use adaptive skills when stressed.
- 6) The client knows the stressors that exacerbate symptoms and what to do about them. He or she usually will successfully minimize stressors or their impact and uses adaptive strategies when stressors do occur.
- 7) The client knows the stressors that exacerbate symptoms and what to do about them. He or she successfully minimizes stressors and routinely and effectively uses adaptive strategies with the stressors that do occur.