



## CHAPTER 1

# A Multidimensional Approach

### AIMS OF THIS CHAPTER

This chapter examines the core aspects of a multidimensional approach. It considers the following questions:

- » What are the major dimensions within a multidimensional approach?
- » How does a multidimensional approach help in understanding the individual, their contexts, time, experiences and adaptive capacities?
- » What are risk, protective and resilience factors?
- » What are the theory and practice implications of a multidimensional approach for workers in the human services?
- » How do we engage in reflective and reflexive practice?

Stress, trauma and grief are common experiences for people all around the world. Threats and acts of terrorism and war occur, affecting the lives of millions of people. Millions of others live without adequate nutrition, medical care, housing or employment. Communities are threatened by natural disasters such as floods, fires and droughts. In the privacy of homes, family violence and the maltreatment of children continue to occur. Relationships end as a result of disagreement, disappearance or death. Illnesses, accidents and injuries leave many with physical and emotional wounds. Unemployment and poverty lead to daily stress and worry. As individuals, families, groups and communities, we inevitably experience a wide variety of events and conditions across the course of our life. These events and conditions are experienced in the context of our unique developmental trajectories. We adapt to these experiences in many different ways.

Social workers, along with educators, welfare workers, psychologists and other health professionals are concerned ultimately with influencing environments, relationships and inner experiences so that they are supportive of human growth, health and satisfaction (Germain & Gitterman 1995 p. 5). Human services exist in recognition of the fact that there are devastating consequences for individuals, families and communities if certain conditions and experiences are encountered and if adequate resources and supports are not in place. To this end, social workers need a framework for understanding human development and well-being, and the impact of adversity, in context. This includes finding ways of bringing together a wide range of knowledge about what it is to be human and what are the various impacts of key experiences, conditions and resources.

Over time, many forces have shaped understandings of human development. While understandings shift, often quite significantly, as a result of political, economic, religious, psychological, biological, legal or cultural forces, it is important that the search continues for deeper and more accurate understandings of what it is to experience and cope with adversity in different contexts. In highlighting the diversity and uniqueness of individual experience, postmodernism has left us thinking that we cannot assume any experiences are common to all individuals. The ‘truths’ of previous eras have been thoroughly questioned (Trainor 2002). While the uniqueness of individual experience must be acknowledged, such deconstructed perspectives have the potential to leave us with few grounds for understanding risk and resilience or for acting in the interests of vulnerable and marginalised groups—for example, children who have been abused or neglected. This book explores the many understandings we have of individual responses to adversity and brings them together through a **multidimensional approach** to understanding human development across the **life course**. Social workers in the Australian context have traditionally used Western theoretical perspectives to understand well-being, often privileging concepts of the individual and their independence. Recognising the limitations of these perspectives, a multidimensional approach offers a way of integrating culturally diverse ways of viewing well-being.

## A multidimensional approach

For many years, ecological or ecosystemic theories informed much of the theoretical basis of social work. They gave the **biopsychosocial dimensions** prominence in proposing that individual and environmental influences were inseparable from each other, forming a system of interaction. More recently, a multidimensional approach has emerged as an overarching perspective of human behaviour and development (Hutchison 2003), which offers a holistic approach to understanding well-being but

is not as tightly aligned with systems theory. In Chapter 14 (p. 402) we look at some of the reasons why a multidimensional approach, rather than ecological theory, is used in this book.

Within a multidimensional approach, each person is recognised as having unique biopsychosocial and spiritual dimensions (Germain & Bloom 1999; Hutchison 2003) as well as structural and **cultural dimensions**. The term **biopsychosocial-spiritual dimensions** is used to reflect the idea that an individual occupies more than any one dimension at any time—experience is continuously and simultaneously influenced by individual (biological, psychological, and spiritual) and environmental (social, including structural and cultural) factors. The interdependence of these dimensions is considered so fundamental in determining our lived experience that ecological theorists, such as Germain (1991), use the term, **person:environment configuration** or person:situation configuration.

Another way of thinking about these dimensions is to think of the **inner world** we occupy. This typically refers to our biological, psychological and spiritual experiences—which both influence and are influenced by the **outer world** we occupy—the relational, social, structural and cultural contexts. By referring to them as inner and outer worlds, the intention is not to see them as two different dimensions. Rather, they are interrelated and fluid in their reciprocal interactions, as this chapter will describe. Dividing aspects into inner and outer dimensions, or into personal and environmental dimensions, can therefore be inherently problematic, as any dimension is necessarily *both* an inner and an outer world dimension. However, for the purposes of discussion, the contrived separation of these dimensions needs to be maintained at first to enable the exploration of the significance and interrelationship of each to the other, before bringing them together to fully understand a multidimensional approach.

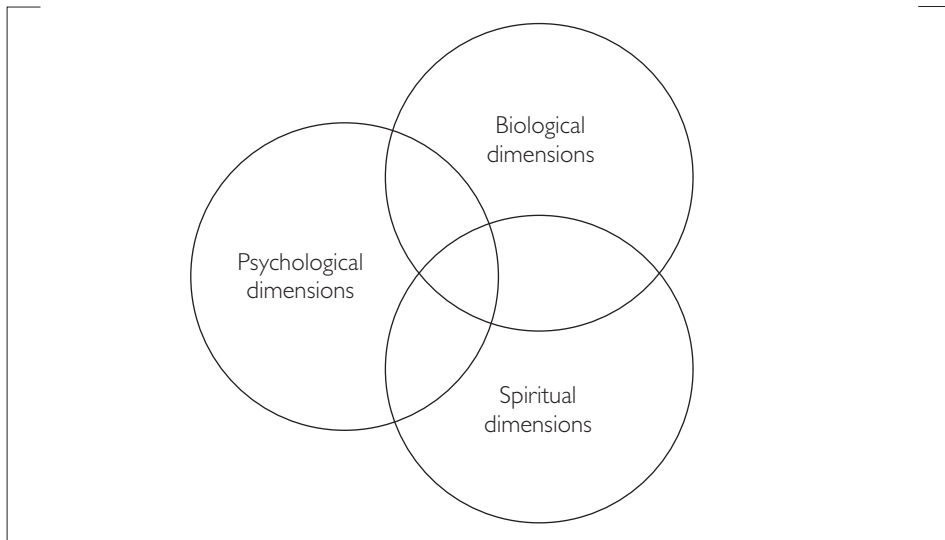
## **An individual's inner world is multidimensional**

Each of us has a unique sense of our own **inner world**. No one else can ever experience what goes on in another person's thoughts and emotions, or know what it is like to live in someone else's body or to experience their sense of spirituality. This is the **subjective experience**, sometimes referred to as the lived experience. Three dimensions are central to the inner world—the biological, psychological and spiritual dimensions. Each one of us has unique biological, psychological and spiritual experiences, as shown in Figure 1.1.

### **Biological dimensions**

Biological processes determine our human existence. From its beginning in conception and birth through to its end in death, the body profoundly affects much

FIGURE 1.1 Inner-world dimensions



of human experience. **Biological dimensions** can be thought of as including ‘all those processes necessary for the physical functioning’ of the human body (Newman & Newman 2003 p. 6). These include the genetic, skeletal, sensory, motor, respiratory, endocrine, circulatory, waste elimination, sexual-reproductive, digestive and nervous systems (Newman & Newman 2003 p. 6). These systems change as a human matures throughout their life. They change also as a result of influences in the outer world, such as the impact of the physical environment, diet, social interactions and exposure to stress, to name a few.

The theory of lifespan development proposes that ‘normal’ milestones mark transitions across the life trajectory, particularly biological transitions such as those that occur in early childhood, adolescence, mid-life and late adulthood. Although important, the notion is controversial, as it can be seen to be prescribing normal behaviour and labelling anything outside of prescribed ranges as abnormal or deviant. Critics of a lifespan approach argue that human experience is too diverse to be adequately described using culture- and history-bound notions of what it is to be a particular age. Proponents of a lifespan approach argue that there are certain tasks and transitions associated with ages across the lifespan that are typically predictable and **normative**. In addition, social inequalities can be identified and addressed when there are key indicators of risk or lost opportunity—such as recognising the social and health inequalities that lead to the seventeen-year gap in longevity between Indigenous and non-Indigenous Australians.

The genetic basis of the human experience has been researched extensively in recent years, with the completion of the human genome project in 2003. Although

concern has been expressed about the potential discrimination that may arise from genetic screening and intervention (Australian Academy of Science 2004), the project has enabled a far wider understanding of the genetic bases for human behaviour and many diseases such as cancer and neurological disorders. Similarly, neurobiological understandings have profoundly influenced understandings of development in infancy and early childhood, in particular, and the lifelong impact of adversities such as traumatic events on the developing brain of the child and adult.

The biological dimension is inextricably connected with other dimensions of experience. Our emotional well-being and cultural context have a strong impact on our biological experience and vice versa. For example, Vaillant, in his study of resilience in later life has found that ‘objectively good physical health was less important to successful ageing than subjective good health. By this I mean that it is alright to be ill as long as you do not feel sick.’ (2002 p. 13) Similarly, we do not think of our sexuality as a purely biological phenomenon. In conjunction with our biology, sexuality is a complex interplay of social and psychological influences.

While this book is focused primarily on the psychosocial aspects of human experience as the sites for social work intervention, it is critical to keep in mind the influences of the biological dimension or the role of the body in human experience and well-being (Cameron & McDermott 2007). This means taking into account the realities of the physical experiences people have—of pain, illness, limited mobility and/or disability (Barnes, Mercer & Shakespeare 1999).

### **Psychological dimensions**

In addition to our bodily experiences, how we think and how we feel emotionally influences every aspect of our daily experience—our **psychological dimensions** are central to our sense of well-being. Our capacities for thought and memory, for emotion and for anticipating the future reflect some of our most uniquely human qualities. These aspects are all part of the psychological dimension. This is undoubtedly the dimension where most attention is focused in relation to intervention in the aftermath of adversity, as explored in Chapters 4 to 6, in particular.

**Gender** is also part of the psychological dimension, as the classification of someone as masculine, feminine or androgynous arises not necessarily directly from a person’s physical status as male or female, but from both innate characteristics and the social environment. Whereas sex refers to biological characteristics, gender refers to the complex interaction between individuals, societies and cultures regarding the expectations, identities and roles associated with masculinity and femininity. Thus, gender is a complex, socially constructed phenomenon, derived from multidimensional interactions across the lifespan.

A key aspect of the psychological dimension is the cognitive aspect. This includes our conscious cognitive capacity—our capacity for thought, for memory, and for the

appraisal of events and ourselves. Across the lifespan, we experience changes in our cognitive capacity. Cognitive theorists such as Piaget (1995) and Vygotsky (1998) proposed that there are a series of cognitive stages across the lifespan. With the successful acquisition of each stage of cognitive development, higher levels of cognitive functioning are reached, to the point where individuals are capable of complex, abstract thought in adulthood. We develop critical memory, verbal capacity and reasoning skills, for example.

Other theorists propose that we each have an unconscious psychological life. This includes our dream life and our primary drives and motivations. These drives have been understood differently by theorists—for example, Freud argued for a theory of sexual drive and later the death instinct, Adler (1956, reproduced in Ansbacher & Ansbacher 1970), for a theory of power, Bowlby (1984) for a theory of attachment and Maslow (1968) for a theory of self-actualisation. Research in consciousness studies—for example, at the University of Arizona and Cambridge University—is also highlighting the impact on others of our unconscious life and the capacity to influence our environments, a view consistent with many Indigenous perspectives.

The capacity for memory and self-reflection means that we come to develop individual meaning structures, or schemas, (Kelly 1955) for how the world and our relationships operate. As a result of these cognitive schemas, we develop a sense of the world that is understandable and predictable, and we know how to act within it. In each of the chapters of this book, we explore aspects of these schemas. For example, we look at how young children develop an understanding of the mind (Baird & Sokol 2004) that becomes a foundation for empathic relational behaviour.

Another aspect of the psychological dimension is the emotional aspect—the feeling or mood responses a person has to their circumstances. Our distress, sadness, depression and anger are part of this emotional aspect, as is our capacity for the positive emotions of happiness, excitement and enthusiasm (Fredrickson 2000a; Fredrickson 2000b; Lyubomirsky 2000). Emotions and thoughts work together to form a sense of self-efficacy and agency (Kondrat 2002), factors that are explored in greater detail in Chapter 4. Ultimately, these dimensions also influence our moral reasoning, embedding our psychological responses in social attitudes and behaviours.

Many different theories have been used to explain our psychological dimensions and how they influence our behaviour. These include cognitive-behavioural, psychodynamic, existential and the more recent narrative theories. While each has a different focus, fundamental to all psychological theories is the belief that our thinking patterns, either conscious or unconscious, profoundly influence adaptation and well-being.

These theories are discussed in more detail in Chapter 5.

### Spiritual dimensions

Discussion of the **spiritual dimensions** of human experience is frequently absent from texts dealing with human development and/or human experience. When it is present, it is often as an afterthought (see for example Garbarino & Abramowitz 1992a). While centuries ago in Western contexts, it was taken for granted that spirituality was a critical dimension in mental and physical well-being, social workers have only recently revived interest in this dimension and begun to actively research its influence in coping with adversity.

Of all the inner-world dimensions, spirituality is the most elusive dimension to define (Lindsay 2002; Rice 2002; Tacey 2003), although widely recognised as a universal dimension of human experience. Spirituality relates to our search for meaning and purpose in our own existence. Tacey (2003 p. 38) describes spirituality as:

concerned with connectedness and relatedness to other realities and existences, including other people, society, the world, the stars, the universe and the holy. It is typically intensely inward, and most often involves an exploration of the so-called inner or true self, in which divinity is felt to reside.

The US National Institute of Healthcare Research defined spirituality as ‘the feelings, thoughts, experiences and behaviors that arise from a search for the sacred’ (as cited in George et al. 2000 p. 104). The sacred they defined as ‘a divine being, higher power or ultimate reality’. Lindsay (2002 pp. 31–2) describes spirituality as relating to ‘a search for purpose and meaning, and having a moral dimension which reflects a concern with relationships to others, the universe, and to some transcendent being or force’. For many of the world’s indigenous cultures, such as the Australian Aboriginal culture, an intrinsic relationship with the land is core to a sense of the sacred. Spirituality has the capacity to connect people through fostering a sense of identity and purpose, creating ritual and building a sense of community and connectedness. Studies have shown a strong connection between spirituality and well-being, in relation to physical, psychological and social health (George et al. 2000).

Spirituality is somewhat different from religion (Tacey 2003), although researchers often confuse these concepts. **Religion** is considered to be the formal structures and doctrines of a faith tradition such as the Muslim, Christian, or Jewish traditions, whereas **spirituality** is defined as a more uniquely personal experience of a divine, spiritual or transcendent force, not necessarily requiring any formal structure or public expression. Spirituality has often been criticised for being a more individualised concept. This criticism is not necessarily accurate, as many people express their spirituality through a strong commitment to social justice and the environment. Research is consistently showing small to moderate positive correlations between spirituality and/or religion and better physical and mental health outcomes (George et al. 2000). This is discussed more extensively in Chapters 7 to 13.

Unlike the other dimensions, matters of the soul or spirituality continue to be considered cautiously, if at all, by social workers and other health professionals. In part, this is due to the very complex position of religion within the largely secular Australian community, the variety of spiritual perspectives and the difficulties experienced in researching this dimension of human experience. Nevertheless, spirituality is increasingly recognised for its significance across the lifespan, particularly in the aftermath of experiences of adversity.

### **An individual's outer world is multidimensional**

In shifting a focus to the outer worlds, we look now at the many external dimensions, both direct and indirect, which influence experience.

Understanding the outer-world dimensions, or contexts, of an individual involves consideration of five key questions:

- 1 What relationships is the person involved in and what is the influence of these relationships?
- 2 How do these relationships interact as a social network, if at all?
- 3 What are the wider structural influences on a person's experience?
- 4 What are the cultural influences?
- 5 In what ways are the relational, social, structural and cultural dimensions influenced in turn by individuals and their families and communities?

Each of these four dimensions—relational, social, structural and cultural—is explored briefly below, and then discussed more comprehensively in Chapters 2 and 3.

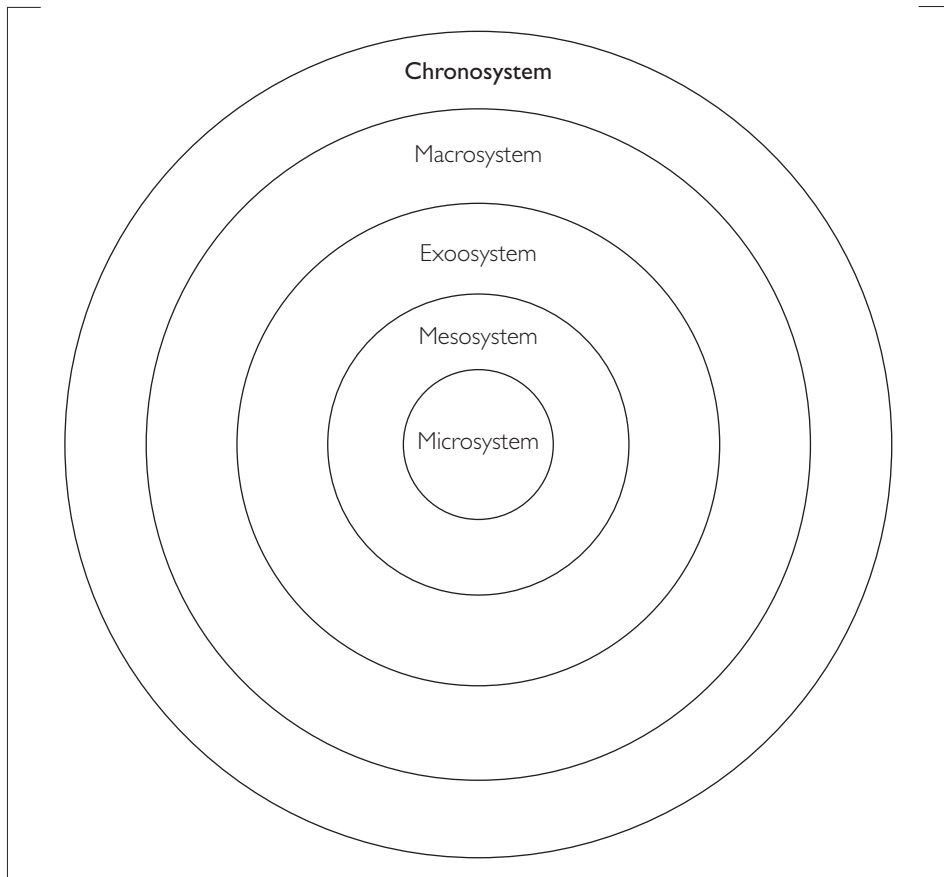
#### **Relational, social, structural and cultural dimensions**

Urie Bronfenbrenner (1979) highlighted that an individual's experience was always occurring in a context of both direct and indirect social influence. He proposed four systems of major influence in individual behaviour, as part of an ecological approach—the microsystem, mesosystem, exosystem and macrosystem, all within a fifth system, the chronosystem, as represented in Figure 1.2

Other theorists have developed different interpretations of these layers or systems in the environment, referred to as the micro, mezzo and macrosystem (see, for example, Greene & Ephross 1991). Others, such as Thompson (2006) and Mullaney (2002) incorporate these dimensions into an anti-discriminatory or anti-oppressive framework, looking at a PCS (personal, cultural and structural) model. The visual representation of Bronfenbrenner's model indicates the embeddedness of each of these systems—that is, no one system can be interpreted without understanding the other four. Each system of the model is both influenced by and influences the others. In this model, the individual is seen as the central unit of analysis, although



FIGURE 1.2 Bronfenbrenner's systems of influence



this need not be the case. Families could be seen as central (as Richmond first proposed in 1917; see Richmond 1945). It is important to think of it as a three-dimensional layering of systems with permeable boundaries between all of the layers. The model as it appears here is deceptively simple. In fact, the model is complex: it is not just about the person in their context and the influences the context has on an individual, family or group's experience; it is also about the ways in which individuals, families and groups change and influence contexts. *Both* are changed by each other. This way of thinking about the person and the environment informs interventions profoundly—intervention in any part of the complexity of factors will typically bring about change in others.

Bronfenbrenner's nested model of the environment continues to be profoundly useful. Social workers have drawn traditionally on his ecological theory, along with other systems theories, to understand the reciprocal influences of individuals on environments and vice versa. However, in recent years, developments in chaos

theory and quantum physics have transformed understandings of systems, including human, as predictable and closed. There is often no clear cause and effect between human experience and environmental influences (Hudson 2000). In addition, some of the language of Bronfenbrenner's model (such as mesosystem and exosystem) has not readily been adopted in the practice context. A more contemporary perspective based on this model is therefore introduced in this book to place it within an Australian context in the twenty-first century. It also enables a deeper incorporation of the inner-world dimensions, often neglected within ecological perspectives. While Chapters 2 and 3 focus on these issues more specifically, we look briefly here at how each of these dimensions is understood.

Each one of us has unique relationships and connections with a variety of individuals and groups of people—with intimate partners, family members and friends, with peers and colleagues in the workplace or in educational settings, with health professionals or front-line staff in many organisations, and with many others in our world. We rely on these interpersonal relationships within our **relational dimensions** or context for our sense of well-being and identity, and, indeed, in many phases of our life, for our survival. They are the worlds, or settings, in which we live, work and play in some direct way, even if not on a daily or regular basis. Bronfenbrenner referred to these interpersonal relationships as our **microsystem**. Analysing microsystems is typically about analysing the face-to-face transactions that take place between the individual and each of their various worlds and examining their impact on the individual. Bronfenbrenner (1979 p. 22) defined a microsystem as 'a pattern of activities, roles and interpersonal relations experienced by the developing person in a given setting with particular physical and material characteristics'. This definition emphasises that these relationships determine for us a particular pattern or way of being that links profoundly with our sense of identity. This dimension of experience is understood by asking who the person interacts with and how they interact, as shown in Figure 1.3.

These relationships are initially dependent upon parental or caregiver networks. As a person moves from infancy into later stages of the lifespan, microsystems change too, as a result of the developing person and their changing contexts (Figure 1.4), and as a result of external influences on the microsystem. For example, in recent decades, the use of technology has enabled interaction beyond the face-to-face context.

Our adaptations do not rely only on our direct relationships and what goes on between them. When we shift our interest to consider the ways in which these various relationships interact with each other, we are analysing the **mesosystem**, the next layer in Bronfenbrenner's model. This is a layer of social connectedness, the layer of our **social dimensions** or networks. Rather than looking at the individual relationships a person has with each setting in their immediate environment, the

FIGURE 1.3 Relational dimensions

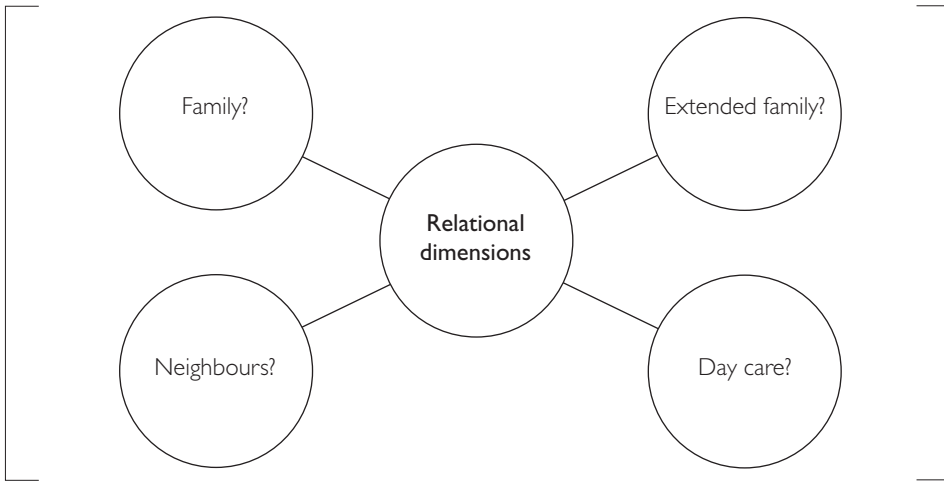
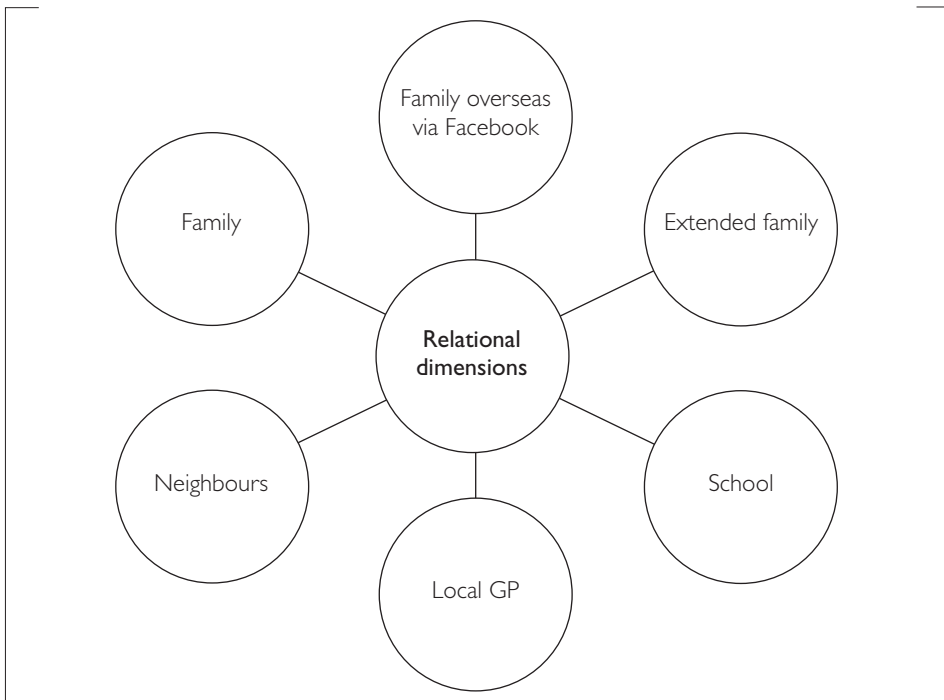
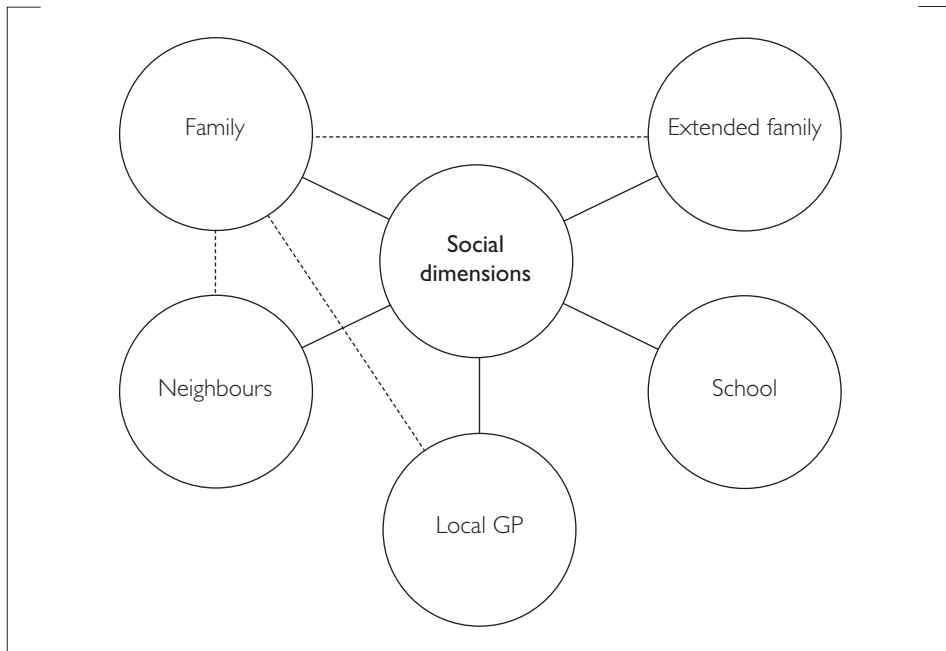


FIGURE 1.4 Relational dimensions change over time



social network layer is about observing the interconnectedness or linkages *between* the settings themselves. While we are part of all worlds in a social network, the focus is on the interaction between these worlds, rather than our direct interaction with any of them (Figure 1.5).

FIGURE 1.5 Social dimensions (networks)



Each one of us also exists in broader **structural dimensions** (Figure 1.6), or contexts, or what Bronfenbrenner (1979) called the **exosystem**. We do not have direct, face-to-face relationships with the structural context. Rather, our individual experience and interpersonal and social contexts are all profoundly and indirectly shaped by these factors. Some key systems within our structural context include our political and legal systems. Resources such as the labour market, the transport system, income-maintenance structures, educational and health service systems are part of our structural context. Religious systems also influence many aspects of daily life. The structural context, like social networks, can be either a source of adversity or a vital resource in the face of adversity.

Giving shape to the experiences in our various relational contexts is the cultural dimension (Figure 1.7) or context in which we live. Bronfenbrenner called this the **macrosystem**, the social 'blueprint' (Bronfenbrenner 1979 p. 26). Our cultural context refers to the norms, principles or mores of a culture. Garbarino and Abramowitz (1992b p. 49) state that culture 'defines what is normal for one time and place'. The cultural context in which we live relates to our implicit assumptions about gender, generational cohorts, ethnicity, sexuality and sexual preference, religious and political beliefs. The dominant beliefs of a particular nation or community in relation to these issues, and many others, will profoundly influence an individual, family and community, as will the availability, beliefs and resources of subcultures.

FIGURE 1.6 Structural dimensions

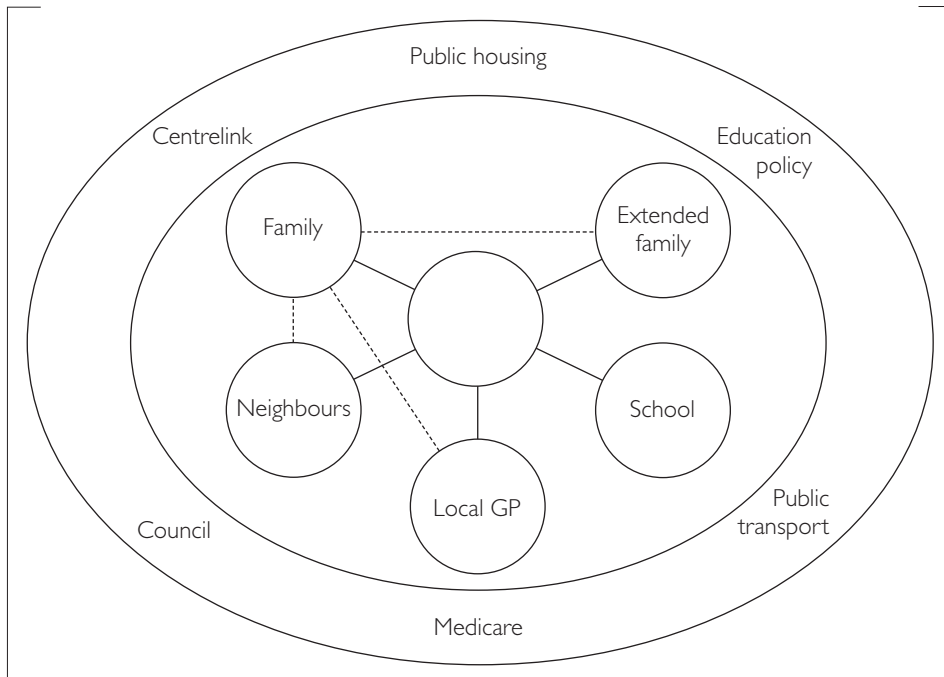
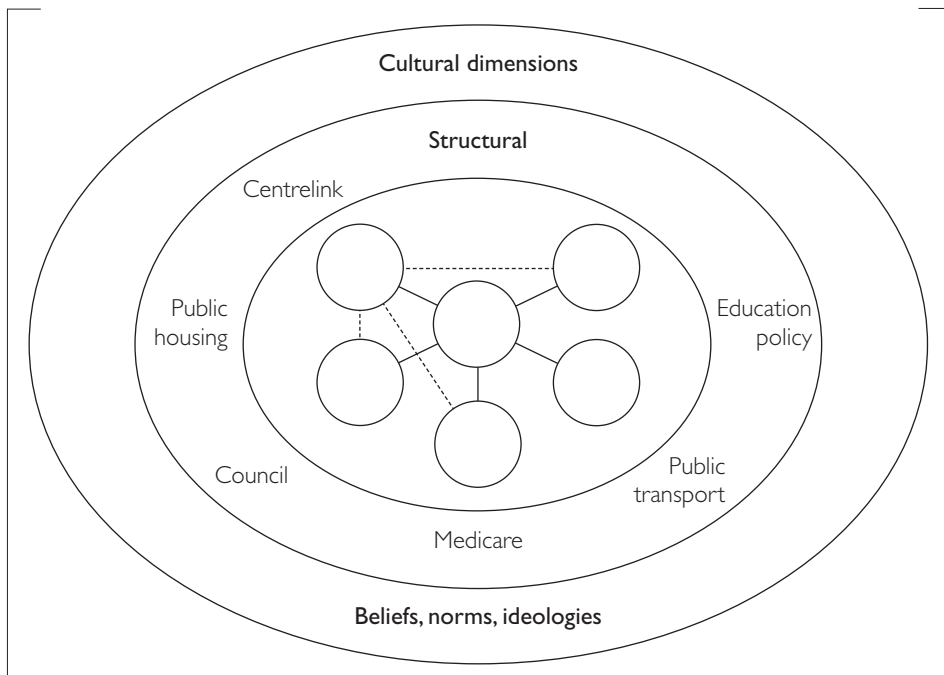


FIGURE 1.7 Cultural dimensions



The cultural context is often hard to articulate or even to be aware of until we step into alternative cultural contexts or critically reflect on our core cultural assumptions. Shifting our thinking in relation to time and place can be one way of reflecting on what cultural assumptions are influencing our way of being and thinking. For example, marriage is an experience that exists in many parts of the world. However, in terms of both the rituals of marriage and the expectations of men's and women's roles within marriage, there is enormous variation between cultures. For example, in some countries, a husband can have multiple wives or gay and lesbian couples can marry—none of these forms of marriage are legal in Australia. An analysis of cultural influences also enables analysis of dominant cultural beliefs and the ways in which these connect with power and allow some groups to be privileged while others are oppressed or marginalised.

At the time when Bronfenbrenner developed his ecological model, he was part of a more singular and ethno-specific understanding of culture, and thus talked about culture in the singular. With global mobility and technological developments, it is impossible to think of culture as a singular phenomenon, as we tend to be influenced by many different cultural contexts—both subcultures and dominant cultures. These issues are expanded on considerably in Chapter 3.

Like the inner world, the outer world can be understood using a variety of theories—theories that seek to understand what both causes adversity, and facilitates or impedes adaptation. These include feminist theories, systems theories (from ecological to chaos), conflict theories, and Marxist theories.

## Time is multidimensional

Influencing all of the other dimensions discussed are the dimensions of time. Five significant time dimensions exist—biological, biographical, historical/social, cyclical and future time—forming what can be called the **chronosystem** (Bronfenbrenner 1979).

The **biological time** dimension is the chronological experience of being born and moving through various biological transitions and milestones across the lifespan until our death. It is a linear process. Certain biological processes occur because we are at a particular point in the biological timeline—we are born; we grow through infancy and childhood; we reach puberty and develop a reproductive capacity, we age and that brings about its own unique changes in functioning.

Closely associated with our biological time is the development of our own meaning structures or biography. Over time, we develop our own repertoire of

coping methods and our understanding of who we are. Our individual sense and experience of time shapes our self-perceptions, our opportunities and our attitudes. This can be referred to as our **biographical time**. As Garbarino and Abramowitz suggest (1992a p. 18), our ‘interest in development is really an interest in biography. We must discover how the lives of individuals and the lives of societies are interdependent’.

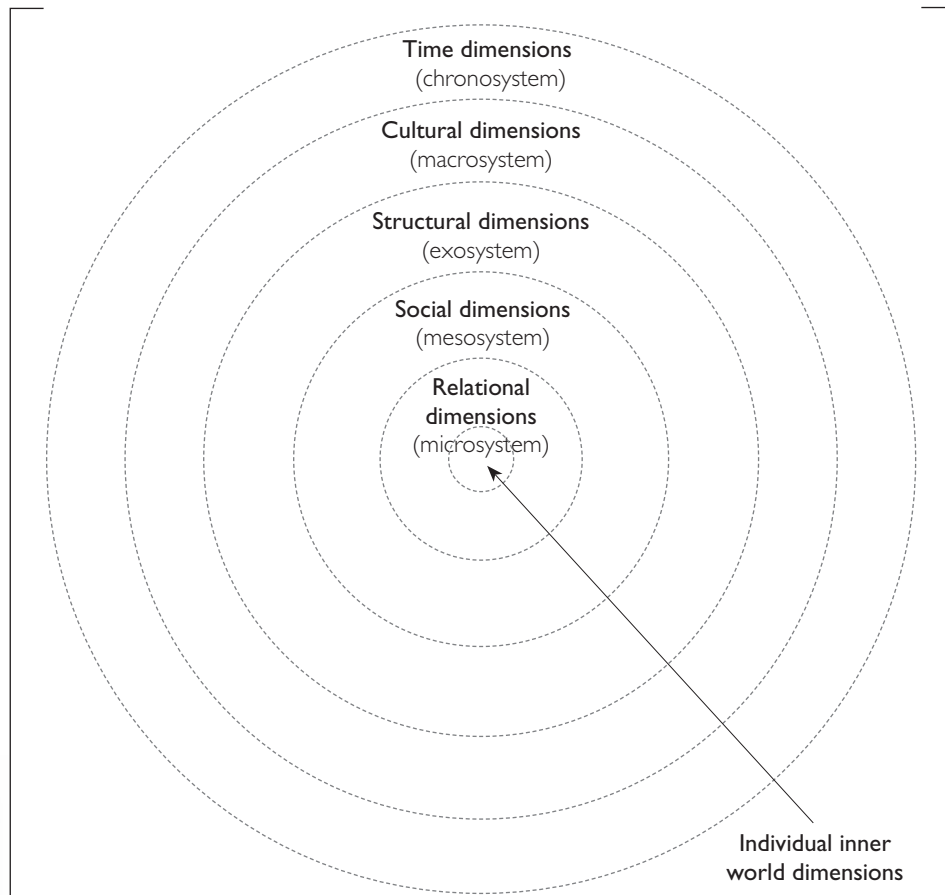
We are born into a particular generational **cohort** and, as a result, are exposed to cultural and historical adversities that shape our experience, which differ from those of people in other eras. Bronfenbrenner also emphasised **historical time**—human development is necessarily culture-bound and time-bound. These influences lead to the development of distinctive ‘rules and expectations about how people at various ages should behave’ (Peterson 1996 p. 14). This concept of historical time can also be understood as **social time**, referring ‘to the incidence, duration and sequence of roles, and to relevant expectations and beliefs based on age’ (Elder 1994 p. 6). For example, in the 1940s and 50s in Australia, a common path for professionals was to proceed from school to university to work, and then family and children followed, with many women required to resign from their employment and maintain the home and family. Only 8.6 per cent of married women were in the paid workforce in 1947 in Australia (Murphy 2002 p. 63). Today, most professionals do not follow this linear pathway, but participate in education, employment and family opportunities and responsibilities at different times throughout the lifespan.

Our experience of **cyclical time** is connected with both our own biography and historical time dimensions. Cyclical time refers to the patterns, seasons and anniversaries (Hutchison 1999 p. 22) that recur throughout our lives, which are unique to our own family, community, or religious context. For example, we celebrate or mourn at different times throughout the year, typically in memory of past events.

Our sense of **future time** is one that is often overlooked. The extent to which we anticipate a future significantly influences our present status. For example, young children and adolescents often have a sense of a long future ahead of them, but middle-aged and older people can be confronted by the shortening of their future time. People experiencing depression, trauma or grief often find it hard to engage with any sense of a future for themselves given their current state of mind.

Drawing all these dimensions together, a multidimensional approach can be presented in the following diagram (Figure 1.8).

FIGURE 1.8 A multidimensional approach



## THEORY IN CONTEXT

### A MULTIDIMENSIONAL APPROACH TO WORKING WITH SEXUAL ASSAULT

**Kate, a social work student, describes how she found the multidimensional approach helpful in thinking about her work with a client in a sexual assault service.**

Hoe, a Vietnamese mother, was interviewed at a children's sexual assault centre. Hoe's eleven-year-old daughter, Amanda, had been sexually abused by her stepfather, who at the time was in remand and about to go on trial for the murder of a person who was unknown to the family. An interpreter assisted at the interview, as Hoe's understanding of English was insufficient for the sexual assault centre staff to clarify



information such as Amanda's safety or to explain the services that could be offered to Amanda and Hoe. The purpose of the interview was to put the circumstances of the incident in context, and to establish some practical strategies to initiate the beginnings of a holding process (to foster a sense of emotional security) upon which counselling would later build.

Because I think visually, I found it useful to apply theory to practice by thinking of theories in visual terms. For instance, planning how to question Hoe was assisted by using the multidimensional approach (see Figure 1.8) as a way of developing a client map. As information unfolded about Amanda's case, the external realities of her circumstances, such as her school, cultural links, other agencies involved and her extended family connections, were mapped out. The map evolved into a three-dimensional perspective, with exploration of the relationships between the connecting elements and theories such as attachment theory that were required to begin a deeper understanding of Amanda's internal world.

### Questions

- 1 What is your personal reaction to this situation?
  - 2 In what ways did Kate use a multidimensional approach to understand Hoe and Amanda's situation?
  - 3 Are there other aspects of a multidimensional approach that you think could be usefully applied?
- 

## Human experience is multidimensional

Human experience is a combination of an individual's unique developmental trajectory and unique life events. An understanding of both the more normative tasks of development and the non-normative tasks provides a more holistic understanding of a person's adaptive capacities and resources.

Understanding human development is typically referred to as a **lifespan approach**. This is a normative approach, understanding individual experience and behaviour in the context of what most people within a particular cohort are experiencing in a particular context, using **prevalence** data as the basis for this understanding. For example, within the Australian context, longevity can be calculated for the population, and based on this calculation an expectation about how long we will live can be formulated. On the basis of difference or deviations from the normative developmental stages, policies and programs are put into place to provide individuals with resources. Thus, we understand human behaviour in the context of being at a particular age and stage in the human lifespan. There are some expectable transitions, aspects of healthy development, which are universal,

although profoundly influenced by cultural and context. The strengths of this approach are that there is recognition of the needs of individuals and attempts can be made to resource and support them when these needs are not being met—for example, knowing the developmental milestones of infancy has enabled children at risk to be supported by early intervention programs when these milestones are not being reached. However, an obvious limitation of this approach is that it can lead to stigma and **othering** (Young 1990 p. 60) or to assumptions made by researchers and others that ‘one size fits all’. There is also the potential for it to limit the capacity for individually or culturally appropriate strategies.

Another approach to understanding human experience is an adversity-focused approach, or a **life course approach**. This focuses on understanding human behaviour in specific contexts and experiences, particular adversities. It looks at particular events, stressors or traumas, and at the resources and deficits of individuals, families and communities. Individual developmental stages are acknowledged, but so too is the impact of these ‘non-normative’ life events that influence development and adaptation. The strength of this approach is that there is an understanding that single incidents do have a profound impact on subsequent human experience, right across the life course. Importantly, it recognises that what happens in adulthood is also influential. However, the limitation of such an approach is that it sometimes decontextualises coping and provides a sense that it is only the event and not the circumstances in both the pre-event and post-event context that influences coping.

Negative experiences are an inescapable aspect of being alive. Throughout this book, the term **adversity** is used as a way of referring generally to these negative life events. The adversities of life are the experiences that have the potential to harm us in some way; to cause distress and injury to many dimensions of our self. Adversity is experienced in many ways, arising from sudden and unexpected incidents or from lifelong burdens or states of being. An adverse event can profoundly influence one person yet seemingly have little or no impact on someone else. Some experiences of adversity, such as those of loss and death, are inevitable human experiences. Others are the result of particular environments and circumstances and are uniquely traumatic for those affected by them.

Adversity is referred to by many different terms, including threats, demands, stressors, structural constraints (Gottlieb 1997) and traumas. Marris (1986) refers to conditions of uncertainty, which lead to anxiety for individuals, families, groups and communities. Transition is another commonly used term (Germain 1991; Germain & Bloom 1999), although it is typically used in a more neutral way, to describe changes that have the *potential* to be negative, positive or indeed neutral in their impact. While all of these terms refer to negative human experiences or conditions, they differ slightly in their emphasis.

## Adaptation and coping are multidimensional

Adaptation is the vital task for each person, in the context of our family, the groups to which we belong and our wider community. Yet, just as the causes of adversity are multidimensional, so too are the consequences—an understanding of the consequences of adversity for individuals, families and communities needs to incorporate the possibilities of both adaptation and **maladaptation**, and the range of experiences in between. **Adaptation** refers to our active responses to circumstances of change, with positive adaptations enabling the maintenance or re-establishment of health and well-being in their broadest sense (Bornstein et al. 2003). Querelt (1996 p. 17) describes adaptation as ‘the continuous process of mutual accommodation between an active and evolving human being and the ever-changing settings within which the person functions’.

Adaptation is often a constant and even unrecognisable process, in that we must continually respond to the demands of each day. These daily adaptations tend to be gradual. Adaptation can also be a more radical process, under circumstances of greater adversity, when daily patterns of behaviour and beliefs are shattered by unexpected events. Adaptations are both conscious and unconscious processes.

In any adaptation, all dimensions of our experience are involved—the biopsychospiritual dimensions of our inner world and the socio-cultural dimensions of our outer world. More will be said about this in a moment. Driving our need for adaptation is our appraisal of what is going on for us—that is, do we perceive the experiences as being experiences of harm or loss, threat or challenge (Lazarus & Folkman 1984; Lazarus 1998)? Chapter 6 explores these issues more fully. When we are confronted with experiences outside of the familiar, we attempt to return to a recognisable and manageable way of being.

This adaptive tendency is often referred to as our self-righting tendency (Vaillant 1993). Adaptation processes are ideally about moving towards a steady state, or homeostasis, although not necessarily a stress-free one (Gottlieb 1997). Families and communities similarly seek to restore some sense of steady state. According to this line of argument, well-being occurs when there is an optimal balance between all dimensions. Positive adaptations depend on a degree of goodness of fit or compatibility between all of our lived dimensions. As Chapter 3 highlights, our cultural dimensions influence these adaptations profoundly.

For optimal mental health and well-being, research suggests that we need to maintain our meaning structures (Marris 1986) or a sense of coherence (Antonovsky 1979; 1987). We develop meaning structures in our own minds across the lifespan that reinforce for us who we are and how the world is—the world and our place in it develops some kind of predictability, even if this predictability is primarily negative. As Marris (1986 p. 2) suggests, we have a conservative impulse:

the impulse to defend the predictability of life is a fundamental and universal principle of human psychology. Conservatism in this sense is an aspect of our ability to survive any situation; for without continuity, we cannot interpret what events mean to us, nor explore new kinds of experience with confidence.

Others have suggested that not only can we adapt and cope well with stressful or traumatic life events, but we may be able to, as Carver (1998) suggests, thrive in the face of adversity, and come to an enhanced state of being, or we might experience what Tedeschi and Calhoun (1995; Tedeschi et al. 1998) term post-traumatic growth. This is a major shift in focus, away from a focus on maladaptation or the development of psychiatric disorders to focusing on the strengths and resilience that can also emerge in the aftermath of life experiences.

Central to the notion of adaptation in the aftermath of adversity is the process of coping. **Coping** refers to the specific psychosocial adaptations, the thoughts, behaviours and resources we use in our attempts to respond to stressors. That is, coping is about the thinking and doing that we engage in after an event in an effort to maintain or regain a sense of coherence or functioning. Similarly, families, groups and communities engage in various coping processes.

Moos and Schaefer (1986 p. 22) argue that coping capacity is dependent on a number of factors. These are:

- » our demographic and personal characteristics, such as age, gender, socio-economic status or personality factors
- » specific aspects of the crisis or transition itself
- » the physical and social environment, and the resources it is able to provide.

Coping resources are therefore any of the above three factors associated with lowering our levels of distress or physical symptoms following experiences of adversity. As Moos and Schaefer highlight, dimensions of the environment are critical determinants of coping capacity.

The coping capacity of an individual is determined by complex interaction between the available resources in the inner and outer worlds of the individual. A range of factors determines an individual's response to a particular experience. These factors are often called **risk factors** and **protective factors**, although they may also be referred to as vulnerability and resilience factors respectively. Adaptation is a complex interaction between individual and environmental risk and protective factors.

### **Risk and protective factors**

Within each of the dimensions of a person's inner and outer worlds, researchers have come to identify particular factors that can be understood as risk and/or protective

factors. The term 'risk' refers to the probabilities or likelihood of a future negative event. Applied to understanding responses to adversity, **risk factors** are a range of factors that *may* lead to poorer or negative developmental or biopsychosocial outcomes (Werner & Smith 1992). This cautious use of language is important. These factors may lead to negative outcomes, but many studies and autobiographical accounts are testament to the extraordinary resilience of human beings.

Some events can be understood as risk factors in themselves. They are risk factors in that, as events or experiences, they increase the likelihood of later difficulty in life for an individual. For example, the death of a parent in childhood significantly increases the risk of depression in adulthood (Parkes 1972). Similarly, child sexual abuse has been found to increase the risk of self-esteem and sexual difficulties in adult life (Mullen et al. 1996). Other risk factors can be thought of as factors that influence the processes of coping but are not the cause of the adversity themselves. Later biopsychosocial difficulties have been correlated with these factors also. For example, age is an associated (or proximal) risk factor, in that some events occurring at a particular age, such as separation or loss experiences, have a more profound impact than at another age. That is, age influences risk but is not the risk factor itself.

Discussion of risk factors raises two important matters. The first relates to the perceptions of risk, or dangers and hazards (Adam & Van Loon 2000). Who determines risk and for whom are crucial questions, with notions of risk closely associated with economic and political factors. For example, these issues are particularly relevant when we consider some of the issues of adolescent risk-taking.

The second matter relates to the fact that not everyone who is exposed to particular risk factors is adversely affected. There are varying degrees of effect. This raises the critical question as to what makes the difference, leading to attention being paid to the important role of protective factors. Werner (1995 p. 81) defines **protective factors** as the factors 'that moderate (ameliorate) a person's reaction to a stressful situation or chronic adversity so that his or her adaptation is more successful than would be the case if the protective factors were not present'. Protective factors are the buffers to the risk factors. For example, having a network of friends enables both practical and emotional support to be offered at times of high stress or loss. The loss might still occur, but the friends provide a buffer to its impact.

Therefore, a balancing act of risk and protective factors exists. Too many risk factors or too few protective factors can mean the difference between good and poor outcomes. The image of scales is sometimes used to denote this relationship (Gilligan 2000). This image is useful in that it highlights that positive experiences have the capacity to outweigh negative ones and that there is a need for a balance to be achieved between the two. We are not only looking to understand risk factors, we are also looking to understand why individuals in the face of adversity have not

been overwhelmed. What protective factors are critical in enhancing their coping capacity? Another salient reminder exists in this image of scales: scales can only tolerate so much weight before they collapse altogether. This may hold true for humans too. The accumulation of risk factors does lead to higher risk of poor outcomes (Fraser et al. 1999). Ultimately, reducing risk factors to minimise the overall burden an individual carries is the most effective intervention.

While reducing risk is clearly important in enhancing the well-being of individuals, families and communities, there are some inherent challenges with this approach. The onus for prevention can very quickly fall onto individuals, families and communities—that is, risks are personalised and individualised—even when the risks stem from broader structural and cultural factors. For example, the current emphasis on obesity reduction can be seen as an individual responsibility involving diet and exercise (the primary approach) or a structural and cultural responsibility, involving limiting the marketing of junk foods and implementing strategies regarding the availability and pricing of healthy foods. A multidimensional approach brings an analysis of the person *and* their environments together simultaneously to avoid seeing risk management as the responsibility of individuals only.

### Resilience and thriving

The increasing recognition that individuals in situations of high risk have not necessarily experienced the poor outcomes anticipated has led to a major shift in emphasis in understandings of adaptation at the end of the twentieth century. The new focus is on **resilience** (Rutter 1985; Werner & Smith 1992; Werner 1995; Fraser et al. 1999), thriving (Carver 1998) and strengths (Saleebey 1997). That is, research has focused on why it is that not everybody succumbs to adverse events and circumstances, and what factors either protect in the first place and/or enable people to recover and adapt positively in the aftermath of traumatic life events or extreme adverse conditions. While these notions are not necessarily new, with many writers such as Maslow (1968; 1996) writing about these issues in the 1960s, they continue to be taken up in the twenty-first century and incorporated into research, policy and interventions in a way never seen before.

#### WERNER AND SMITH: RESILIENCE

The notion of resilience gained particular recognition following the studies conducted by Emmy Werner and Ruth Smith on the Island of Kauai, Hawaii. Werner and Smith followed 505 children who were born in 1955, from pre-birth to adulthood, monitoring the impact of a variety of biological and psychosocial risk factors, stressful life events and protective factors at birth, infancy, early and middle childhood, late adolescence

and adulthood' (Werner & Smith 1992 p. 1). They found that one-third of this cohort was born into families where the odds were against successful development. The specific risk factors these children faced were:

- » moderate to severe peri-natal stress (stress around the event of birth)
- » chronic poverty
- » having parents with little formal education
- » living in disorganised family environments in which there was 'discord, desertion, divorce' and/or where parents were dealing with issues of alcoholism or mental illness (Werner & Smith 1992 p. 2).

Of this vulnerable one-third, two-thirds were encountering four or more cumulative risk factors by the age of two. They subsequently developed serious learning and behaviour problems by the age of ten or had a record of delinquencies, mental health problems or pregnancies by the age of eighteen. However, their key finding was that of the high-risk children, one-third (some ten per cent of the total cohort) had developed into 'competent, confident and caring young adults by the age of eighteen' (Werner & Smith 1992 p. 2).

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The children in Werner and Smith's study were initially referred to as 'stress-resistant' or invulnerable, but they became more aptly described as resilient. This was in recognition of the fact that it was not that these environments had no effect, but that, in spite of these conditions of extreme adversity, these children had managed to reach normal developmental milestones. Resilience has therefore come to be defined as 'a successful adaptational response to high risk' (Fraser et al. 1999 p. 137; Luthar, Cicchetti & Becker 2000). Others have defined resilience as the capacity to 'bounce back' (Vaillant 1993) or achieve normal or optimal adaptation and development despite considerable threat to that development. Masten (2001 p. 235) has described it as coming from 'the everyday magic of ordinary, normative human resources'. In recent years, the view that resilience relates to a universal set of transferable inner- and outer-world human capacities has shifted. Rather, resilience is currently seen as 'a multidimensional construct, the definition of which is *negotiated* between individuals and their communities, with tendencies to display both homogeneity and heterogeneity across culturally diverse research settings' (Ungar 2008a p. 219). In a similar vein, Gilligan (2004 p. 94) suggests:

While resilience may previously have been seen as residing in a person as a fixed trait, it is now more usefully considered as a variable quality that derives from a process of repeated interactions between a person and favourable features of the surrounding context in a person's life.

In thinking about how to promote resilience, some key factors have been identified. Three clusters of protective factors were identified by Werner and Smith (1992 p. 192) that differentiated the resilient group from other high-risk children who developed serious and persistent problems, both in childhood and in later life. These three clusters—involving intelligence, affectional ties and support systems—are presented in the box below.

### WERNER AND SMITH'S CLUSTERS OF PROTECTIVE FACTORS

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The three clusters of key protective factors are:

- 1 at least average intelligence and dispositional attributes that elicited positive responses from family members and strangers, such as robustness, vigour and an active, sociable temperament
- 2 affectional ties with parent substitutes, such as grandparents and older siblings, which encouraged trust, autonomy and initiative
- 3 an external support system (in church, youth groups or school) that rewarded competence and provided them with a sense of coherence.

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Source: Werner and Smith 1992 p. 192

From a review of the literature on resilience, fifteen factors that appear to be key protective factors have been consistently identified (Fonagy et al. 1994). They are:

- 1 a good social and economic environment
- 2 an absence of organic deficits
- 3 an easy temperament
- 4 younger age for those who have suffered a traumatic experience
- 5 absence of early separation or losses
- 6 a warm relationship with at least one caregiver
- 7 the availability in adulthood of good social support
- 8 positive school experiences
- 9 involvement with organised religious activity, or faith
- 10 high IQ
- 11 superior coping styles
- 12 higher sense of autonomy and self-worth
- 13 interpersonal awareness and empathy
- 14 willingness to plan
- 15 a sense of humour.



What becomes evident from this list is the interaction between individual and environmental factors.

From more of an inner-world focus, Flach (in Granot 1996 p. 141) identified thirteen humanistic factors in psychological resilience:

- 1 insight into oneself and others
- 2 a supple sense of self-esteem
- 3 ability to learn from experience
- 4 high tolerance for distress
- 5 low tolerance for outrageous behaviour
- 6 open-mindedness
- 7 courage
- 8 personal discipline
- 9 creativity
- 10 integrity
- 11 a keen sense of humour
- 12 a constructive philosophy of life that gives meaning
- 13 a willingness to dream dreams that can inspire us all and give us genuine hope.

These critical protective factors are explored in later chapters.

In addition to a focus on resilience, researchers have begun to examine the issue of thriving. While resilience refers to a return to functioning or a bouncing back, **thriving** refers to being 'better off afterwards' (Carver 1998). Carver (1998 pp. 252–3) suggests that:

psychological thriving appears to represent a kind of growth: growth in knowledge, growth in skill, growth in confidence, greater elaboration and differentiation in one's ability to deal with the world at large.

Experiences of resilience and thriving are context-dependent. Importantly, they are not about the absence of vulnerability—many situations are inescapable and enduring but individuals are able to display high levels of resilience. As Fraser et al. (1999) emphasise, resilience only emerges under conditions of risk—it is about a successful adaptational response to high risk. This viewing of resilience in context is critical, as some researchers are now critiquing it as an overly optimistic emphasis on the devastating effects of difficult life events. As Garbarino and Abramowitz suggest, 'the fact that humans can survive in the face of these risks should not be enough to excuse or rationalize the threats that these risks present' (Garbarino & Abramowitz 1992b pp. 63–4) or indeed become the basis for inaction. The risk with the notion of resilience is that a survivor can be expected to overcome difficulties, and a 'blame the victim' mentality can arise in that they are perceived to 'fail' in

recovering. On the other hand, if the ultimate goal is about the enhancement of well-being at individual and social levels, we need to know far more about the experience of resilience and the ways of promoting it than we currently do.

In the Constitution of the World Health Organization, established by the United Nations, a statement is made about the principles that are 'basic to the happiness, harmonious relations and security of all peoples' (World Health Organization 2003). These principles are fundamental to how we think about well-being and resilience, both locally and globally, and are outlined below.

## THE PRINCIPLES OF THE WORLD HEALTH ORGANIZATION

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- 1 **Health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- 2 The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- 3 The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and States.
- 4 The achievement of any State in the promotion and protection of health is of value to all.
- 5 Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.
- 6 Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- 7 The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- 8 Informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people.
- 9 Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

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Source: World Health Organization 2003, reprinted with permission

### **Attempts to theorise human development and adaptation should be multidimensional**

Human experience, behaviour and adaptation can all be understood from multiple theoretical dimensions—theories of the inner world, theories of the outer world, and those that attempt to bridge the two. Rather than this seeming as if social workers do

not have a firm theoretical base from which to work, to the contrary, a multidimensional approach acknowledges that there are many ways of understanding the complexities of the human experience and that these understandings constantly change and evolve. The task is to discern how we come to reach certain understandings and to work towards a 'goodness of fit' between the identified issues and the possible social work responses, particularly in our multicultural contexts.

A multidimensional approach helps in the identification of a range of factors that are influential in determining positive or negative adaptation. It gives the 'what' we should be alerted to in considering individual situations. Although many argue that it does not necessarily give the 'how' or the 'why'—that is, that it is not clinically useful (Wakefield 1996)—it does provide a map of the important experiential and contextual dimensions that shape and are shaped by adversity experiences.

A multidimensional perspective attempts to understand the influence of the critical dimensions of a person's situation. It extends beyond thinking about the individual causes and responses to considering interacting and competing issues as well. It encourages us to step out of our own comfort zones to think about problems in different ways—if we tend to think about individual adversity from an inner-world, or intrapsychic, point of view, we are encouraged to think more broadly in terms of the influence of the social and political environment. If we tend towards more structural theorising about adversity, we are reminded of the importance of individual factors in understanding a person's, family's or community's coping capacities.

Particularly at the individual casework level, it is argued that for intervention purposes more specific theories are required (Mattaini et al. 1998). These theories are referred to as domain-specific theories because they relate to specific domains or dimensions of human functioning, and they tend to be more explanatory of functioning in these specific domains. Some of the inner-world domain-specific theories include psychodynamic, cognitive-behavioural and narrative theories, each of which provides an explanation for the motivation of human behaviour. As you will see in later chapters, understandings of experiences of grief, stress and trauma tend to be viewed from theoretical perspectives that relate primarily to the inner world. Some of the outer-world domain-specific theories include Marxist, ecological (or systems), feminist, post-structural and chaos theories.

### **Human services responses must be multidimensional**

In highlighting the many dimensions of both the inner and outer worlds that influence individual experience, it is apparent that a range of responses is essential in the human services. Responses must be multidimensional, including practices, programs

and policies that incorporate prevention, intervention and postvention strategies. Research informs and evaluates all of these responses. If the various dimensions of an individual's world are constantly interacting to influence experience, changes in one dimension will potentially lead to change in others. This leads to a variety of considerations for practice.

Three different time dimensions influence the focus of human services practice. The Oxford Dictionary defines **prevention strategies** as 'the action of stopping something from happening or making impossible an anticipated event or intended act'. Prevention strategies have a future focus: they are devised on the basis of known risk factors. When we are referring to **intervention strategies**, we are referring to 'the action or an act of coming between or interfering, especially so as to modify or prevent a result' (Brown 1993 p. 1401). Thus, intervention strategies are present-focused in the face of risk having occurred, increasing the likelihood of damage occurring. In some instances, a further distinction is made, with **postvention strategies** referring to an action taken after an event, so as to modify or prevent *further* damage or disruption. This is most typically used in the trauma context, when arguably some psychosocial damage has already occurred and further damage is being prevented. In Chapter 5, critical incident stress management strategies will be introduced, giving examples of postvention strategies in the aftermath of trauma. Often within social work, it is necessary to start with intervention and postvention strategies in order to identify the critical risk factors and then begin to address issues from a preventive point of view.

Applying this, prevention strategies for mental health issues include many of the initiatives developed within primary and secondary schools in relation to self-esteem issues. Intervention strategies for mental health issues—that is, when they have become problematic for the person concerned—include the availability of mobile crisis assessment and treatment teams, designed to respond to people who are in the midst of acute and serious mental health problems. In this instance, the problem has occurred, but intervention is mobilised so as to prevent further negative consequences.

The method of prevention, intervention or postvention must be considered in the strategy. Social workers use a wide range of methods, including counselling, advocacy, liaison and referral, community development, policy development, information/resource development and education and program development. Sometimes a distinction is made between direct practice and indirect practice methods. **Direct practice**, or casework, is typically delivered in a face-to-face context and can be focused on an individual, a family, a group or a community. With **indirect practice** methods, the person directly affected is not involved in the intervention but is influenced by it—for example, policy interventions are indirect practice methods.

In addition to considering the time frame of strategies and the methods used, a range of skills is required. The skills of engagement and attending, interviewing, assessment, intervention and evaluation are core to all practice. A detailed discussion of these skills is beyond the scope of this book; instead it focuses on the theoretical issues that then inform the interventions required.

## Locating yourself: Engaging in reflective and reflexive practice

Many value-laden issues are inherent in a discussion of human development, relating to judgments about adaptation, coping and well-being, and conversely about maladaptation or coping poorly. These terms may refer to developmental experiences as well as behaviours that are perceived by an individual or by others to be outcomes that are either good or bad or, more typically, somewhere in between. It is important to remember that much behaviour considered adaptive is culturally determined. It is not adaptive per se; it is only adaptive because of a particular context. Implicit in all research on human adaptation to adversity are assumptions about what it is to be human and what is the best expression of that humanity.

Our own values, based on our own experiences and contexts, become critical, therefore, in considering all of this material. We need to reflect on our own beliefs as to what it is to be human, what human rights are, what issues of adversity are, and how we understand their causation and their consequences. We need to be mindful of the ways in which our own experiences of gender, culture and class; of our biological, psychological and spiritual dimensions; and of our unique social networks and place come to influence these assumptions. It is important that we engage in critical reflection as to where we locate ourselves in relation to these matters. In turn, these reflections can enable us to change what we do and who we are. When our reflections transform our actions and change what we do, we refer to this as reflexive practice. It moves beyond our own reflective practice to effect change for others.

### CHAPTER SUMMARY

Understanding human development and behaviour is an extremely complex yet necessary task for workers in the human services. A multidimensional approach highlights that there are many different ways in which human development can be understood. No single theoretical perspective can adequately account for the diversity of individual experiences and the many contextual dimensions that

give rise to these experiences. Instead, a multidimensional approach invites us to think about the significance and interconnectedness of a person's biological, psychological and spiritual dimensions and their relational, social, structural and cultural dimensions. In this chapter, we have looked at how each of these dimensions can be conceptualised.

A multidimensional approach also encourages us to think about the ways in which these many dimensions can function as risk and/or protective factors, and later chapters will explore these more specifically. In examining risk and protective factors, we are considering the absence or availability of various resources for individuals in different contexts. The adaptation that each individual makes to particular circumstances is therefore dependent upon a unique combination of these inner- and outer-world resources. The shift in recent years to understand protective factors more fully has led to a focus on resilience and thriving, the positive developmental outcomes following experiences of adversity. Many questions remain in relation to the processes of fostering resilience—within individuals, families and communities.

## APPLYING A MULTIDIMENSIONAL UNDERSTANDING

### CASE STUDY

#### **Mandy: Fifteen and homeless**

Mandy is fifteen and has been homeless for the last six months. Since the age of twelve, her stepfather had been sexually abusing her. She had told no one about this, being terrified that she would be removed from the home if she said anything. Her mother found her diary and read of the abuse. However, she didn't believe Mandy and screamed at her for making up stories. Mandy left home after this argument and moves now between a friend's house, emergency accommodation and sleeping out on the streets.

Mandy has left school as well, although she occasionally keeps in touch with a teacher. She wants to finish secondary school but just can't get her life organised at present to return. She finds that she often feels overwhelmingly depressed, and has slashed her arms and legs on several occasions.

Her mother and stepfather have since separated, and her mother wants Mandy to come back and live with them again. She has a thirteen-year-old brother.

#### **Questions**

- 1 What is your personal reaction to Mandy's situation? Why?
- 2 Which dimensions of Mandy's experience do you see as risk or protective factors for her?
- 3 What about the risk and protective factors for her family?

- 4 In what way would your understanding of Mandy's experiences change if you knew that she lived in a rural or remote area?
  - 5 What are some possibilities for intervention at a:
    - direct-practice level?
    - program level?
    - policy level?
- 

## KEY TERMS

adaptation	macrosystem
adversity	mesosystem
biographical time	microsystem
biological dimensions	multidimensional approach
biological time	normative
biopsychosocial-spiritual dimensions	outer world
chronosystem	person:environment configuration
cohort	postvention strategies
coping	prevention strategies
cultural dimensions	protective factors
cyclical time	psychological dimensions
direct practice	relational dimensions
exosystem	religion
future time	resilience
gender	risk factors
health	social dimensions
historical/social time	spiritual dimensions
indirect practice	spirituality
inner world	structural dimensions
intervention strategies	subjective experience
life course approach	thriving
lifespan approach	

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## QUESTIONS AND DISCUSSION POINTS

- 1 What are the three key dimensions of our inner worlds?
- 2 What are the four key outer-world dimensions that influence and are influenced by individuals?
- 3 What are the key dimensions of time?

- 4 What are risk factors and protective factors?
  - 5 What is the nature of resilience?
  - 6 Which dimensions of the human experience interest you most and why?
  - 7 Think of your own context and how it influences your current life situation. Draw a map of your current relational, social, structural and cultural context, using Figure 1.8 as a guide.
  - 8 What do you see as the strengths and limitations of a multidimensional approach to understanding human development?
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### FURTHER READING

- Bronfenbrenner, U. 1979, *The ecology of human development: Experiments by nature and design*, Cambridge, MA: Harvard University Press.
- Germain, C. & Bloom, M. 1999, *Human behavior in the social environment: An ecological view*, 2nd edn, New York: Columbia University Press.
- Gilligan, R. 2004, 'Promoting resilience in child and family social work: Issues for social work practice, education and policy'. *Social Work Education*, 23(1), pp. 93–104.
- Hudson, C. (2000), 'At the edge of chaos: A new paradigm for social work?' *Journal of Social Work Education*, 36(2), 215–30.
- Luthar, S., Cicchetti, D. & Becker, B. 2000, 'The construct of resilience: A critical evaluation and guidelines for future work' *Child Development*, 71(3), pp. 543–62.
- Wakefield, J. 1996, 'Does social work need the eco-systems perspective? Part 1: Is the perspective clinically useful?' *Social Service Review*, March, pp. 1–32.
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### WEBSITES OF INTEREST

**Australian Commonwealth Government:** [www.australia.gov.au](http://www.australia.gov.au)

This site provides you with access to a wide range of federal government policy and program frameworks, including both a research and a practice perspective.

**Australian Institute of Health and Welfare:** [www.aihw.gov.au](http://www.aihw.gov.au)

This site is an invaluable source of national health and welfare statistics and information.

**Bronfenbrenner Lifecourse Center, Cornell University:** [www.blcc.cornell.edu](http://www.blcc.cornell.edu)

This centre conducts research relating to the ecology of human development. The site contains research and program information, both past and present, and has useful links to other related sites.



**The Children's Research Centre, School of Social Work and Social Policy, Trinity College, Dublin:** [www.tcd.ie/childrensresearchcentre](http://www.tcd.ie/childrensresearchcentre)

This site, compiled by Professor Robbie Gilligan, has an extensive publication list relating to resilience and excellent links to other resilience- and development-focused sites.

**Embrace the future:** [www.embracethefuture.org.au](http://www.embracethefuture.org.au)

This site, developed by the Mental Health Foundation of Australia, provides information about resilience for young people.

**Resilience Research Centre:** <http://resilienceproject.org>

This site provides research by Michael Ungar and the International Resilience Project team, with a focus on multi-site, cross-cultural resilience research.

**ResilienceNet:** <http://resilnet.uiuc.edu>

This site was developed by the University of Illinois at Urbana-Champaign and has information about resilience, resiliency models and resilience research at a range of other centres.

**The United Nations:** [www.un.org](http://www.un.org)

This site provides extensive information about international human rights issues and global approaches to health and well-being.

**World Health Organization (WHO):** [www.who.org](http://www.who.org)

The World Health Organization is the health agency of the United Nations. This site has information, research tools, publications and links relating to international health topics.

**Information for practice:** World Wide Web resources for social workers: <http://blogs.nyu.edu/socialwork/ip/>

This jointly sponsored website of New York University's School of Social Work and the Division of Social Work and Behavioral Medicine and Mount Sinai's School of Medicine provides over 85,000 links to relevant electronic full-text journals, as well as to other scientific, technical and policy reports.