

# Case Study 1-1

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## Using the Ecological Model in Generalist Practice: Life Transitions in Late Adulthood

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This case uses the ecological perspective as a guide to generalist practice. This perspective offers a framework for how the social worker organizes her work and helps the client cope with a serious life transition.

### *Questions*

1. Why is the ecological perspective considered a good framework for generalist practice?
2. What were the essential skills and abilities the social worker used in this approach?
3. How were ecological concepts used to help the social worker?
4. How was the concept of person and environmental fit used in this case?

I met Mrs. Lilly Goodman at the medical center in Kansas City on the long-term care unit where I work. She is a 77-year-old woman who is thin, small in stature, with straggly gray hair, who peers at you above her glasses, which keep slipping down her nose. When I met her for the first time, I was struck by her sad demeanor. However, as I got to know her, I came to love her wry sense of humor that is often masked to those who do not know her well.

Mrs. Lilly Goodman has been a hard-working laborer all of her life. She grew up in poverty—living in apartments and moving frequently as her father sought new work opportunities. She was not encouraged to go to school and, in fact, quit school after completing a fifth-grade education. Despite this, she is a well-spoken woman who is articulate, well-read, and has seized new learning opportunities all of her life.

Mrs. Lilly Goodman began work as a “cleaning lady” at 12 years old and has been doing it ever since, until she became too frail to continue. She recounts the very day she could not work anymore: “It was about half past noon when I bent over to put fresh sheets on the bed. As I tried to straighten up, my back experienced sharp shooting pains and I knew that I could not work any longer.” As she tells me about her life, I can sense the confident, proud woman that she is. As she talks, you quickly get to know that one of her greatest achievements and joys is her home. She bought and paid for her own home, and she is very proud of having accomplished this goal. Also, her home is a central source of comfort: “I have lived in my home now for 30 years. I have one of the neighborhood’s best gardens. My neighbors stop by to see me on a regular basis.”

I try to think back to what life must have been like for her prior to landing in the hospital. I can see her getting up early in the morning to tend to her flowers, sitting and reading in an old overstuffed chair, and having a few old friends over for afternoon tea. Everything is different now. Her independence has come to an end, and she has not had much time to prepare for it. After suffering two strokes, one right after the other, and developing crippling and painful arthritis, I know that her life must have changed dramatically.

She, however, has not accepted these changes. Mrs. Goodman has consistently told the hospital staff that she plans to return home to live as soon as she gets out of the hospital. Because staff were unsure about the possibility of her returning to home, I was brought in as the long-term care social worker. Mrs. Lilly Goodman did not directly ask for help, but she willingly accepted my offer for help, proffered help—I was reaching out to her.

An ecological perspective was used in thinking about and guiding my approach to practice (Gitterman, 2009; Gitterman & Germain, 2008). From an ecological perspective, Mrs. Lilly Goodman is best understood as someone who is in a *life transition*. She is at a place in her life where she is facing a major transition—from an independent person who took care of herself to a person who is dependent and needs some assistance. There are three aspects of her life transition that help in thinking about how to offer her help:

- Her developmental stage
- Her change in status and roles
- The crises she faces

Mrs. Lilly Goodman is in the final stages of growth. The *developmental stage* that confronts her has a biological base, and the associated tasks of this stage of development

arise out of biological pressures and the social and physical environment. In other words, her residency in long-term care is not of her own choosing; rather, it is a result of illness, limited resources, and lack of family support.

Mrs. Lilly Goodman is also being thrust into some very new *statuses*, none of which she is particularly happy about. These include being:

A resident of a nursing home

A displaced homeowner

A dependent person

An older adult with fairly limiting health problems, which are difficult for her to accept

In addition to new statuses, Mrs. Lilly Goodman has new *roles* that she must adapt to, including being:

A lucid, ambulatory resident among many residents who are neither

A protected mother (and mother-in-law) in a sheltered environment

A welfare recipient, who receives Medicaid to supplement her social security that pays for her care in the long-term care unit

These roles are a striking contrast to the Mrs. Lilly Goodman of only a few months ago—someone who lived independently, tended her garden, cared for her home, and shared tea in the afternoon with friends.

As the team of workers at the hospital staffed this case, they recognized that Mrs. Lilly Goodman faces several *life stressors*. They are considered critical life stressors because they are situations that exceed the personal and environmental resources she has for managing them. The critical life stressors she faces include:

Loss of health

Denial of the limitations her strokes have caused

The threat of losing her home

Her daughter's poor health, which prevents her from providing her mother with support

Client strengths are an important part of the ecological model (Gitterman & Germain, 2008). As I thought about Mrs. Lilly Goodman, I needed to be aware that there is an innate strength in her—toward health, continued growth, and the development of new potentials. Although many of the people on the team exclusively discussed her limitations and what she could *not* do, I was always quick to point out her strengths—what she *could* do. As a social worker focused on helping Mrs. Lilly Goodman obtain self-determination, I empathized with her desire for discharge in order to live in her own house. Out of respect for her, I wanted to honor her wishes. Also, I knew that health could not be easily separated from obtaining satisfaction and meaning in life.

## USING THE ECOLOGICAL MODEL TO GUIDE PRACTICE: A TEAM APPROACH

As the team members began to get to know Mrs. Lilly Goodman, they could see a determined woman who really did deserve an opportunity to try to return home. The team agreed that this was a reasonable goal that everyone could help her achieve. We set about a specific set of actions to make this happen.

Being in the long-term care unit had taken an emotional toll on Mrs. Goodman. Over time she had become increasingly despondent. The first goal was to rejuvenate her passion to seek a more meaningful life. To do this, we agreed to provide her with *our* support to supplement the limited support she received from her daughter in her wish to return home. We spent time talking with Mrs. Goodman about her home—getting her to tell us what it was like and to describe what her priorities would be when she returned. One team member who is an amateur artist sat down with Mrs. Goodman and drew a picture of her house—the outside and inside. You could observe an instant impact from this intervention. This helped shift her focus away from being a “patient” and helped her focus on what she wanted to achieve.

The team knew that to release Mrs. Lilly Goodman back to her home, they would have to be confident that she could function independently. This called for an assessment of the feasibility of discharge. To conduct this assessment, different team members took on separate tasks.

The occupational therapist conducted a cooking evaluation with Mrs. Goodman. This was done in the hospital occupational therapy kitchen. The assessment did not focus on her skills of cooking but on her stamina in cooking for herself. Mrs. Goodman rather enjoyed this challenge. Trying these tasks gave her an opportunity to show others what she could do. Each team member was instructed to help emphasize the positive competencies that she was able to demonstrate. Indeed, Mrs. Goodman did have the necessary stamina for cooking.

The nurse set out to help Mrs. Goodman plan daily activities while she was still on the long-term care unit. This was done to help her develop the stamina to live alone and care for herself. Mrs. Goodman was encouraged to take on increasing amounts of daily living activities. Also, to improve her physical stamina, the nurse worked with her to increase the amount of walking she could do.

As the social worker on the unit, I helped Mrs. Goodman assess what resources and support she would need when she returned home. I talked with her about the kinds of resources other older persons I had helped find useful, such as homemakers, visiting nurses, meals-on-wheels, transportation, telephone reassurance, neighborly support, and the kinds of supplemental income she might be eligible for when she returns home. I also helped Mrs. Goodman realize that she was facing new changes in her life and that she had a lot of adaptations to make. I wanted her to become more accepting of her new challenges. I tried to help her see that she could face these new challenges with new solutions. Although adaptations had to be made, some resources could help make those adaptations easier.

Our work culminated when we decided to take Mrs. Lilly Goodman to her home for a visit. This allowed the team to make further assessments to bolster our confidence

that she would be able to go home. In particular, we wanted to assess her *physical environment*. How easy was it for her to manage her home environment? Was her cooking stove easy to operate? Would she be able to run a bath for herself? How would she get the laundry done? We also examined the outside environment. How easy would it be for her to take the trash out? What kind of neighbors did she have? Would they be able and interested in helping her occasionally? We wanted to know what kind of support was available to her in her *social environment*. As we assessed the daily skills needed to operate a home, we could see how difficult it was for someone like her—with two strokes and painful arthritis.

Lastly, the team brought Mrs. Goodman and her daughter together for discussion of the home assessment and to provide specific information about finances, the daughter and son-in-law's support, and how the daughter felt about her mother's wish to go home. The team wanted to assess the quality of Mrs. Goodman's *interpersonal interactions*.

These assessments were focused on *action*, which takes place in physical, social, and interpersonal environments. The team approach operationalized the notion of treating Mrs. Lilly Goodman *as a whole person*. We were attempting to deal with all aspects of her life in order to facilitate a smooth life transition. From an ecological perspective, when habitats are rich in resources required for growth and development, then human beings thrive. However, when habitats are deficient in vital resources, then physical, social, and emotional functioning are adversely affected.

The primary function of the social worker in addressing life transitions is to help people move through stressful life transitions—to help them adapt and cope. The social worker acts simultaneously as an enabler, facilitator, and teacher. Our work with Mrs. Lilly Goodman certainly sought to enable her by embracing her desire to return home as an important way to help her cope with her life transitions. We helped her develop a plan to return home and helped her assess that plan realistically. We sought to empower her as an individual.

Overall, the team acted as facilitators by serving several different functions. The team supported Mrs. Lilly Goodman's competence through building her skills. We set realistic and measurable goals. For example, we made a contract with her to take more walks in the long-term care unit and assume responsibility for her medication. This aided her stamina and gave her renewed confidence in her own abilities.

We mobilized environmental supports by encouraging Mrs. Lilly Goodman's participation in an organized group in the hospital that was discussing discharge planning. We helped shift her focus from "patient" to consumer. In so doing, we helped her recognize that resources are available to her and that they can be used to help her meet her goals. She became more active and involved in working with us.

We also actively sought to help her develop a sense of self-direction. We knew that to empower her, she would have to take some degree of control over her life and accept increasing responsibility for her decisions and actions. Making age- and health-appropriate decisions and taking purposeful action was key to helping her fulfill her wish to return home. Team members facilitated this by setting up problems that she had to solve. For example, when it was decided that we should visit her home, she had

to make the arrangements with her daughter to secure the house key. Although these actions were small, together they combined to create a new sense of self-direction.

Teaching was an important function in helping Mrs. Lilly Goodman. I took a major role in teaching her several critical skills. For example, I provided pertinent information about how she could manage following discharge from the hospital. This included not only talking about community resources but also teaching her exactly how to use these resources: where to find them, how to contact them, what to say to them, and how to follow up on contacts made. I knew from past experience that too often social workers only talk about resources rather than *teach* clients how to use resources.

Although ultimately Mrs. Goodman decided that she did want to return home, I provided a great deal of education concerning other alternatives that would be available to her. I helped her learn about the range of available options, such as assisted living, boarding homes, and the like. Although none of these alternatives were what she wanted, it helped her see that when you are facing difficult life decisions, resources are available to help you find the best fit for your circumstances.

My teaching also included helping her restructure her perceptions about certain issues. In particular, her reliance on her daughter's moral support and her own continued insistence that she could still care for herself as she had always done in the past. Lastly, the team members taught her the importance of systematic problem solving, which takes into consideration the individual abilities of the person and the resources available to the person. The problem-solving process was highlighted when we asked Mrs. Goodman and her daughter to meet with us to discuss what needed to be considered for a feasible and safe discharge.

## CONCLUSIONS

This case study described the elements of the ecological perspective in recognizing and dealing with an older adult's life transition. The approach included understanding the developmental stage, the changes in status and roles, and the life stressors present in Mrs. Goodman's final stage of growth and development. The social worker—in conjunction with a team of professionals—worked to enable, teach, and facilitate discharge planning for the client. Of course, the unanswered question is: Did Mrs. Lilly Goodman go home?

She did not. After all the planning and work, *she* decided that the obstacles were too many and the support insufficient. In effect, there was not a good enough fit between her individual abilities and the resources and support in the environment. In the end, it was her decision, which made her subsequent adaptation much easier. Mrs. Lilly Goodman benefitted tremendously from the work the team had done. She made progress toward adaptation and learning to cope with her nursing home “home.” She still is not completely satisfied, but now when she talks about going home, she adds, “I'd like to, but I'm not sure I can. I'm not the same person I used to be.”

Further adaptation occurred for Mrs. Goodman a year later when she assumed a resident leadership role by assisting the long-term care professional team in designing

an outdoor space for the residents to enjoy, spring through fall. Materials and labor for this project were donated by a local construction company, a concrete company, and a landscape nursery. The outdoor living space consisted of lovely tree and shrub plants, picnic tables and benches, comfortable seating areas, and a raised garden bed that accommodated wheelchairs. The latter, of course, was Mrs. Goodman's idea. As I look from my office window, I often see her tending her own flowers and helping other residents tend theirs.

## REFERENCES

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