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A Common Thread: Social Justice in Disparate Social Work Settings

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A Common Thread: Social Justice in Disparate Social Work Settings

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Mission Statement

The School of Social Work at Loyola University Chicago created *Praxis: Where Reflection & Practice Meet* to provide a platform for the scholarly work of students and alumni. Our mission is to encourage and support the development of social work knowledge that will enhance the lives of the clients we serve, embody the humanistic values of our profession, and promote social justice and care for vulnerable populations. *Praxis* respects and welcomes all viewpoints.

Editorial Policy

Praxis is published by students in the School of Social Work at Loyola University Chicago. The editorial board is composed of masters and doctoral social work students. The board encourages students and alumni of the School of Social Work to submit papers that provide insight into clinical, policy, research, education and other areas relevant to social work practice. Submissions are accepted throughout the year. Articles should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc or .docx). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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Editorial

A Common Thread: Social Justice in Disparate Social Work Settings

Social work is an expansive field that occurs in a myriad of settings and at different levels. While it may seem as though drafting innovative social work policy is drastically different than providing direct service to individuals facing housing instability, these roles share a common thread.

All social work practice is informed by social justice. These sacred common values are instilled in us not only through our essential code of ethics, but through our coursework and experiences. As social workers, we are called on to challenge injustice wherever we encounter it.

Each article in this issue reflects that theme. The authors have identified sources of injustice in different settings and offer possible solutions to provide better and more comprehensive services to clients. Some social work roles push you out of your comfort zone and require you to think about the lives of others.

We have an article about social support for stroke caregivers. It is important to understand who the client is, and what services they need. We must be creative in our approach to service, as examined through a discussion on iatrogenic depression and treatment options, proposed changes to addiction treatment models, and the push for more community-based treatments.

On a macro level, social work demands that we critically engage in the models we study, so we can develop better policies for our clients, as discussed through the impact of neoliberalism on community-based services. One article calls us to think

about racial microaggressions as an ethical concern in our practice, as well as the potential for far reaching policy impacts. Another author proposes a multidisciplinary approach between lawyers and social workers to provide better services to immigrants. One author identified unintended consequences of criminal justice legislation and suggests an innovative role that social workers can play when working with and advocating for populations impacted by those policies.

Social justice is a common thread in all social work practice, which is only truly possible – and only truly achievable – when social service providers strategically communicate and collaborate. The Co-Editors-in-Chief have seen first-hand how this collaboration enriches the practice. The diverse experiences of our authors and editors enhanced each article and the volume. The authors represented here demonstrate how social workers are called to social justice.

As Co-Editors-in-Chief, we profusely thank our editorial board members and their commitment to Praxis. Significant thanks are given to our publication editor, Yesenia Roman, who has revamped the production and publication of Praxis. We also thank Dr. Nathan Perkins, our faculty advisor, for instilling his trust in Jason Pica II for serving as Co-Editor-in-Chief for two years and for Kate Malcom's faithfulness during her year of service.

Katharine Malcolm
Jason A. Pica II

Stroke Caregiver Support Group in Rural Hospitals

Nicole Betteridge, MSW

Abstract

This article will explore what a stroke is and causes for why strokes occur among people of all ages, but mainly older adults. It will also explore the toll people face who take on the role of caregiving for stroke survivors. Social workers play an important role in making sure caregivers take care of themselves while also caring for someone who has suffered a stroke. This article will discuss why the creation of more support groups may be beneficial for caregivers of stroke survivors and how social workers can play a key in organizing and facilitating more support groups, specifically in isolated, rural communities. This article will use data as it relates to a small rural health center in northeast Iowa. There is still more work to be done for social workers to better support caregivers of stroke survivors in rural communities.

Keywords: stroke survivor, ADL's, caregiver

Introduction

Data from the American Stroke Association show that approximately eight hundred thousand people in the United States have a stroke each year (Meschia et al., 2004). Strokes are sudden and unexpected and result in drastic changes to an individual's cognitive and physical functioning. Stroke survivors often have to relearn gross and fine motor skills, such as walking and balance, as well as cognitive abilities, such as speaking (Meschia et al.,

2014). After stroke victims lose mental and physical functions, research shows that many of them rely on caregivers to assist them with daily tasks and needs (Shannon, 2003). Caregivers play a critical role in the lives of an individual's post-stroke recovery but caring for a stroke survivor can produce high levels of emotional, physical, and mental distress. Clinton Health Center, a rural hospital in northeast Iowa, is one medical center that has recognized the need for more caregiver support. By establishing a stroke support group, Clinton Health Center will help to decrease levels of caregiver burnout, stress, and mood disorders.

Definition of Terms and the Effects of a Stroke

A stroke occurs when a blood vessel transporting oxygen and nutrients to the brain is either blocked by a clot or ruptures (Shannon, 2003). The three types of strokes that can occur are ischemic, hemorrhagic, and transient ischemic attacks. Ischemic strokes and transient ischemic attacks are caused by blood clots. Ischemic strokes occur more often than hemorrhagic strokes (McCullagh, Brigstocke, Donaldson, & Kaira, 2005). People with high blood pressure or high cholesterol are at a higher risk of having an ischemic stroke. Hemorrhagic strokes result from a brain aneurysm or from brain arteries leaking blood or breaking open (Meschia et al., 2014). Furthermore, blood may leak around the brain, causing brain swelling and pressure and damaging

brain tissue and cells (McCullagh et al., 2005; Meschia et al., 2014).

Although strokes affect people differently, some of the following changes, behaviors, and concerns can result. First, an individual may experience hemiparesis or hemiplegia. Hemiparesis as defined by Shannon (2003) is “a weakness, whereas hemiplegia is a paralysis” (p. 47). The paralysis occurs on the side of the individual’s body that is opposite the side of the brain damaged by the stroke. In addition, aphasia and dysarthria can result from a stroke. Aphasia is an impairment to the brain’s functioning that may cause some individuals to lose the ability to read, write, or comprehend speech (Shannon, 2003). Dysarthria is a motor speech disorder that occurs when muscles that control speech production (lips, diaphragm, tongue, and the vocal cords) are damaged (Meschia et al, 2014). Along with language impairments and body weakness or paralysis, stroke survivors experience challenges with balance and coordination, fatigue, pain, and numbness, and they often have trouble controlling bowel and bladder movements (McCullagh et al., 2005; Shannon, 2003;).

In addition to physical challenges, people who suffer strokes often develop cognitive barriers. Cognitive barriers include memory loss; poor judgement, thinking, decision making, and attention to other people; or learning challenges (Meschia et al., 2014; Shannon, 2003). Stroke survivors also often experience sudden outbursts of emotion. Stroke survivors may unexpectedly cry, laugh, or become angry without any rational explanation for their emotion. People who suffer a stroke sometimes experience depression or dysphagia (Meschia et al.,

2014). Dysphagia, which is defined as a difficulty in swallowing, drastically affects a person’s ability to ingest adequate food and liquid (Meschia et al., 2014). Whereas dysphagia affects a person physically, through swallowing, depression affects a person mentally and emotionally. Depression may produce feelings of hopelessness and thoughts of suicide, as well as prolonged recovery efforts for the stroke patient (Plank, Mazzoni & Cavada, 2012).

Realizing the many challenges and disabilities an individual faces after a stroke is important for medical professionals as well as caregivers. Although stroke survivors receive acute care in the hospital and rehabilitation with therapists, much of the burden and care associated with a stroke survivor’s new obstacles and disabilities becomes the responsibility of the caregiver (Andrew, Kilkenny, Naylor, Purvis, & Cadilhac, 2015). A caregiver is defined as “a family member, a spouse, daughter, or grandchild, or an unpaid friend or neighbor who comes to assist the stroke survivor with daily tasks” (Chow, Wong, & Poon, 2007, p. 136). A caregiver’s required responsibilities for the stroke patient vary based on severity of the stroke and age of the individual.

Population Experiencing Strokes

Strokes can happen to any individual at an age in life, but the chance of having a stroke increases with age. Most strokes occur in women aged 65 or older (Andrew et al., 2015). The higher rates of stroke among women versus men is attributed to women’s higher life expectancy in the United States. Furthermore, women face higher risks of having a stroke due to hormones, reproductive health, pregnancy, and

childbirth (“Heart Attack and Stroke in Men and Women,” 2014). The United States population is aging. By the year 2030 it is estimated that the number of people aged 65 or older will double, reaching 75 million (Covinsky, Newcomer, Dane, Sands, & Yaffe, 2003). With the Baby Boom generation aging and becoming more dependent on other people, there is a higher risk of baby boomers having a stroke and thus a larger demand and need for caregivers (Covinsky et al., 2003).

Many social and demographic factors have contributed to an increased need for caregivers to work with older adults who are stroke survivors. Older adults have a higher risk for a stroke due to the development of cardiovascular and metabolic diseases. These diseases include hypertension, diabetes, atrial fibrillation, heart damage from smoking cigarettes, high cholesterol, physical inactivity, and obesity, which have a direct correlation to stroke (Plank et al., 2012).

Older individuals also present higher risks of falls, less stability when standing and walking, and memory loss (Alzheimer’s disease). A stroke doubles the chance of an older adult losing coordination, concentration, and memory (Covinsky et al., 2003). Getting older can present many challenges, and with additional complications due to a stroke, these challenges can place a heavier burden on the caregiver.

Benefits of a Caregiver for Stroke Survivors

Plank and colleagues (2012) found that approximately 45 million Americans provide a combined 38 billion hours of unpaid services to individuals living with chronic conditions or disabilities such as stroke each

year. With the help of caregivers, people with chronic illnesses or disabilities resulting from a stroke may remain in their homes longer or prolong a nursing home placement (Buhr, Kuchibhatla, & Clipp, 2006).



By Brian Walker (flickr)

According to Andrew and colleagues (2015), a person who has had a stroke requires emotional and physical support from family members and other hired or volunteer caregivers. A caregiver’s primary role is to help the stroke patient perform activities for daily living (ADLs). Daily activities that require assistance for the stroke patient may include laundry, house cleaning, grocery shopping, meal preparation, and transportation to doctor appointments (Plank et al., 2012).

Along with performing ADLs, caregivers often assume nursing duties. Caregivers for stroke patients regularly handle injections (e.g., insulin), showering, grooming and dressing needs, transfers from a bed to a chair or a car, medication administration, and feeding, as well as catheter or colostomy care. Caregivers report that they do not have proper training on how to accomplish the nursing needs of the stroke survivor and frequently feel anxious or stressed when left alone to care for the patient (Chow et al., 2007).

Toll on the Caregivers

Caregivers of stroke victims report spending between seventeen and thirty-two hours a week assisting a stroke survivor (Chow et al., 2007). Many caregivers are unpaid and give up time they could spend with their own families or at paid employment to care for an individual who has suffered a stroke. Some caregivers are older themselves, with their own health concerns; others are part of the “sandwich” generation (Andrew et al., 2015). Individuals in the sandwich generation are not only taking care of an older adult but they also have children of their own (Buhr et al., 2006). Due to the time required to care for aging adults as well as their own children, caregivers may be forced to reduce their hours of paid employment. Caregivers thus face economic burdens with less income.

In addition, caregivers have little time for self-care. While juggling their financial and family responsibilities, many caregivers forget to set aside time for themselves (Andrew et al., 2015). Reports show that a lack of self-care increases physical strain, stress, burnout, and risk of mood disorders (Buhr et al., 2006).

Regardless of age, a caregiver’s mental health is also a concern. Caregivers reported having a higher level of depression and mental illness symptoms than their non-caregiver friends. Studies by the Family Caregiver Alliance show that 40 to 70 percent of caregivers have symptoms of depression and that half of caregivers meet the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders* for major depressive disorder (McCullagh et al., 2005). Caregivers also reported that their anxiety and depression

levels worsened if they decided that having a stroke survivor live at home had become too difficult and nursing home placement was required (Buhr et al., 2006).



By Brian Walker (flickr)

National Policies Affecting Caregivers

Caregivers often face stress working with stroke survivors, but there are some national policies to assist them. One such policy is the Family and Medical Leave Act. The Family and Medical Leave Act (2018) allows certain employees to take unpaid job-secure leave to assist with specific family medical concerns. Under the Family and Medical Leave Act the employee will continue to be eligible for the insurance benefits they received while present at work.

Two other policies that help caregivers are the National Family Caregiver Support Program and Lifespan Respite Care Act (James & Hughes, 2016). These policies help meet the needs of family caregivers by providing education and offering home modifications and respite care. Nevertheless, these programs are underfunded on a national level and difficult to access if a patient has Medicaid. Many Medicaid waivers contain a “self” component that requires patients to pay their caregivers. Although the National

Family Caregiver Support Program and Lifespan Respite Care Act have been enacted nationally, the ability for patients to hire a caregiver and pay using Medicaid funds varies from one state to the next (James & Hughes, 2016).

Treatment for Stroke Survivors

Caregivers become an intricate part of a stroke survivor's recovery process immediately following a stroke. In addition, with more medical advancements, limited hospital discharge planning, and shorter inpatient hospital stays, more responsibilities fall on the caregiver once the stroke patient returns home (Buhr et al., 2006).

After a stroke, a patient must first have acute care from his or her medical team. During acute care the doctors determine the type and location of the stroke and begin to foster patient self-care tasks such as eating and getting out of bed (Plank et al., 2012). The caregiver is available to ask questions of the doctors and begin to emotionally support the patient. During the acute care stage of recovery, the caregiver wants to understand the details of the stroke, but it has been reported that the complex medical terminology and recommendations for home medical treatment only add stress and confusion to the caregiver's life.

After acute care in the hospital, the stroke survivor will begin rehabilitation. During rehabilitation, the patient will work with speech, occupational, and physical therapists to regain strength and mobility. The caregiver has an important role during rehabilitation (Plank et al., 2012). Although the stroke patient may devote a number of hours to working with a trained therapist each week, he or she

must continue working on stretches, mobility, balance, or speaking skills at home with the caregiver (Chow et al., 2007).



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Barriers to Creating Hospital Support Groups

Support groups for caregivers are often nonexistent at rural hospitals. There are several reasons for this. First, hospital support groups are not easily accessible in rural locations. Many caregivers live many miles from a hospital and are not able to spend time driving to and from the hospital for a group that is not mandated (Chow et al., 2007). In addition, because caregivers know their patients' needs best, they worry about patient safety if they are gone for too many hours at a time.

Another reason for the lack of support groups at rural hospitals is that some hospitals are understaffed and have small yearly budgets. These hospitals may not have the personnel necessary to run a support group (Chow et al., 2007). Employees are already overworked with large caseloads and do not have the time to take on extra projects. Due to a tight budget at many small hospitals, there are often no extra financial resources to fund a support group. Furthermore, many small hospitals do not have access to endowments and grants that could

provide additional finances to run a support group for caregivers.

The Value of a Support Group for Caregivers of Stroke Survivors

Because caregivers take on multiple roles in high-anxiety and stressful environments, support groups can help caregivers cope by connecting them with other people who serve as caregivers. Support groups cost little to nothing to create and maintain, have open membership, and offer flexibility with no commitment required for participation (Williams, 2012). Moreover, support groups foster valued group dialogue that can help a caregiver with feelings of guilt, anger, frustration while emphasizing and fostering self-care techniques (Diefenbeck, Klemm, & Hayes, 2014).

Medical doctors and hospital boards need to recognize the physical, emotional, and mental strains, anxiety, and stress experienced by a caregiver for stroke survivors. As evidenced by the rates of physical and mental illnesses caregivers face, more caregiver stroke support groups need to be formed to help to decrease feelings of stress, anxiety, social isolation, depression, and helplessness felt by caregivers (Buhr et al., 2006).

Psychiatrist Irvin Yalom believed that an individual's therapeutic needs could be met through support groups (Diefenbeck et al., 2014). First, Yalom stated that support groups can help caregivers of stroke survivors by providing optimism and hope. Through a caregiver support group, individuals can hear stories of how other caregivers have handled their work with stroke survivors. Caregivers may share stories of how their clients made improvements in their speaking ability. By hearing success

stories, caregivers receive the energy and motivation they need to continue their work with stroke survivors (Williams, 2012).

Support groups also protect against feelings of social isolation in caregivers. Social isolation is avoided by group cohesiveness, interpersonal learning, and the sense of belonging that a support group fosters for its members (Williams, 2012). Support groups allow caregivers to form friendships and engage in fellowship with people doing the same type of work and to collaborate with each other to solve problems (Diefenbeck et al., 2014).

Support groups help caregivers of stroke survivors to gain encouragement, empowerment and control in managing the disorders and disabilities of others. By listening to the feedback and suggestions of others in similar circumstances, caregivers can be rejuvenated and refocused managing a stroke survivor's needs (Williams, 2012). When caregivers are able to see and learn about techniques other people have tried to help stroke survivors, they are encouraged to continue their work and treatment plans with their stroke survivors.

Support groups also allow caregivers to take a break from their daily routine to care for themselves. Hence, support groups can be a form of self-care for caregivers (Williams, 2012). It is important that caregivers devote as much time caring for themselves as they spend caring for the stroke survivor. Without self-care, a caregiver's mental, physical, and emotional health may decline. Support groups can also provide caregivers with resources on ways to care for themselves at home, whether it be taking a warm bath or reading a fun novel.

There are numerous advantages to creating support groups in rural hospitals for caregivers of a stroke survivor, but it is the medical social worker who is best equipped to create and manage support groups. Social workers can be equipped to network and meet with families in their homes and thus recognize the needs of communities. In this role, social workers are able to connect people who may not know one another for conversations and support. Medical social workers also know how to work on a multidisciplinary team and how to navigate difficult conversations among family, doctor, and therapists (Plank et al., 2012). Medical social workers can act as facilitators of meetings, asking topic questions that spark thought and conversation between participants (Plank et al., 2012). Furthermore, medical social workers often have an educational background in health and trauma and can provide

counsel and advice to struggling caregivers.

Although social workers play a vital role in working with caregivers to support their needs, caregivers face many daily struggles in caring for stroke survivors. Specifically, in rural areas, there is a greater need for hospitals to provide support groups for caregivers of stroke survivors. Caregivers can receive a plethora of benefits from a support group. Not only do support groups allow caregivers to make new friends with others who can relate to their situations, but they also help caregivers avoid feeling isolated and provide a safe place to share feelings and ideas for working with stroke survivors. It is hoped that more rural hospitals will begin to recognize the importance of providing support groups for caregivers of stroke survivors, and with the help of social workers, create more support groups for these caregivers.

Nicole Betteridge is a 2017 alumna of the Master of Social Work program at Loyola University Chicago. She also holds a BA in Religious Studies and Social Work. Throughout her studies she had the opportunity to complete an internship in a rural hospital in Iowa. This article was inspired by her experiences at that hospital as well as her personal encounters due to a stroke she had. Nicole currently resides in Chicago where she works in schools with children and refugee families.

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A Biopsychosocial Approach to Comprehending Suicide

Jasmine Chandy, MSW

Abstract

Suicide is a major public health issue that proves to be more widely interpreted than meaningfully understood. The lack of competency around suicide and harmful language contributes to the disenfranchisement of suicide-related grief. The following paper seeks to explore suicidality through a biopsychosocial perspective. The paper then emphasizes the importance of gaining competency to solidify social work core values and advocate for those grieving a loss by suicide.

The ability to overcome challenges increases when professionals and local community members are committed to investing themselves and their resources in the effort. One such uniquely human challenge is suicide, which is continuing to become more prevalent. According to the American Foundation for Suicide Prevention (AFSP; n.d.), in 2017 there were 129 suicides in the United States every day, 47,173 deaths by suicide, and 1.3 million suicide attempts. Although the numbers are staggering, it is also important to consider the complexities the loss introduces into the deceased individual's microsystems. A suicide does not end with the lost life. Its intricacies continue in the children, family, and friends who grieve the loss of their loved one while facing added layers of disenfranchisement, misunderstanding, guilt, and anger.

Although the topic of suicide is slowly coming out of the dark, breaking the stigma is not sufficient without education on the complexity of suicide. Awareness should increase in tandem with adequate information regarding the causes, challenges, realities, and prevention of suicide. Social workers have a unique opportunity to seeking understanding of individuals from a biological, psychological, and social perspective. It is important to view suicide among these layers. Education on suicide solidifies social work core values of the dignity and worth of the person, the centrality of human relationships, and competence while normalizing the grief process for bereaved individuals affected by suicide.

Conversation about suicide can be a form of advocacy. One must consider the implications of saying someone committed suicide. Such a statement implies that the individual knowingly and intentionally committed an act, even though suicide can involve an interplay of complex biological, social, or psychological phenomena. The word *commit* also criminalizes the individual, in the sense of committing a crime. Suicide is not an unlawful deed; rather, it is a misunderstood yet all too common act. Moving away from the phrase *committed suicide* and instead using *died by suicide* can help acknowledge the complexities of the act while decriminalizing the individual. The following case study of a community grieving the loss of a loved one to suicide

will illustrate the role of suicide awareness, education, and dialogue.

Case Example: Frank

Frank, a forty-three-year-old businessman, owned a children's art studio and was happily married. He was known by the children in his art studio for being a friendly and happy man who always said "stay positive!" when the children struggled with their work. Frank's wife was pregnant with their first child. All seemed well until one day when Frank's family and friends were shocked to learn that he had died by suicide.

As a clinical social work intern within a grief organization, I had the opportunity to attend a crisis intervention event at Frank's art studio for the families who regularly attended the studio. Alongside incredible professionals in the field of suicide and grief, I was available to answer questions and host a conversation. We were there to be present with what was scary and uncomfortable, a privilege of the social work profession.

During the event, Nancy Perlson, a social worker in the field of grief and a prominent advocate for suicide education, responded to the overarching comment "I just don't understand why he would do it." Nancy said, "During an act of suicide, it is as if the individual is putting on a pair of glasses that is not their prescription." She went on to explain the role of mental illness that goes untreated. When an individual is not given proper support, coping strategies, education, and in some cases medications, he or she undergoes an even more blinding experience. This statement offered unexpected comfort for Frank's friends while it simultaneously spurred curiosity in me. Why does suicide happen? I realized that I had heard about suicide far

more often than I had learned about it, and as a future social worker I felt committed to gaining more competency.

Biological Realm of Suicide

There is a misconception in society that suicide is an intentional end to distress. The completed suicide is rarely viewed from a deeper level, the individual's own biology. Since the 1960s, there has been a growing body of research uncovering a unique biology of suicide. Research by Asberg, Träskman, and Thorén (1976) suggested that there were decreased levels of 5-hydroxyindoleacetic acid, a metabolite of serotonin, in the cerebrospinal fluid of a substantial subgroup of individuals who attempted suicide. Further evidence sustains this finding that the serotonin transporter may play a role in the biology of suicide. Investigators have used postmortem brain tissue and platelets to study alterations in the brain that may relate to suicidal behavior, with particular interest in the binding of the serotonin transporter (Purselle & Nemeroff, 2003). Within this realm, there was evidence of serotonin transporter binding changes in suicides compared to non-suicidal volunteers (Arato et al., 1987). This study reported significantly higher serotonin transporter binding in the left frontal hemisphere and no hemispheric differences in the volunteer group. Such findings have yet to be replicated, leaving the current academic climate lacking a clear binding pattern.

Suicidal behavior can also have a genetic component. Genes involved in neurotransmitter systems have been found to have altered function in suicides. For example, in the serotonergic system, monoamine oxidase A has been found to be altered (Currier & Mann, 2008). In

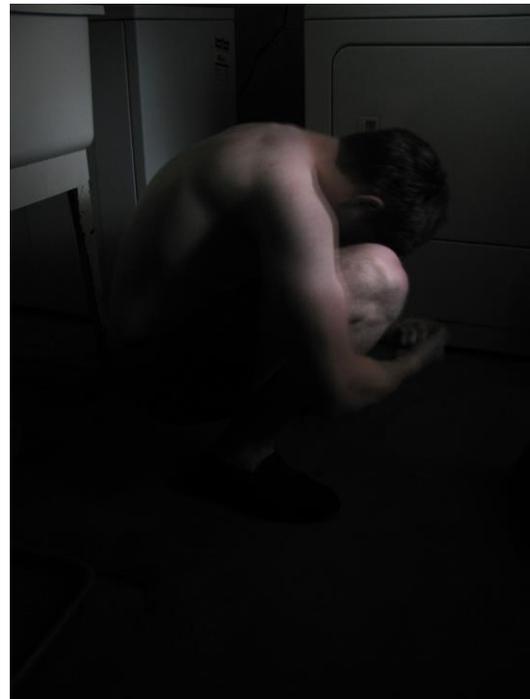
addition, twin studies have provided evidence for the heritability of suicidal behavior (Brent & Mann, 2005). Twin studies are particularly advantageous because they reveal the importance of genetic influences on suicidal behavior. Although there remains the challenge of distinguishing the depressed brain from the suicidal brain, postmortem research has shown that there is a difference in the serotonin transporter deficiency in particular areas of the brain. In suicides, there are fewer serotonin transporters in the hypothalamus. In major depression, there are fewer serotonin transporters in the occipital cortex. For both suicides and major depression, there are fewer serotonin transporters in the brainstem (Purselle & Nemeroff, 2003). The biology of suicide is an important area of research as further studies can help acknowledge the differences between the mind and the brain to ultimately comprehend the complexities behind an act of suicide.

Psychological Realm of Suicide

The psychological context of suicide can further distinguish the mind and suicidal behavior. Suicide may serve as an escape from seemingly intolerable psychological experiences. Such psychological experiences may be categorized as psychological pain, harsh self-evaluations, and perspectives in which solutions to current situations appear to be absent. In fact, a study by Baumeister (1990) found that the majority of suicide notes described the desired function of suicide attempts as an escape from emotional pain. In a study of adolescents, those who had a higher tendency to suppress undesired thoughts reported that suicidal behaviors worked to reduce their negative emotions (Najmi,

Wegner, & Nock, 2007). Thus, suicide may serve as an extreme mode of experiential avoidance (Chiles & Strosahl, 2005).

In parallel with these studies, the American Foundation for Suicide Prevention (AFSP) reported that suicides occur when the stressors exceed current coping abilities of someone with a mental health condition. In fact, according to the AFSP, “ninety percent of people who die by suicide have a mental disorder at the time of their deaths” (2019). It is therefore important for social workers to help individuals struggling with mental illness to understand that the illness is not their fault. Treating the mental illness with medication and psychotherapy is a promising way to reduce suicide rates. For example, in patients with bipolar 1 disorder mixed episode, olanzapine in combination with a mood-stabilizing agent has been suggested to reduce suicidal ideation (Houston et al., 2006).



“Depression” by Billie Wilson (thebillywilson.com) on flickr

Social Realm of Suicide

In conjunction with biology and psychology, social connection and conceptualization have a vital role in suicidal behavior. Human beings create descriptions of themselves. In suicidal individuals, the conceptualized self is quite negative. Suicidal individuals view themselves as broken, damaged, or hopeless (Luoma, Hayes, & Walsler, 2007). In such cases, mindfulness practices can help these individuals transcend the distorted views of themselves.

Media also plays a role in increased suicide rates. There have been increases in suicide rates after both fictional and nonfictional reports of suicide. Nonfictional suicidal reports have proven to most greatly increase the rate of suicides (Stack, 2003). Conversely, there is a decrease in suicide rates when there are fewer accounts of suicides in media (Motto, 1970). Thus, it is important that both fictional and nonfictional accounts of suicide emphasize warning signs and prevention resources more than the suicides themselves. The preceding factors should be normalized to a far greater extent than the suicide in order to validate the challenge and acknowledge potential solutions.

Due to the developmental stage, teen risks for suicide can also be understood as assortative relating, which is the tendency to preferentially associate with others experiencing shared life stresses (Joiner, 2003). The aggregation of assortative relating with the influx of access to fictional and nonfictional suicide accounts through social media and entertainment poses a new threat to suicidal inclination in teens. It is therefore necessary for school social workers to

prioritize competency in the complexities of suicide and to normalize suicide prevention resources in schools.

The Role of Social Workers

Gaining competency in the nature and reality of suicide will allow social workers to acknowledge the dignity and worth of the individual and the complexities of their relationships. After a suicide, the loss is often defined by the way the person died and not by the actual personality, character, and stories of the individual. Bereavement resources should do justice to the deceased individual's lived life. Social workers should offer guidance when families struggle with the societal exclusion of suicide grief. Those who are bereaved as a result of suicide unfortunately face added layers of marginalization. Family members have described feeling excluded by their religious groups and even being blamed for not predicting the suicidal behavior of their loved one. Such societal attitudes often lead these family members to choose to lie about the cause of death. It is essential that social workers normalize these feelings and situations.

Guidance to families may also include referrals to suicide support groups and support when talking with a child about a suicide loss. Discussions with a child should assert that the deceased individual killed himself or herself because he or she suffered an illness of the brain and did not know how to get help. It is important to convey that mental illness is not an intentional choice, but a disease of the brain that requires medical support and the support from others. It is crucial that adults are honest with children because a child's imaginations are often far worse than the truth itself. As a byproduct of honesty,

trust is a comforting element in the grieving process because it offers a safe space for the grieving family members to confront their confusion.

Everyone can contribute to changing societal views on suicide and advancing research on the topic. The world of social work is broad and reaches a profound range of the community. Let us use that to our advantage to advocate change. In working on competency and intentionality, we can take the blame away from the individual and family and instead acknowledge that “for suicidal people, thinking is less flexible and more negative” (AFSP, 2019).

Clinicians need to continue learning how to support suicidal clients in managing their symptoms and alleviating their illnesses through psychotherapy and proper medical referrals. According to Kleiman and colleagues (2017), the intensity of suicidal ideation changes

dramatically over a few hours. Gaining competency and affecting change on a micro, mezzo, and macro level will have a ripple effect in influencing those few hours. As social workers, we must seek to be experts in our field and advocate for those with suicidal ideations and for families who have lost a loved one to suicide. This professional due diligence was demonstrated in the crisis intervention for Frank’s community. Nancy Perlson used the space to spread awareness, education, and comfort in a time of deep distress and confusion. By refining our own competence and becoming comfortable with what is misunderstood, we can solidify social work core values of dignity and worth of the person, centrality of human relationships, and competence while normalizing and validating the grief process for this complex loss.

Jasmine Chandy is a recent MSW graduate from Loyola University Chicago with a specialization in Health. She has earned her Bachelor of Science degree with a dual major in Biology and Spanish at the University of Illinois at Chicago and is working to interlace the realms of science, language, and social work to better serve those in need. Jasmine completed her first level internship at Willow House, a non-profit grief organization, where she worked with children, teens, families, and communities grieving the loss of a loved one. Jasmine completed her second level internship at NorthShore University Health System’s Highland Park Hospital on a general inpatient and orthopedic unit. In congruence with her goal of integrating language and science within a social work career, Jasmine hopes to bring her interests to a hospital setting while continuing to immerse herself in social work education.

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The Pain Response Model of Addiction

Alicia Conway, MSW

Abstract

Currently, there are many theories that attempt to explain the for the causes of drug abuse and dependency. Often these models of addiction do not consider the pain experienced by many substance users. This article will examine the disease model, natural recovery, disorder of choice theory, and the self-medication hypothesis theories of addiction and then provide a conceptualized pain response model. Overall, this article will review substance-related disorders as a response to pain by providing evidential information about current opioid trends, opioid use disorder, comorbid mental health disorders, and substance use as a coping mechanism for mental and physical pain.

Keywords: opioid use disorder, substance use disorders, addiction theory, pain

According to the National Institute on Drug Abuse (NIDA, 2019), “on average, 130 Americans die every day from an opioid overdose.” Currently, opioid use in America is a national crisis due to increased acceptance of opioid prescriptions, increased opioid dependency among many populations, and increased number of opioid-related deaths (Centers for Disease Control and Prevention, 2018; NIDA, 2018; U.S. Department of Health and Human Services, 2019). The misuse of both prescription and nonprescription opioids can lead to substance dependency or

overdose. The number of prescription opioids provided to patients to treat chronic pain is increasing steadily, even without sufficient evidence proving long-term effectiveness (Centers for Disease Control and Prevention, 2018). In 2016, 40 percent of opioid overdose deaths were related to prescription opioid use (U.S. Department of Health and Human Services, 2019).

For the purpose of this article, nonprescription opioid use will be considered heroin use. Heroin is a highly addictive drug, and users of heroin tend to have a history of prescription opioid use. Approximately 80 percent of new heroin users abused or misused prescription opioids prior to heroin dependency (NIDA, 2019). To understand the issue of opioid use disorder, the trends of use by users of both prescription opioids and heroin must be considered.

With more people meeting the criteria for opioid use disorder each year, it is necessary to reconsider current addiction perspectives, examine common reasons for opioid use, and acknowledge the relationship between opioid dependency and psychopathology. Opioid use disorder must be considered as a coping mechanism for pain, rather than simply an unavoidable genetic disease. Yet, within the field of addiction treatment and research, addiction is commonly viewed as a result of genetic predispositions rather than external factors (Gabbard, 2014). This article will further evaluate current models of addiction and introduce a perspective that

considers the presence of pain in many individuals who use opioids. The purpose of this article is to examine substance-related disorders as a response to pain by providing evidential information about current opioid trends, opioid use disorder, comorbid mental health disorders, and substance use as a coping mechanism for mental and physical pain.



"A whole galaxy of multi-colored uppers, downers..."
by ep_jhu (flickr)

DSM-5: Opioid Use Disorder

The commonality among all substance-related disorders is the requirement for "ingestion of chemicals that may lead to addiction, life-threatening physical problems, and a host of emotional problems" (Gabbard, 2014, p. 345). Substance-related disorder diagnoses include the severity of dependency based on the number of specific criteria met by the individual (APA, 2013). Opioid dependency is listed as a disorder in the *Diagnostic and Statistical Manual Mental Disorders, 5th edition (DSM-5)*, because the APA considers substance-related dependency to be a biological disease. The term *dependency* is used within the *DSM-5* to avoid the potential negative implication of the word *addiction*. However, because the term *addiction* is used throughout other substance-related literature, this

article will refer to addiction and dependency as equivalent.

The diagnostic criteria for opioid use disorder requires an individual to experience significant impairment or distress due to a pattern of opioid use (APA, 2013). Significant impairment or distress is measured by a year-long occurrence of two of the following symptomatic characteristics: unsuccessful efforts to control opioid use, a large amount of time spent attempting to obtain opioids, cravings, failure to meet obligations due to opioid use, tolerance, or withdrawal. According to the APA, this disorder usually develops in individuals who are in their early twenties and can continue for several years. The only risk factors for opioid use disorder identified in the *DSM-5* are genetic and physiological.

Other opioid-related disorders included in the *DSM-5* are opioid intoxication, opioid withdrawal, other opioid-induced disorders, and unspecified opioid-related disorders. Opioid intoxication occurs as a result of the recent use of an opioid, leading to behavioral and psychological changes whereas opioid withdrawal symptoms result from stopping or reducing heavy or prolonged opioid use. In the *DSM-5*, a disorder qualifies as other opioid-induced disorder if it shares symptoms with another psychopathological disorder. In other words, the APA acknowledges that psychological disorders may be induced by opioid use. Finally, unspecified opioid-related disorders include any presentation in which opioid use causes significant distress or impairment without meeting the criteria for previously listed opioid disorders.

The Disease Model

Most addiction treatment providers, the APA, and federal research institutes use the disease model to conceptualize substance-related disorders. This section will provide both a description of the disease model and an explanation of why it is not the most comprehensive perspective for considering opioid use trends and opioid-related disorders.

Description of the Disease Model

Use of the disease model to understand substance-related disorders implies substance dependency is a disease, such as diabetes. Both NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) describe addiction as a chronic relapsing brain disease similar to diabetes, asthma, or heart disease (Branch, 2011). In the same way individuals do not choose to have diabetes, they do not choose to be addicted to substances (Gabbard, 2014). Therefore, addiction is explained as an inherent genetic predisposition toward an action rather than a result of psychological or environmental factors. This perspective removes the responsibility for dependency from the individual and attributes it to genetics. The disease model is supported by research on the genetic influence of substance-related disorders comparing dependency among twins (Gabbard, 2014).

The *DSM-5* appears to follow the disease model for various substance-related disorders. Criteria for opioid use disorder include intense psychological changes in the brain, resulting in the development of compulsive behaviors. These behaviors often include planning

daily activities around obtaining or using opioids. Additionally, the *DSM-5* states an individual with impairments of brain inhibitory mechanisms or impaired self-control or impulse-control is more likely to develop a substance use disorder. Thus, it is clear the *DSM-5* seeks to explain addictive behaviors to substances, including opioids, as a genetic predisposition rather than a response to environmental factors. Furthermore, the only risk and prognostic factors identified for opioid use disorder in the *DSM-5* are genetic and physiological. This implies the APA believes genetic and physiological factors are the most significant factors leading to addiction. It is not directly stated in the *DSM-5* that the APA follows the disease model in the theoretical application of substance-related disorders. However, identifying only genetic and physiological factors in the *DSM-5* implies the APA does not recognize the potential for behavioral or psychological factors to lead to substance dependency.

Disputing the Disease Model

The popularity for the disease model among addiction treatment providers, the APA, and federal research institutes leads to the use of the model as a theoretical background for multiple addiction services including Alcoholics Anonymous. Alcoholics Anonymous programs encourage participants to accept they have no control over their drug addiction because it is a chronic and progressive disease (Gabbard, 2014). The popularity of these programs encourages the acceptance of the disease model. However, it is worrisome that encouraging individuals to view their dependent behaviors as unmanageable or chronic will reduce their belief in their

ability to make meaningful lifestyle changes. Although the disease model may offer individuals with chemical dependency relief from the responsibility of their choices (Gabbard, 2014), this model does not recognize the initial reasons an individual sought out substances or recognize substance use as a mechanism for managing pain.

Due to the development and increased acceptance of the disease model, NIDA and NIAAA spent large amounts of time and money researching the disease model and drug-related disorders (Branch, 2011). However, the increase in available support for the disease model has not lead to a decrease in drug use. In fact, drug dependency rates remain the same or continue to increase. Therefore, the effectiveness of this conceptualization of addiction is in question. Although there is truth to the hypothesis that genetics influence dependency, this is only one part of a very complex issue.

Overall, the disease model favors biological predispositions over behavioral or psychological factors as the causes of substance dependency. Although genetic and biological influences are necessary considerations in the conceptualization of addiction, other factors must be acknowledged. Research shows treatments related to the disease model are typically less successful for individuals with drug-related disorders than for alcohol dependency (Gabbard, 2014). Evidence disproving the effectiveness of the disease model in treating drug-related disorders suggests other theories must be considered in the conceptualization of opioid use disorder. The behavioral and psychological factors not acknowledged in the diagnosis of individuals with opioid dependency may be related to the

increasing number of people affected by the opioid crisis.

Opioid Use Disorder, Pain, and Coping Mechanism

As previously mentioned, identifying only genetic and physiological factors as causes of substance dependency in the *DSM-5* implies the APA does not recognize the role of behavioral or psychological factors. However, various studies on opioid trends support the relationship between opioid misuse and the occurrence of mental or physical pain (Boscarino, Hoffman, & Han, 2015; Khantzian, 1985; Raheb, Khaleghi, Moghanibashi-Mansourieh, Farhoudian, & Teymouri, 2016; Richardson et al., 2012). Mental pain includes mental health disorders or trauma-related pain. Physical pain can be post-operative pain, pain related to cancer treatment, or chronic non-cancer-related pain. The author's perspective is that the use of opioids is the individual's learned or chosen coping mechanism to numb or eliminate their pain.

Mental Pain

There is an extensive amount of empirical research supporting the comorbidity between mental health disorders and drug dependency, including opioid use disorder. For example, 60 percent of people coping with a substance use disorder suffer from another mental illness (NIDA, 2018). Mental health disorders frequently associated with opioid use disorder include alcohol-related disorders, major depressive disorder, generalized anxiety disorder, and posttraumatic stress disorder (Boscarino et al., 2015). Psychological

traumas and childhood adversity are other factors related to the emergence of opioid use disorder. Due to a frequent presence of co-occurring mental health disorders, it is essential to consider the causality between the two disorders when attempting to understand opioid addiction.

In the *DSM-5*, the APA acknowledges the occurrence of psychopathological symptoms in response to the use of substances. However, it fails to include psychopathological symptoms or disorders as risk factors for opioid dependency. Mental health disorders lead to an increased risk for opioid dependency in patients with chronic pain and an increased likelihood of nonmedical use of prescription opioids (Richardson et al., 2012). Therefore, it must be asked why the description of opioid use disorder and other drug dependency disorders in the *DSM-5* do not reflect this information. It is necessary to understand the relationship between pain and dependency because individuals with comorbid mental disorders are often resistant to treatment and more likely to relapse (Raheb et al., 2016). Although treatment is not the focus of this article, this evidence must be acknowledged in the attempt to understand dependency disorders. Information about effective treatment provides insight into the origin of the disorder itself.

Additionally, individuals experiencing mental health disorders often show a somatic display of symptoms, such as chronic back pain, headaches, and joint pain (Richardson et al., 2012). The potential for mental health concerns to cause physical pain may cause misguided coping mechanisms

leading to the misuse of prescription or nonprescription opioids.

Physical Pain

In the 1990s, prior to understanding the addictiveness of opioids, providers quickly began to prescribe opioid pain relievers (U.S. Department of Health and Human Services, 2019). This increase in opioid prescriptions is associated with the increase in the misuse of opioids. Today providers continue to prescribe opioids for chronic non-cancer-related pain or any long-term pain caused by conditions other than cancer, such as back pain, headaches, or arthritis (Center for Disease Control and Prevention, 2018; Richardson et al., 2012). Although both prescription opioids and nonprescription opioid use can lead to dependency (NIDA, 2018), providers continue to prescribe these medications, even with a lack of clinical evidence supporting their use (Boscarino et al., 2015). Furthermore, more than 20 percent of patients misuse the opioids prescribed for the management of their chronic pain (National Institute on Drug Abuse, 2019). This implies opioid use and the experience of physical pain are risk factors for the development of opioid use disorder. Thus, individuals who experience mental or physical pain and lack positive coping mechanisms for this pain appear to be more likely to begin using or become dependent upon opioids.

Addiction Theories

Currently there is no comprehensive and identifiably correct model of addiction in the medical field. As previously discussed, the disease model does not comprehensively identify

potential factors for drug dependency. There is evidential support for several different theoretical conceptualizations of the complex factors leading to drug dependency. In order to develop a well-rounded understanding of addiction, evidence from a variety of theories is considered and applied. The theories discussing natural recovery, choice, and self-medication all provide evidence that drug addiction is not an unmanageable and chronic disease, but one based on an environment that dictates an individual's decisions for pain management.

Natural Recovery

Natural recovery theory is based on evidence that some individuals are able to recover on their own. Each individual's ability to recover from drug dependency is based on the amount of recovery capital available to him or her. Cloud and Granfield (2001) interviewed people who reported recovering from drug addiction without help from substance use treatment groups or programs. Recovery techniques reported by the individuals in the study included focusing on other activities, depending on close relatives or friends, and avoiding drug-related environments. Although the majority of the participants were white, middle-class, and employed college graduates, the findings provide valuable information about the various aspects of recovery capital and the ability to recover naturally.

The reported techniques fall into three categories of recovery capital: social capital, physical capital, and human capital (Cloud & Granfield, 2001). Social capital includes resources from social relationships (e.g., emotional support, trust, preferential treatment). Physical capital includes any tangible

property or wealth (e.g., cars and homes). Lastly, human capital includes personal attributes or skills that help the client achieve goals (e.g., a college degree, vocational skills, acquired knowledge). Coping mechanisms for physical or mental pain fall into the category of human capital. Individuals with the learned skills or personal attributes needed to make healthy coping decisions are less likely to rely on drugs to eliminate pain. An abundance of recovery capital allows some individuals to benefit from natural recovery (Cloud & Granfield, 2001). However, many individuals have limited recovery capital and may be less capable of natural recovery due to factors outside of their own control. Nevertheless, the research supporting the natural recovery process leads to the inference, if recovery is possible among some individuals, the supposition that addiction is an unmanageable disease of the brain cannot be generalized to all individuals. This information suggests addiction in some people may be a "choice" if they are able to recover without seeking further substance abuse help.

Disorder of Choice

Disorder of choice theory is based on the concept that addiction is a choice rather than a disease. To be clear, this does not mean the individual is directly choosing to be addicted to drugs, but instead he or she is making small daily decisions that lead to an addiction (Branch, 2011). This concept explains that individuals choose their best current option, and often they choose the short-term benefits of substance use (Branch, 2011). Evidence supporting this theory includes research showing both the higher remission rate of addiction

compared to other psychiatric disorders and the fact that the majority of individuals with addictions are able to quit without professional help (Heyman, 2013).

According to disorder of choice theory, individuals meeting criteria for opioid use disorder find the immediate pleasure of opioids to be the better choice amongst the other potential options. Thus, it can be argued that these individuals find immediate relief from physical or psychological pain to be the better choice than experiencing the pain and opioid use becomes the coping mechanism they use to respond to their pain. The self-medication hypothesis further supports this idea.

Self-Medication Hypothesis

The self-medication hypothesis states specific individuals are predisposed to drug dependency by their psychological vulnerabilities and pain (Khantzian, 1985). This theory associates an individual's drug of choice with the type of pain they are attempting to eliminate. Khantzian reports individuals abusing heroin often struggle with dealing with their feelings toward others. They choose heroin because they prefer the numbing effects and can use it as a defensive mechanism. Thus, using heroin is an attempt to self-medicate emotional distress because they have not developed healthier coping mechanisms. This further supports the concept of drug use as a coping mechanism for pain.

Overall, the self-medication theory implies individuals with drug addictions have a specific drug of choice. Understanding this drug choice provides information about how the individual uses the drug to deal with "overwhelming affects,

relationships, and behavioral disturbances" (Khantzian, 1985, p. 1262). There is evidence of a significant relationship between heavy reliance on narcotics, such as opioids, and severe psychopathology. By suggesting individuals with addictions to opioids are self-medicating to treat the symptoms of intruding psychological disorders, self-medication theory supports a conceptualization of drug use as pain response. Therefore, we must consider opioid use as a response to psychological pain rather than an unavoidable and unmanageable disease.

Conceptualized Pain Response Model

There appears to be an understanding that psychiatric disorders can be caused by substance use, but there is a lack of current theoretical perspectives recognizing substance-related dependency as a possible result from prior psychiatric disorders. Behavioral and psychological factors leading to drug dependency must be recognized. Drug use is likely initiated as a response to some level of mental or physical pain. Aspects of natural recovery, disorder of choice, and self-medication models lead to the emergence of this pain response perspective. The ability of some individuals to successfully complete natural recovery from addiction suggests addiction is not unmanageable for all people, particularly those with an abundance of recovery capital. Next, if it is not a disease, there must be some aspect of choice involved in maintaining a substance addiction. There must be a reason for an individual to choose the long-term consequences of drug dependency. This reason is likely the short-term benefit of self-medicating. Therefore, individuals are responding to

and self-treating their experienced pain with opioids or other substances because they have not developed a healthier way to cope. Further research examining ways to cope with pain as alternatives for substance use will be beneficial to both this pain response model and the field of addictions treatment and research.

Social Work Implications

Social workers play a key role in working with clients suffering from substance use disorders and mental health disorders. The comorbidity between mental health disorders and substance dependency means social workers must learn about the factors causing substance use. Opioid dependency is increasing in individuals from many different populations. It is highly probable that all social workers will interact with clients who have experienced the impact or consequences of drug addiction. Social workers must acknowledge the impact of opioid trends in the United States to best serve and understand various clients.

The prevalence of opioid use continues to increase, leading to an increase in opioid dependency and opioid-related deaths in the United States (Center for Disease Control and Prevention, 2019; National Institute on Drug Abuse, 2019). Opioid-involved overdose deaths have increased among many different groups, including males

and females, individuals older than 25, non-Hispanic whites, non-Hispanic blacks, and Hispanics (Center for Disease Control and Prevention, 2019). This data indicates an opioid crisis occurring in the United States. In fact, approximately 57 percent of drug overdoses between 1999 and 2017 involved opioids.

The current field of addiction treatment and research emphasizes addiction as a disease over which an individual has no control. This perspective is relieving the individual of the responsibility of addiction and attributing it to genetics. However, with more people meeting the criteria for opioid use disorder each year, it is necessary to reexamine the factors influencing opioid dependency. Effective social work treatment is multidimensional and considers the biological, psychological, social, and environmental factors influencing the client's dependency (Raheb et al., 2016). Combining information from the natural recovery, disorder of choice, and self-medication models leads to the theory that opioid dependency is the result of an individual's response to pain. Further studies are needed to determine if this information is generalizable to other substance use disorders. Additionally, future research should examine therapeutic strategies and positive coping mechanisms that fulfill the same role of previously used substances.

Alicia Conway graduated from Loyola University Chicago in May 2019, where she earned her MSW with a concentration in Schools. Prior to attending graduate school, she earned a degree in Psychology at Michigan State University. During the graduate program, Alicia interned at the Kenmore Center in Chicago and Maine East High School. Her internship on the Medical Detox Unit at the Kenmore Center inspired her to write this paper and examine the relationship between substance use and pain. Alicia currently works for Chicago Public Schools as a school social worker.

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Iatrogenic Depression and Psychosis: A Case Study

Sue E. Cook, MS, L.Ac.

Abstract

Antidepressants are a common preventative treatment for many chronic conditions, including migraines and chronic pain. However, they may cause significant side effects such as suicidality, particularly when used by adolescents. This paper examines the case of Persephone, a 15-year-old girl who experienced suicidal thoughts as a result of treatment for migraines with amitriptyline. During her subsequent hospitalization, she received an additional cocktail of medications that included fluoxetine, bupropion, olanzapine, and clonazepam. Approximately six weeks after starting these medications, she developed overdose- and psychosis-like symptoms such as psychomotor retardation, tardive dyskinesia, and auditory hallucinations. Despite initially receiving a diagnosis of bipolar or schizoaffective disorder based on these symptoms, Persephone challenged the diagnosis, discontinued her medications, and made a full recovery. Her case emphasizes the need for behavioral health workers to receive expanded training in psychopharmacology as well as the importance of strong environmental support systems in the lives of individuals who take these medications.

Keywords: iatrogenic depression, iatrogenic psychosis, adolescence, psychiatric misdiagnosis, antidepressant side effects, bupropion, amitriptyline, suicide, black box warning, medication interactions

Iatrogenic Depression and Psychosis: A Case Study

Depression is the leading global cause of disability, disrupting the lives of over 300 million people across the planet (World Health Organization, 2017). It can affect people of all ages, from small children to senior citizens. Antidepressants are a commonly used and effective treatment, yet they can have severe side effects, particularly in children, adolescents, and young adults. Antidepressants are also a frontline treatment for chronic pain conditions, such as migraines and neuropathy. The U.S. Food and Drug Administration (FDA; 2018) requires that all antidepressant labels carry a warning that they may cause suicidality in children and adolescents. Despite this warning, some young people continue to receive antidepressant prescriptions without adequate screening for risk factors that may precipitate suicidal thinking.

This article will examine the case of Persephone, a young woman who experienced a major iatrogenic depressive episode with suicidality at age 15 after beginning amitriptyline as a preventative treatment for migraine prophylaxis. An iatrogenic condition is one that is inadvertently caused by a medical examination or treatment. Following an inpatient commitment for these suicidal thoughts, Persephone was prescribed a cocktail that included three antidepressants and an antipsychotic, which caused her to experience overdose- and psychosis-like symptoms such as psychomotor retardation, tardive dyskinesia, and auditory hallucinations.

After initially receiving a diagnosis of bipolar or schizoaffective disorder based on these symptoms, Persephone used her support network to help her dispute the diagnosis and to discontinue her medications. She then successfully recovered from her depression and brief psychotic symptoms and resumed a normal teenage life. This case underscores the need for all mental health providers, from nurses to social workers, to study basic psychopharmacology during their training, as well as the importance of strong environmental support systems and interventions such as psychotherapy for individuals who are prescribed these medications.

Discussion of Depression

An episode of major depression is characterized by a chronic lowering of mood and a decrease in ability to experience interest or pleasure that persist for more than two weeks (American Psychiatric Association [APA], 2013). Other diagnostic criteria include changes in sleep, eating habits, body movement, energy levels, sense of self-worth, and cognitive function. The most impairing symptom is arguably the presence of intrusive thoughts about death and suicide, with or without suicidal ideation or intent. The presentation of these symptoms can vary significantly among genders, developmental stages, and cultures. Children, adolescents, and adult men may exhibit irritability and anger rather than sadness. Members of cultures that place less importance on emotional expression may focus on symptoms such as debilitating fatigue and insomnia, distressing body aches, or the development of motor tics.

People who have experienced depression remember feeling like they

had lost the ability to see in color; that everything they ate tasted like ashes; or even that something jagged-toothed and slaving lurked just out of their field of vision, ready to pounce (S. Cook, personal communication, October 26, 2018). Best-selling American author David Foster Wallace (1996), who died by suicide after his recurring depression stopped responding to medication, described the feeling as “total psychic horror: death, decay, dissolution, cold empty black malevolent lonely voided space” (p. 649) and “time in the shadow of the wing of the thing too big to see, rising” (p. 651). These symptoms can be so debilitating that people lose their jobs, drop out of school, cut off friendships and family ties, or even develop self-injuring behaviors such as cutting and burning themselves. The World Health Organization, an agency of the United Nations that manages international public health concerns, recently attributed almost 800,000 deaths per year to suicide (2017).

In the United States alone, an estimated 3.1 adolescents aged 12 to 17 and approximately 16.2 million adults have experienced at least one major depressive episode (National Institute of Mental Health, 2017). Depression is more common in women than in men, as well as in people who report that they are of mixed race. Young adults aged 18 to 25 have higher incidences of depression than their older counterparts. Of the people who experienced a major depressive episode in 2016, 64 percent of adults and 70 percent of adolescents experienced severe life impairment.

The World Health Organization ranks depression as the leading global cause of disability; it accounts for 7.5 percent of the overall time that people reported being unable to function due to a

disabling health condition. Although depression can affect individuals of all social classes and origins, the number of people who experience it is on the rise in lower income countries. The World Health Organization (2017) attributed this rise to these countries' rapid population growth, theorizing that a greater number of their inhabitants had started surviving past adolescence, the time when depression is more likely to manifest.



"winter depression" by Tobi Gaulke (flickr)

There are a number of risk factors that can predispose an individual to develop major depression. People with immediate family members who have depression are two to four times more likely to develop it in their lifetime, especially early in their development. Those who exhibit neurotic personality characteristics, as well as those who have experienced multiple adverse events as children, are also far more likely to become depressed (APA, 2013). Environmental and social factors such as living in poverty or war zones, losing a job, the death of a loved one, the end of a relationship, and health issues can also play a part. Adolescent women are at a particularly high risk due to the finding that their increased estrogen levels may sensitize the prefrontal cortex to stress

(Thapar, Collishaw, Pine, & Thapar, 2012).

Certain factors such as psychological resilience contribute to an individual's ability to resist and survive depression. Resilience refers to a person's ability to change and adapt to stressful circumstances. People who display personal strength, social competence, a network of social resources, and family cohesion are more likely to have a cheerful, hyperthymic temperament, characterized by a predominance of positive moods, and in turn are less likely to develop depression (Kesebir, Gündoğar, Küçüksubaşı, & Tatlıdil Yaylacı, 2013). Children and adolescents who have well-developed emotional regulation abilities and positive interpersonal relationships with peers are more resilient to depression, as are those whose relationships with their parents are characterized by warmth, acceptance, and low parental control (Thapar et al., 2012).

Case Study

Persephone, a 15-year-old girl, was hospitalized after reporting suicidal thoughts two weeks after she had begun taking amitriptyline as a preventative medication for migraine prophylaxis. After her release from the hospital, Persephone continued to participate in intensive outpatient treatment. Although the suicidal thoughts had temporarily stopped, she continued to feel hopeless and exhausted and was overwhelmed by simple activities like showering. She was a sensitive and introverted person who felt disconnected from her peers and mainly relied on her boyfriend for social support. During the next few weeks she intermittently experienced suicidal thoughts. In response, her doctors

continued to change her medications until she was taking eighteen pills a day.

Persephone was the child of two emotionally distant university professors. When she was 8, her father spent a year doing research in a country that was experiencing a civil war. During the period while her father was away, Persephone recalled feeling constantly sad and lonely, brooding about his possible death, and thinking about suicide; she used to scratch herself until she bled. According to the APA. (2013), these are all symptoms associated with acute and posttraumatic stress disorders (PTSD).

Persephone presented for treatment of migraines at a small private acupuncture clinic shortly after her release from her inpatient psychiatric commitment. At the time of her initial visit, she was taking amitriptyline, fluoxetine, bupropion, and clonazepam and exhibited a flat, dull affect with a low, shaky voice and minimal facial expressions. During the following weeks, she also had olanzapine added to this cocktail. Approximately six weeks after her initial visit to the acupuncture clinic, and three months after first beginning amitriptyline, Persephone gave her acupuncture clinician a letter she had written during the previous week because she was having difficulty remembering her thoughts and felt that she didn't know whom to trust. She had presented that day with psychomotor retardation and tardive dyskinesia and was exhibiting delayed reflexes and impaired mental functioning, as well as involuntary movements of her hands and face.

Persephone's letter stated that during the previous week she had experienced two episodes of hearing voices telling her to kill herself and was feeling extremely scared and helpless

because no one, including her parents, would take her seriously. She wrote that the doctor at her outpatient facility told her that she was probably manifesting bipolar or schizoaffective disorder and recommended adding lithium to her cocktail. Persephone insisted that these symptoms were not normal and that she didn't think the diagnosis was correct.

Despite the limits of her scope of practice, the acupuncturist expressed extreme concern about Persephone's care to Persephone's father and suggested that Persephone was experiencing iatrogenic (i.e. medication-induced) symptoms from drug interactions and was in danger of being misdiagnosed. She recommended discussing these concerns with the prescribing physicians. Persephone's father replied that he was also concerned about the number of medications she had been prescribed. He agreed to discuss the matter with Persephone and his wife before following up with their physicians.

Despite her doctor's recommendation, Persephone's parents decided not to force her to take lithium. Instead, her parents insisted that Persephone's doctors begin tapering her medication doses. As a result, the auditory hallucinations ceased over the following weeks. Approximately four months after her initial hospitalization, Persephone insisted on returning to the hospital to discontinue all of her medications cold turkey. After two weeks off all medications, she reported that "I'm not on a crazy rollercoaster anymore. I'm just a moody teen who hates high school" (S. Cook, personal communication, August 24, 2014).

Persephone went on to graduate from high school the following spring, then took a year off to work and travel, and is currently in her second year at a top art school where she studies photography.

The auditory hallucinations have not recurred.

Impact of Depression on Psychosocial Development

Adolescence is a time of great change and turmoil. Physically, it is characterized by a growth spurt and the onset of puberty, in which the child begins to develop adult secondary sex characteristics as the body increases production of sex hormones and glucocorticoids. Synaptic pruning in the brain occurs as grey matter shrinks, and white matter proliferates. The sensorimotor systems mature more quickly than the prefrontal cortex, which is the area that governs executive functioning processes such as attention, emotional regulation, and decision making, and does not fully develop until early adulthood (Alloy & Abramson, 2007). Although adolescents are newly capable of complex formal operations and tremendous increases in creativity and abstract thinking, there is a lag in their ability to fully judge the consequences of their actions (Laser & Nicotera, 2007). This can lead to poor impulse control and sensation seeking, causing risky behaviors such as substance abuse, reckless driving, and unsafe sex.

Psychologically, adolescence is a period of transition between the dependency on adults that characterizes childhood and the autonomy of adulthood. Adolescents must integrate their newly sexual bodies into their self-representation, reframe their relationship with their parents, and situate themselves within their peer groups, all while considering their identities, values, and life goals (Gilmore, Meersand, Hales, Yudofsky, & Roberts, 2014). They must navigate strong surges of emotions while

developing moral considerations such as the ability to participate in social contracts by considering the greater good, contemplating the outcomes of their actions by being able to see all the possible consequences of their choices, and internalizing their behaviors. Adolescents solidify their racial and gender identities during this period and prioritize input from their peers over that of adults (Laser & Nicotera, 2007).

The effects of a psychiatric misdiagnosis at this crucial stage of development can have lasting consequences. Zimmerman, Ruggero, Chelminski, and Young (2010) found that an earlier misdiagnosis of bipolar disorder was significantly associated with higher lifetime rates of major depressive disorder, PTSD, and impulse control disorders. As previously stated, the FDA (2018) determined that there was a high risk of suicidality associated with the use of antidepressants in children and adolescents.

Persephone's childhood history of depressive and PTSD-like symptoms should have alerted her physician to the serious risk of triggering suicidality involved in prescribing an antidepressant for her migraines. Not only did Persephone's doctors fail to screen her adequately for depressive symptoms before starting her on amitriptyline for migraine prophylaxis but they also failed to consider the dangers of prescribing multiple medications that use the same set of liver enzymes—the cytochrome P450 system—for their metabolism and to recognize the subsequent signs of antidepressant drug interactions and bupropion overdose: tardive dyskinesia and auditory hallucinations (Botts & Alfaro, 2001; Ereshefsky, Riesenman, & Lam, 1995; Kumar, Kodela, Detweiler, Kim, & Detweiler, 2001). When the liver

has to break down multiple medications that are all competing for the same set of enzymes, the result is higher levels of these medications in the bloodstream, which can lead to an overdose.

Persephone was fortunate that her experience with major depression and a near-misdiagnosis served to deepen her relationship with her parents and perhaps even hastened the development of her identity and values. After discontinuing the medications and recovering from her iatrogenic depression and brief psychosis, she continued to work with a psychotherapist both alone and in family therapy sessions because her experiences had left her with a heightened sense of anxiety. She responded well to treatment and established a strong set of emotional regulation skills. Her parents, whom she had described as emotionally distant during her childhood, recognized the importance of emotional intimacy with their daughter while learning to respect her boundaries.

She enrolled in a photography class during her senior year of high school and soon exhibited a great gift for capturing emotionally evocative images, which led her to contemplate a career in photography. Persephone remained active in her family's church group, while learning to rely less on her boyfriend as a sole means of emotional support. When her parents initially pressured her to go to a small religious college that many family members had attended, Persephone started to feel overwhelmed but managed to convince her parents to allow her to take a gap year. Through the skills they learned in family therapy, her parents delighted in the autonomy and independence of their daughter as she discovered her own path. She graduated with the rest of her class and spent the summer working and volunteering while

saving money to travel alone across Europe as well as to visit her parents while they pursued scholarly research outside of the United States. She developed an impressive photography portfolio and was accepted to a prestigious art school in a major metropolitan city, where she is currently in her second year.

As an emerging adult, Persephone is facing the tasks of exploring her identity, navigating the transition between adolescence and adulthood, and focusing on herself while learning to become fully independent (Arnett, 2016). On her twentieth birthday, looking back on how far she had come since age 15, she wrote, "I could not even a tiny bit picture what life would be like at 20 and I truly didn't think I could get here and it feels very very good to be here" (S. Cook, personal communication, June, 2018). She is able to see a clear line between herself as a teenager and herself as a young adult. Persephone currently plans to pursue an MFA after graduating from college and hopes to find a job that will allow her to travel, since she has realized "how much happier I am when I am traveling."

Persephone believes that her experiences as a teenager put her ahead of her peers by pushing her to mature earlier, by providing her with the drive to stay focused, and by strengthening her values. Through the support of strong environmental systems such as her parents and her family's church, as well as the timely interventions of her acupuncturist and therapist, she was able to develop tremendous resiliency and strength of character. Her parents' positions as academics not only provided her with access to quality health care but also situated them within a community that validated their support of their

daughter's independence and self-discovery.

Conclusion

Persephone's story underscores the necessity of thorough screening for depression when using antidepressants for non-psychiatric conditions such as pain, as well as the general need for restraint in prescribing multiple medications that may cause harmful interactions. Despite her intense experience with suicidality and psychosis-like symptoms, Persephone was able to progress through the developmental stage of adolescence into emerging adulthood without suffering lasting harm. She has surpassed many of her peers in self-sufficiency and emotional regulation. Her ability to bounce back after experiencing a terrifying iatrogenic depression and brief psychosis demonstrates the importance of strong family and other environmental systems as well as of interventions such as psychotherapy.

The Council on Social Work Education (2015) currently does not require classes in neuropsychology or psychopharmacology as part of its accreditation standards. If social workers and other psychotherapists received training about the medications that so many of their clients are taking, they would be better equipped to recognize potentially dangerous changes in these clients' behavior that could result from these medications. Although psychiatric medications can be very effective for many clients, the American health care system is set up so that the prescribing physician is unable to truly monitor the impact of these medications on the client's day-to-day functioning. Much of the work performed by mental health

workers is constrained by insurance reimbursement guidelines. A client usually spends almost an hour with a therapist, but a medication management session with a psychiatrist is usually limited to fifteen minutes. Because psychotherapists spend so much more time with their clients than psychiatrists, it seems logical that the additional intimacy they develop during this time would allow them to distinguish their clients' true symptoms from those that develop as a result of medication side effects. They are uniquely poised to mediate between clients and their psychiatrists in order to maximize the client's agency.

Psychiatric medications can cause side effects that resemble mental illness. It is well documented that the use of antidepressants in adolescence can trigger suicidality (FDA, 2018). Persephone's case demonstrates how the incautious use of an antidepressant for migraine prevention caused an escalation of side effects that almost led to her receiving an incorrect and life-altering diagnosis of schizoaffective or bipolar disorder at age 15. If her acupuncturist had not recognized that Persephone's auditory hallucinations and other symptoms were medication induced, Persephone's life might have turned out very differently. Her case underscores the need for all psychiatric support staff, including psychotherapists, to receive expanded training that covers medication side effects. All mental health providers, from nurses to social workers, should be able to recognize medication-induced behavioral changes in order to protect the well-being and right to self-determination of clients like Persephone.

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Alcohol Use Disorder as Explained by Object Relations

Sarah Kelly

Abstract

This article aims to provide a fresh perspective on the potential causes of alcohol use disorder from the lens of object relations theory. The root cause of alcohol use disorder, like many other addictive disorders, is unknown. Current literature explains alcohol use disorder as a result of genetics, environmental pressures, and socialization, but fails to see the disorder as potentially resulting from poorly formed object relations. This article will look at the development of object relations theory, the history of the diagnosis of alcohol use disorder, and how alcohol use disorder can be attributed to poor object relations.

Keywords: alcohol use disorder, attachment, cognitive remediation, object relations, psychoanalytic theory, transitional objects

Introduction

Alcohol use disorder impacts a wide variety of individuals in both the United States and the global community. Much research has been conducted to identify different causes of alcohol use disorder that range from early exposure to alcohol as a child to genetics (APA, 2013). Although there is certainly truth to some of these arguments, there are likely many other factors that contribute to alcohol use disorder in different individuals. For example, as argued in this article, one hypothesis is that relationship formation from infancy through early adulthood may be a

contributing factor. This article will examine object relations theory and apply its theoretical perspectives to alcohol use disorder to provide a new perspective on the development and persistence of alcohol use disorder.

An Explanation of Object Relations Theory

Object relations theory is a theory that was stemmed from ego psychology and Freudian psychoanalytic theory. What differentiates object relations theory from the psychoanalytic theories that preceded it is that it includes the client's interpersonal world and their intrapsychic experience. Previously, the interpersonal worlds of clients were not viewed as influential in their psyche (Cooper & Lesser, 2017). Many theorists have expanded the development of concepts of object relations theory. Melanie Klein, whose research started in the 1940s and 1950s, is widely regarded as one of the founders of object relations theory. Her work was expanded by many other theorists including Ronald Fairbairn, Harold Guntrip, and Donald Winnicott.

As one of the first theorists to develop a full theory of object relations through her concept of the internal object, Klein explained that from birth infants experience destructive internal fantasies that may be intolerable to them. Thus, infants project these fantasies onto their caregivers, or as Klein called them, *objects* (Cooper & Lesser, 2017). Other concepts that Klein introduced in her description of object relations theory are

splitting and projective identification. According to Klein, projective identification occurs when the self needs to rid itself of dangerous and unwanted aspects. To reduce further harm to themselves, individuals split a piece of themselves off and project it onto an external object (Cooper & Lesser, 2017). For most individuals, that external object would be a parent or caregiver.

Klein theorized that individuals also project positive parts of themselves onto objects. The self does this because, if it does not, only negative parts of the self are projected on the object, which would make the object inherently negative. Through positive and negative projection, individuals can create a safe relationship with their primary object (Cooper & Lesser, 2017). Klein added a caveat that projecting too many objects of the self could potentially lead to self-impoverishment. Klein's work on object relations theory is valuable to social work because it reveals how early stages of one's relational development can affect and even overtake self-worth and later relationships in life. These poor relationships would result from poor object relations (Cooper & Lesser, 2017).

Klein's work on object relations highly influenced other theorists. One such theorist was Ronald Fairbairn. Fairbairn's theoretical perspective took Klein's perspective one step further, asserting that individuals' internal objects were not fantasies but were rather reflections of their experiences with people from their real life. He stated that children could not view their caregivers as bad because that would diminish their sense of security. Fairbairn theorized that, instead of projecting bad objects onto caregivers, children project the negative aspects of their caregivers onto themselves so that they can see their

caregivers as all good. This process is called internalization (Cooper & Lesser, 2017).

Fairbairn's theory of object relations that includes the internalized bad object can be applied to trauma bonding. Trauma bonding explains how children who are in traumatic situations are able to maintain a cohesive sense of self in the midst of their abuse. For example, if a child has an abusive caregiver, internalizing the bad qualities of the caregiver allows the child to still be able to see the caregiver as good. Children need to experience their caregivers as good in order to survive. Fairbairn explained that, for most children, a bad caregiver is better than no caregiver, which is why this projection occurs (Cooper & Lesser, 2017). For children who are raised in abusive and traumatic situations, trauma bonding that is related to challenging object relations as described above can have significant impacts on them later in life.

Harry Guntrip expanded on Fairbairn's theoretical perspective and focused on the object and its importance in ego development (Cooper & Lesser, 2017). Guntrip's work explained that, when a child's external objects such as relationships with the environment do not meet the child's needs, that child's ego needs to retreat. This negatively affects children's ability to have strong or positive feelings about others because their ego has been wounded by their primary object relations. Later in life this can lead to a person developing a schizoid compromise, which means that he or she does not have a full emotional relationship with others and is typically not fully involved in such relationships (Cooper & Lesser, 2017).

Another important theorist in object relations theory is Donald

Winnicott. Winnicott emphasized the relationship between children and their mothers. His theoretical perspective described mothers as the holding environment that allows a child's psyche to grow safely. Winnicott emphasized that mothers did not need to be perfect, but they needed to be good enough to allow the child to grow in a positive manner. He stated that, because the caregiver relationships for children are the blocks that build a positive psyche, mothers needed to be at least good enough to promote positive growth of their children's psyche. Winnicott also came up with the term *transitional object*. He was curious about how growing children are able to hold onto their primary objects when they are not present. Many children have inanimate objects such as blankets or stuffed animals to fulfill this purpose (Erkolahti & Nyström, 2009). If a child's transitional object is taken away, he or she often experiences anxiety and fear due to the lack of safety this involves. By adulthood, many people have retired their transitional objects, but some still maintain them due to the comfort they provide (Cooper & Lesser, 2017).

Klein, Fairbairn, Guntrip, and Winnicott are all theorists who focused their life's work on developing different concepts that apply to object relations. As described above, their work delved into how children develop object relations and how the quality of those relationships may affect their further development.

An Explanation of Alcohol Use Disorder

Misuse of alcohol has seemingly existed since alcohol could be produced in excess. Alcohol came into existence somewhere between 3000 and 2000 BC,

when farmers in India learned how to create rice wine through the fermentation of fruit (Curry, 2017). As time went on, nearly every country on every continent found a manner of producing alcohol and then did so on a larger scale. In the 1600s, widespread drunkenness became an issue in England and other European countries. England worked to curb widespread drunkenness by banning certain types of alcohol and taxing others, which reduced but did not eliminate public drunkenness. Other countries such as the United States and certain African countries faced these same challenges as industrialization took over the globe (Narconon, 2018). Although drunkenness has been viewed as a public problem for centuries, it was not until 1956 that excessive alcohol use was classified as a disorder by the American Medical Association. The classification of excessive alcohol use as a disorder has evolved over time and is currently labeled *alcohol use disorder* in the *DSM-5* (Narconon, 2018).

In the "Substance Use Disorder" section of *DSM-5*, alcohol use disorder is described as "a problematic pattern of alcohol use leading to clinically significant impairment or distress" (American Psychiatric Association [APA], 2013, p. 490). Over a 12-month period, someone who is described as having alcohol use disorder will have exhibited two of the following actions or symptoms (APA, 2013):

- Alcohol is consumed in excess over more time than expected
- There is a hope of minimizing and/or eliminating alcohol consumption
- Large amounts of time are spent acquiring alcohol, using alcohol, or recovering from alcohol
- Alcohol is craved

- Use of alcohol persists despite continued social or personal issues related to alcohol
- Activities that are important to the user are given up for alcohol
- Alcohol is used in a physically hazardous way such as while driving
- There is continued use of alcohol despite its known physiological and/or psychological impacts
- There is tolerance
- There is withdrawal

Those who exhibit behaviors and symptoms consistent with those described in the *Diagnostic and Statistical Manual of Mental Disorders*, version 5 (*DSM-5*), for alcohol use disorder may have a mild presentation (two to three symptoms), moderate presentation (four to five symptoms), or severe presentation (six or more symptoms).



"One Too Many" by Ias - initially (flickr)

According to the *DSM-5*, alcohol use disorder is often accompanied by depression, anxiety, insomnia, and conduct issues that can occur either before or after intoxication. Alcohol use disorder is commonly found in the United States. Among teenagers, it is present in 4.6 percent of individuals whereas it is

found in 8.5 percent of adults (APA, 2013). This disorder is more commonly reported in men between the ages of 18 to 29 and its prevalence begins to decrease in middle age. The prevalence of alcohol use disorder varies greatly among the various ethnic and racial groups and regions of the country.

There are certain risk factors for alcohol use disorder. These risk factors include cultural attitudes regarding alcohol consumption, alcohol availability and pricing, personal experience involving alcohol, and stress. Other potential risk factors are heavy peer use of alcohol, poor stress management, and positively inflated expectations of the impact of alcohol. An example of a positively inflated expectation of the impact of alcohol would be the belief that overdrinking will take painful feelings away or make someone more social (APA, 2013).

The *DSM-5* also reports that some individuals may be more likely to use alcohol based on genetic and physiological predispositions. It is important to note that appropriate levels of alcohol consumption may vary by culture. For example, in Mormon families alcohol consumption in any amount is rebuked whereas in certain European cultures alcohol is consumed moderately starting at a young age. These cultural discrepancies are important to keep in mind when evaluating alcohol consumption (APA, 2013).

Although the *DSM-5* provides an in-depth description of alcohol use disorder, it has revised prior descriptions of similar disorders and combined the *DSM-IV* diagnoses of alcohol abuse and alcohol dependence (Frances, 2013). These distinctions provide a more descriptive picture of the presentation of different types of alcohol use. Alcohol

abuse involves utilizing alcohol in a way that negatively affects personal functioning, but not so that the individual's body is dependent on alcohol consumption. Alcohol dependence involves such heavy use of alcohol that the person's body is physically dependent on its consumption. Thus, alcohol dependence involves more severe use of alcohol than alcohol abuse (APA, 1994).

Apart from that reported in the *DSM-5*, much research has been done about other experiences that are related to alcohol use disorder. According to Vungkhanching, Sher, Jackson, and Parra (2004), attachment style highly relates to presence of alcohol use disorder. Many individuals who exhibit behaviors related to alcohol use disorder also exhibit behaviors related to insecure attachment that put them at risk of alcohol use disorder. For example, many individuals with insecure attachment who have alcohol use disorder are regulating their affect negatively through heavy drinking and socializing with deviant peers who encourage heavy alcohol consumption (Vungkhanching et al., 2004).

Additionally, Thorberg and colleagues discussed the relationship of alexithymia and anxious attachment to alcohol use disorder. Alexithymia is defined as "difficulty identifying and communicating feelings, difficulty differentiating feeling and somatic sensations of emotional arousal, a diminution of fantasy and imagination and an externally oriented cognitive style" (2010, pp. 427). According to the research, alexithymia partnered with anxious attachment is often found in those whose behavior meets the criteria of alcohol use disorder. According to the authors, the negative feelings coming from anxious attachment and alexithymia may be reduced through the use of

alcohol due to its depressant characteristics. Studies by both Vungkhanching and colleagues (2004) and Thorberg and colleagues indicate that attachment difficulties may put an individual at risk of alcohol use disorder.

Object Relations Theory Applied to Alcohol Use Disorder

As described above, object relations theory focuses on early childhood development in relationship to how children process their experience of the world around them. It then describes how children cope with experiences that feel unsafe, foreign, or conflictual. Descriptions of both positive and negative experiences of relationships to objects and their potential impacts on children indicate that some children may apply those negative relationships to themselves while others will apply them to future relationships. Transitional objects are also described as objects that help children develop a sense of security when their primary object is not present to them. Alcohol use disorder does not develop in childhood for most individuals that experience it. However, it is worth exploring whether an individual's experience of object relations may play a significant part in their development of alcohol use disorder.

Although there are certainly individuals with positive object relations who develop alcohol use disorder, many individuals with alcohol use disorder discuss having experienced poor relationships in their childhood and/or adult life. As stated previously, anxious and insecure attachment patterns are likely to contribute to alcohol use disorder (Fillo, Krieger, Englund, & Simpson, 2018; Goldstein, Vilhena-Churchill, Stewart, & Mackinnon, 2014;

Thorberg et al., 2010; Vungkhancing et al., 2004). Poor attachment patterns result from poor object relations such as relationships in which the primary object is not present or is abusive. These object relationships with primary objects can cause an individual to feel uncomfortable in the presence of other potentially important relationships such as those with a supervisor, friend, or significant other.

As described in the *DSM-5*, some individuals who use alcohol in a disordered manner may do so because of its presumed positive impacts such as improved sociability (APA, 2013). For those who had poor object relations with their primary object, using alcohol may allow them to feel safer in adult relationships. They may start using alcohol to feel more comfortable when they start to date or interact with friends. Before alcohol use is disordered, using alcohol to feel comfortable in social situations may be successful. For those who experience significant distress in relationships because of poor object relations, these successes may lead to use of alcohol in a disordered way (for example, while they are at work or so that they can be more comfortable with a supervisor).

The above scenario relates to Guntrip's theoretical perspective on object relations. Guntrip asserted that those who have had negative object relations may develop a schizoid compromise in which they are unable to fully interact in relationships (Cooper & Lesser, 2017). Perhaps those individuals who exhibit behavior that aligns with alcohol use disorder experience this schizoid compromise and are able to recognize that it is a maladaptive approach to relationships. They may then find that using alcohol allows them to overcome this schizoid compromise

when they interact with other individuals. Those experiencing alcohol use disorder may believe that, by using alcohol, they are able to fully involve themselves in their relationships or at least are able to participate in relationships in a manner that feels safe. Without alcohol, they may feel overly stressed or unsafe.

This use of alcohol mirrors Winnicott's description of the transitional object. Children utilize transitional objects to create safety for themselves when their primary object is not present (Cooper & Lesser, 2017). Therefore, it is possible that those with alcohol use disorder may be using alcohol as a transitional object in adulthood. In social and professional situations, those who have alcohol use disorder may use alcohol as an object to help them feel safe. It may provide them comfort in a stressful situation much like a teddy bear or baby blanket will help children feel at ease when their primary safe object is not present. Because those with alcohol use disorder do not always have safe or healthy relationships with other individuals, they may feel that they need to use alcohol as their transitional object several times throughout the day or week.

Additionally, alcohol appears to act as a transitional object when those with alcohol use disorder are trying to stop using alcohol or use it in a healthier way. For many children, adolescents, and even adults, when their transitional object from infancy is taken away from them, they experience a significant amount of anxiety or distress. They experience this distress because they feel unsafe without their transitional object. For those who exhibit behavior that aligns with alcohol use disorder, when their transitional object (alcohol) is taken away, they begin to experience a significant amount of distress and anxiety. This is likely

because alcohol has allowed them to feel safe for a significant period of time. Additionally, those with alcohol use disorder may not have other positive object relationships in their life so that, when their transitional object is taken away from them, they may not have other outlets to alleviate the anxiety that they are feeling. These anxious feelings may lead many who have alcohol use disorder but who have stopped using alcohol to return to using alcohol because it allows their distress and anxiety to subside.

Implications for Practice

If it is presumed that alcohol use disorder is based in issues related to object relations, providers should consider utilizing treatments that support those with poor object relations. Research shows that cognitive remediation procedures support those with insecure and avoidant attachment in improving their object relations. This treatment approach teaches clients how to search for emotional facial expressions; they can then learn how to appropriately regulate in response to these expressions (Kornreich, 2017). Because insecure and avoidant attachment patterns are most often associated with alcohol use disorder, using treatments for these attachment disorders to manage alcohol use disorder may allow clients to reduce or eliminate their use of alcohol.

Additionally, providers may want to support those with alcohol use disorder by replacing alcohol as a transitional object with something that is more adaptive. Some research suggests that to replace a transitional object, individuals may need to find something that is similar to that object but not the same (Silver, 1996). For example, someone who feels comforted and safe with alcohol may

benefit from a tea drinking routine. Tea is similar to alcohol because it is a beverage and it has calming effects. There are many other replacements for alcohol as a transitional object that can be determined by the provider and client.

There is no substantial evidence that the above practices are helpful. Currently the only applicable research found by the author consists of articles from the 1990s and 2000s (e.g., Sprohge, Handler, Plant, & Wicker, 2002), when attachment theory became more prevalent, and research from medical doctors about how the brain is affected and/or affects the development of alcohol use disorder (Fillo et al., 2018; Goldstein et al., 2014). In recent years psychologists have begun exploring the relationship between attachment and alcohol use, but their research is certainly not all encompassing (Lindberg et al., 2015). More research should be done to explore the usefulness of therapeutic interventions based on object relations theory for the treatment of alcohol use disorder. This information is important for those providers who would like to try the different practice suggestions outlined above to support their clients with alcohol use disorder. Some clients may prefer a more traditional treatment approach whereas others may be interested in something that is new or more experimental.

Conclusion

There are many likely causes and contributors to the development of alcohol use disorder. This article argues that alcohol use disorder may develop due to a person's poor object relations in childhood and the persistent impacts that occur in adulthood. This argument iterates that those who use alcohol in a

disordered way do so to feel safe in anxiety-provoking and distressing situations. Alcohol may act as a transitional object for these individuals. Removing this transitional object can cause a great deal of distress, which may help to explain why alcohol use disorder is challenging to overcome. Object relations in childhood have a significant impact on a child's overall development and these impacts may contribute to the

development of alcohol use disorder in adulthood. Those involved in the treatment of alcohol use disorder may be interested in implementing treatments such as cognitive remediation that are helpful for those experiencing anxious or insecure attachment patterns. They may also be interested in providing treatment that can safely replace alcohol as a transitional object.

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Building Stronger Communities Through Intensive Case Management

Nicole Levine, MSW, LSW

Abstract

This article will discuss gaps discovered in the literature regarding intensive case management (ICM) teams and the caseload assignment process. The evaluation can affect and contribute to growing literature on how ICM teams and other case management models add clients to a case manager's caseload. Additionally, this article discusses limitations in literature on the client-provider relationship and how the caseload assignment protocol can affect the ICM team and client outcomes. Expanding the knowledge of case management perceptions could influence future research on how case management models' assignment process is affecting both staff and clients and potential ways to alleviate these issues.

Keywords: intensive case management, caseload, severe mental illness, client-provider relationship, community support, community functioning

Background and Purpose

Intensive Case Management Overview

The intensive case management (ICM) model emerged out of a growing recognition that many patients with severe mental illnesses (SMI) could not be engaged in treatment using traditional case management practice (Mueser, Bond, Drake, & Resnick, 1998). Individuals with SMI also seem to utilize the most costly treatment services, such as emergency room visits (Mueser et al.,

1998). Intensive case management provides community support and rehabilitative services to adults suffering from serious psychiatric illnesses to decrease hospitalizations and crisis episodes (Bedell, Cohen, & Sullivan, 2000; Hangan, 2006). Providing direct assistance and options to patients in the emergency department, the inpatient unit, the outpatient treatment centers, and within the community (e.g., housing) fosters the ICM team's objective to provide enhanced services to the most vulnerable at-risk patients. Increasing wrap-around services to individuals with a chronic persistent mental illness is expected to decrease recidivism and the need for hospitalization. Encouraging clients to stay engaged in treatment by increasing community functioning and support through housing, disability benefits, food, clothing, transportation, and Medicaid/Medicare can help assist clients in decreasing the number of psychiatric emergency department visits and psychiatric inpatient admissions.

This article will discuss gaps discovered in the literature regarding ICM teams and the caseload assignment process. The following sections will illustrate the importance and success of ICM for adults with SMI. Following this discussion, limitations in literature on the client-provider relationship and the caseload of a case manager will be identified.

Literature Review

Case Management with Individuals with SMI

Providing clients with appropriate services through different models of case management has led to reduced hospital stays. In the late 1970s reforms and movement toward deinstitutionalization, as well as innovations in discharge planning, day treatment, and community support programs started the path toward outpatient services for the chronically mentally ill (Roberts & Kurtz, 1987). With hospitals no longer providing long-term care for those with SMI, mental health and basic human needs are addressed through the alternative system of case management services (Kuno, Rothbard, & Sands, 1999). The case management process consists of four activities a case manager performs to assist the client in negotiating for services: (1) connecting with clients, (2) planning for services, (3) linking clients to services, and (4) advocating for service improvements (Anthony, Cohen, Farkas, & Cohen, 2000).

Intensive case management is more rigorous than typical case management and is modeled partially on the assertive community treatment (ACT) model (Kuno et al., 1999). This type of model is meant to result in more consistent and intensive contact with clients than a more traditional case management model. Encompassing the four main activities defined above, but doing so at a higher level of care, is an important and distinguishing factor of ICM. Unlike the traditional case management model that primarily makes referrals while failing to successfully connect clients to the service system, ICM uses assertive outreach to ensure

that clients are functioning adequately, receiving planned services, and being continuously monitored (Kuno et al., 1999).

The ICM model has demonstrated success in decreasing hospitalizations, improving consumer functioning, and achieving better adaptation to living in the community (Kuno et al., 1999; Nelson, Aubry, & Lafrance, 2007; Shern et al., 2000). Understanding this concept, Northwestern Memorial Hospital (NMH) created the ICM team within the Stone Institute of Psychiatry to provide comprehensive diagnosis and treatment of mental illness (Northwestern Medicine, 2017). The Northwestern Memorial Hospital emphasizes a continuum of care through comprehensive inpatient and outpatient services. Stone Institute of Psychiatry inpatient services consist of acute adult psychiatry and consultation/liaison services. Outpatient services include emergency psychiatry, the Stone Mental Health Center (triage and psychiatric evaluations for adults and older adults, first episode psychosis, adolescent services, and psychosocial rehabilitation programs), the NMH Faculty Foundation, and ICM. The ICM team helps the Stone Institute of Psychiatry achieve its mission, emphasizing a continuum of care through comprehensive services to assist the most at-risk client population. Utilizing a wrap-around approach through direct assistance and options in the hospital, as well as within the community, is consistent with the findings of research relating to case management models.

Case Managers' Caseload and Perceptions

The impact of the client-provider relationship on the outcome of services for people with SMI has been a topic of increasing attention. Understanding and examining the role of the client-provider relationship in the effectiveness of case management has been demonstrated as a priority for research (Gorey et al., 1998; Mueser et al., 1998). Additionally, it has been argued that the supported helping relationship may be equally as important or possibly more important than the identification of evidence-based treatment (Anthony, Rogers, & Farkas, 2003).

However, Angell and Mahoney (2007) posited that the growing amount of literature on the case management relationship is based largely on concepts borrowed from psychotherapy, which varies significantly from case management work. The type of role relationship formed between a client and case manager is different from the client-provider psychotherapy relationship. It has been reported that the case management relationship takes on a more informal tone or mimics other relationships such as those with friends or family members (Buck & Alexander, 2006; Ware, Tugenberg, & Dickey, 2004). This suggests that the case management relationship may assume the form of an informal or primary relationship, which is a unique aspect to be studied. Therefore, this potential importance of the helping relationship in psychiatric services is critical to understanding the case management relationship within ICM services.

Another important factor in a case manager's work is caseload size. King, La Bas, and Spooner (2000) examined the

relationship between caseload size and the personal efficacy of a case manager's role performance. These authors illustrated a negative correlation between the size of a case manager's caseload and personal efficacy. Case managers with larger caseloads reported lower performance in a range of core role activities which had a significant negative association with general well-being (Kington et al., 2000). Additionally, Hodge and Giesler (1997) identified how different levels of case management require differing amounts of a case manager's caseload. For example, the most intensive level of case management is level I followed by level II and level III as the least intensive. These levels differ in terms of the focus of the activities they provide and the mental illness severity of the population served. The authors indicate that level I case management involves no more than thirteen persons per caseload, level II between twenty and twenty-five persons, and level III about sixty to eighty persons. Further understanding how the size of the caseload affects a case manager's ability to carry out their role is important in the potential for recovery of clients (Sherman & Ryan, 1998).

Lack of Research

Although there has been a significant amount of research on different case management models, research is more limited in regard to the client-provider relationship and the caseload of a case manager. The literature focuses on understanding the differences in the case manager-client relationship and the client-provider psychotherapy relationship. It does not focus on the perceptions of case managers regarding their relationships

with clients. Furthermore, there is a lack of attention to case managers' perception of how clients are acquired on their caseload. Several questions arise in in this regard: What are the staff's thoughts about the client's needs? Does the provider believe that he or she is the best person to provide for the client? Is the current caseload too large to bring on a new client? These questions reveal a gap in the current research in terms of the perceptions of ICM team members' about the process of assigning clients to their caseload. There appears to be an overall lack of investigation into different processes for adding clients to a caseload.



"Workload" by Justin S. Campbell (flickr)

There is a need for more research and literature regarding ICM case managers' perceptions related to clients added to their caseload. The current literature does not discuss the process of assigning clients to caseloads. Without discussion or research on this process, how can we understand the factors that influence case management services? Do current assignment processes account for the case managers' perceptions of acquiring clients, case managers' relationships with clients, or the number and needs (high or low) of clients on the current caseload? Understanding the case manager's perceptions of how clients are added to the caseload could potentially lead to learning about relational aspects,

improved services, and client outcomes. Additionally, this understanding could lead to improvement in the process used by ICM teams, as well as other case management services, to assign clients to case managers' caseloads.

The question of caseload assignment is important for an agency to consider because it directly affects clients and in turn the agency's outcomes. Moreover, it directly affects the well-being and effectiveness of case managers on an ICM team. A negative perception of the process for adding new clients to a case manager's current caseload could negatively affect both client and case manager. Understanding ICM case managers' abilities, limitations, and perceptions of how they can best help a client can help influence the effectiveness of services clients receive. This knowledge can potentially lead to a better understanding of a positive way to assign clients to a caseload.

Conclusion and Social Justice Implications

The social work profession's primary mission is to enhance human well-being and help meet the basic human needs of all people, with particular attention to those who are vulnerable, oppressed, and living in poverty (National Association of Social Workers, 2008). A core mission of social work is to promote social justice and social change with and on behalf of clients. This article offers a variety of social justice implications relating to the caseload assignment process.

Examining the assignment process could potentially lead to better services and outcomes for clients. Understanding how case managers perceive the relationships with their

clients can illuminate the working alliance between a case manager and client. Both ICM programs and other case management services can benefit from a better understanding of case managers' perceptions of how clients are assigned to their caseload, as well as their overall perceptions of their caseload. This knowledge could identify factors related to a case managers' well-being and perceived effectiveness in helping clients. With increased knowledge of the case managers' perceptions of the assignment process, the ICM team can become proactive in the process. Furthermore, this increased knowledge can illuminate characteristics of the working alliance that may affect the case management relationship. Exploring relational features, client needs, current caseload size, and case managers' thoughts and feelings of effectiveness can help case managers to create a better protocol for caseload assignment.

The ability to create a stronger case management program could influence client functioning in relationships with family, friends, and community. Increasing client functioning and helping clients achieve rehabilitative, resiliency, and recovery goals could affect the family and friends involved in the client's treatment and life. Clients involved with ICM services have more contact with relatives and caregivers than individuals receiving standard case management (Harvey et al., 2002). Additionally, relatives and caregivers' burden of care for the client and the burden associated with client relationships with psychiatric services could be reduced from more intensive case management services (Aberg-Wistedt, Cressel, Lidberg, Liljenberg, & Osby, 1995). This demonstrates that increased support through ICM services

can potentially affect dynamics of those involved in the care of the client. Moreover, through increased functioning, there is the possibility of affecting the community in which the client lives. By influencing these outcomes, ICM can uphold its intention to help clients become functioning and contributing members of the community again. An evaluation could expand the understanding of case managers' perceptions, which could lead to better services, increased client functioning, and bolster pursuit of the ICM mission.

Consistent with creating a better protocol for caseload assignment and expanding the knowledge of case managers' perceptions, exploring this topic with case managers can yield findings that could potentially be transferred to case management services in other ICM programs. The ICM program at NMH is unique in regard to the team's work setting and the adult population. This team could be viewed as a model that might be used in other hospitals in the Chicago area to decrease recidivism and promote rehabilitation. A program evaluation could help strengthen the program overall and lead to modeling a better program for other Chicago hospitals. The knowledge gained from this evaluation could help to create a stronger ICM. Not only would this evaluation lead to a more informed protocol on adding clients to a caseload but it might also lead to a better understanding of what is required for a successful outcome for clients and how the case managers' perceptions potentially impact this outcome. It could also provide helpful information regarding potentially expanding the number of staff on the ICM team to ensure positive outcomes for clients.

As discussed above, research can contribute to an understanding of how the caseload assignment protocol can affect the ICM team and client outcomes. Moreover, the evaluation can affect and contribute to growing literature on how ICM teams and other case management models add clients to a case manager's caseload. Expanding the knowledge of case management perceptions could influence future research on how case management models' assignment process is affecting both staff and clients and potential ways to alleviate these issues.

Lastly, enhancing the ICM program and utilizing the NMH model as the standard for other hospitals in the Chicago area to create an ICM team of their own can have implications for the future of hospital policy. If the ICM team at NMH positively contributes to the

psychiatric department and is enhanced by the knowledge of this evaluation, one could assume that this program would be beneficial for other hospital's psychiatric departments. Therefore, this evaluation could potentially contribute to more than the case manager perceptions of working alliance. The possibility of strengthening the program and producing better outcomes and well-being for both clients and case managers could demonstrate the importance of a properly executed ICM team and the need for hospitals to have this program in their psychiatry departments. Overall, all these factors could impact the way our society implements mental health treatment.

Nicole Levine completed her Bachelor's degree in Psychology and Legal Studies at the University of Wisconsin-Madison and earned her Master's of Social Work from Loyola University Chicago. She had the opportunity to work with clients of various ages and demographic backgrounds during her academic career. Through her practicum experience, Nicole has developed skills in case management, individual counseling, and crisis intervention. She has gained valuable case management experience while working at Northwestern Memorial Hospital on the Intensive Case Management Team. Currently, Nicole is a group therapist at Compass Health Center and works with adolescents in the Partial Hospitalization Program and Intensive Outpatient Program. Nicole is dedicated to creating strong relationships with her clients and passionate about supporting and empowering them. She maintains an empathetic and client-centered approach, as well as holistically considering all factors that impact an individual client.

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Racial Microaggression as an Ethical Concern in Social Work Clinical Practice

Nicole Marie Malazarte

Abstract

This article aims to promote social and political consciousness of racial microaggression. Historically, a microaggression was mainly focalized towards racial individuals, but has now developed to target other identities covertly. Racial microaggression embodies three forms established by several attributes of an individual's identities. This article also explores why racial microaggression is an ethical concern in micro level of practice analyzed through the values of social justice, dignity and worth of the person, and the importance of human relationships within the NASW Code of Ethics. Lastly, this article advocates for possible change in social work curriculum to be interdisciplinary and further research about microaggressions in micro, mezzo, and macro levels of practice.

Keywords: microaggression, structural racism, institutional oppression, social consciousness, discrimination, social justice, disempowerment

Introduction

Institutional oppression and structural racism have been a powerful force of social control encompassing the African American community; however, they have also affected other marginalized and oppressed groups. Despite the civil rights movement's effect on transforming the way American society interacts with other racial

identities, racial inequities are so deeply ingrained that white helping professionals are not immune to being instilled with biases from their ancestors and showing prejudice against clients of color. Unfortunately, attempting to eliminate inequality for diverse racial communities in this society has led to a new form of discrimination referred to as microaggression, which is much more covert and damaging to people of color.

Over the past several years, the National Association of Social Workers (NASW) has imbued within its ethical standards a sense of cultural awareness and social diversity that calls for social workers to respect their clients' multiple identities and to identify the strengths of their clients' culture. It is an ethical concern when social workers do not recognize how the issues of race are influencing the helping process and how racism impacts the potential of servicing clients of color. It is also an ethical concern when underserved communities do not get the help they need. The detrimental effects of white helping professionals' lack of social awareness obscure the experiences of people of color through countless microaggressions that have made them question whether or not what occurred was racist. If social work professionals lack the knowledge and awareness that microaggressions occur in the therapeutic process, they are not efficiently empowering and advocating with oppressed racial groups.

Racial Microaggression

The term *microaggression* was conceived by Chester M. Pierce, who described it as subtle, mostly automatic, and nonverbal expressions that are put-downs of African Americans (Ross-Sheriff, 2012). Pierce first expounded upon these disrespectful mannerisms and surmised that they were primarily focused on African American youth in school systems. However, the term *microaggression* in its modern form has developed to encompass not only race but also characteristics of gender, ethnicity, ability, status, sexual orientation, and other identities that offenders attribute to targeted individuals or communities. Sue and colleagues (2007) were able to identify nine distinct themes of microaggressions: alien in one's own land, ascription of intelligence, color blindness, criminality/assumption of criminal status, denial of individual racism, myth of meritocracy, anthologizing cultural values/communication styles, second-class status, and environmental invalidation (p. 275). Overall, the term *microaggression* has broadened to affect not only African Americans but other identities as well.



"pantone people" by Nick Normal (flickr)

In contrast to the old forms of racism, which were outwardly blunt and hostile, contemporary racism uses covert, subtle, and sometimes unintentional mannerisms. Contemporary racism is hard to challenge because perpetrators often are not cognizant that their actions can be deemed as racist. As a result, Estacio & Saidy-Khan (2014) coined the term *racial microaggression*, which is a "brief and commonplace daily verbal, behavioral, or environmental indignity whether intentional or unintentional, this communicates hostile, derogatory, or negative racial slights and insults." Consequently, new forms of racism like racial microaggressions can be ambiguous because they invoke deep-rooted prejudices that can be hard to overcome.

Three Forms of Racial Microaggression

Ross-Sheriff (2012) asserted that there are three embodiments of racial microaggression based on the various features of the target individual's identities:

1. **Microassaults.** This first form of racial microaggression is an explicit racial belittlement. It is characterized primarily by a verbal, nonverbal, or environmental attack meant to hurt the intended victim through name calling, avoidant behavior, or purposeful discriminatory actions (Ross-Sheriff, 2012). This is similar to what has been called old-fashioned racism conducted on an individual level. Examples include referring to a person as colored or Oriental, discouraging interracial companionship,

purposely serving a white patron before a person of color, and exhibiting swastikas (Sue et al., 2007).

2. **Microinsults.** The second form of racial microaggression can be identified via various types of mannerisms such as rudeness, insensitivity, and hate for a person's racial heritage or identity (Ross-Sheriff, 2012). Although a statement may not necessarily be aggressive, the context in which it is uttered is key. For instance, a white employer might say to a prospective candidate of color, "I believe the most qualified person should get the job, regardless of race." Alternatively, an employee of color might be asked, "How did you acquire your job?" These types of comments inform the recipient that the speaker believes (a) people of color are not competent and (b) as a part of a marginalized group, a person of color must have obtained a position through some form of affirmative action rather than through capability (Sue et al., 2007, p. 274).
3. **Microinvalidations.** This form of racial microaggression is described by communications that exclude, invalidate, or negate the psychological thoughts, feelings, or experiential reality of a person (Ross-Sheriff, 2012). For example, when South and Southeast Asian Americans who have been born and raised in the United States are commended for speaking good English or are constantly asked where they were born, the effect is to invalidate their U.S. heritage and imply that

they are foreign. When African Americans are told "I do not see color" or "We are all human beings—all lives matter," the result is to negate their experiences as racial/cultural beings (Sue et al., 2007, p. 275).

Due to the subtleness of racial microaggressions, clients or communities often face an additional emotional challenge of trying not to become unnerved (Estacio & Saily-Khan, 2014). Some are left questioning whether an action was racist or not. Ultimately, racism that is internalized can assist in the perpetuation of racially prejudiced actions.

Relevance to Social Work

In the NASW Code of Ethics (2018), social workers are encouraged to adhere to the six ethical principles broadly based on the core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. In this case the values of social justice, dignity and worth of the person, and importance of human relationships can be seen as slightly more applicable.

Social justice

The ethical principle of this value is that social workers challenge social injustice, specifically with and on behalf of marginalized and vulnerable communities. Their efforts are also centered on concerns of discrimination, poverty, and other forms of social inequity. In the current climate the outburst of racial microaggressions is due to the resigned acceptance of injustices. Passively accepting a racial microaggression is an ethical concern in

and of itself because it is a social worker's duty to ensure that clients gain equality of opportunity. However, biases and prejudices must be confronted and acknowledged lest social workers turn against the ethical standards they seek to uphold and begin to passively comply with the racial microaggressions that already exist within the system.

Dignity and worth of the person

It is imperative for social workers to treat each individual in a caring, mindful, and respectful manner. Additionally, social workers must resolve clashes between clients' interests and the ample pursuits of society in a socially cognizant manner, consistent with the values, ethical principles, and ethical standards of this profession. A social worker who commits a racial microaggression toward a client is not respecting the person. If a social worker cannot respect the perspective and identity of a client who is a person of color, that social worker is violating this ethical principle of the profession.

Importance of human relationships

Social workers recognize the importance of human relationships in striving for change. Additionally, social workers engage individuals as equals in the empowering process and comprehend that strengthening relationships with others is beneficial to their well-being. A social worker committing a racial microaggression against a client limits the assistance that client could receive. If the client no longer feels secure in collaborating with the social worker, this is an ethical concern that needs to be addressed.

At times, social workers do not adhere by these ethical principles. However, well-intentioned social workers may not be aware that their behavior can be considered racially aggressive. Defining what is and is not acceptable is important in understanding individuals from various racial and cultural backgrounds (Estacio & Saidy-Khan, 2014).

Micro Level of Practice

At the micro level of practice, racial microaggressions contribute to the failure of developing or sustaining an alliance with a client. This can lead to disproportionately negative results for various sections of the client population because microaggressions deny or invalidate the experiences of individuals whom social workers work with daily. It is important to explore racism, specifically racial microaggressions, at a micro level of practice to understand how it is embodied in our day to day life. In order to create better micro-level practices, Van Sluytman (2013) identified two methods of gaining positive learning experiences from challenging conversations concerning racial microaggressions. Specifically, social workers must fathom that a client's position is subject to assumptions associated with race, class, gender identity, disability, and sexual orientation, which include privilege and disempowerment. Secondly, in a meeting with a client of color, social workers must increase their awareness that privilege and disempowerment threaten a clients' capacity to exercise self-determination and must develop strong ties in order to have meaningful discussions. The combination of the social worker's core values of social justice and the

importance of human relationships allows people to perform daily tasks or to find harmony within themselves and with others in a community (Van Sluytman, 2013).

Clinical Practice

According to Sue and colleagues (2007), President Clinton's Advisory Board on Race concluded in 1998 that racism is especially problematic in the mental health professions because a majority of graduates continue to be trained primarily in Western European models of service delivery. In the context of social work, white social workers are members of the dominant society and are not immune from adopting the racial biases of their forebears and becoming victims of the cultural conditioning process that ingrains in them prejudices and bigotry (Sue et al., 2007). At once unintentional and unconscious, racial microaggressions pose an immense challenge to the majority of white social workers who claim to be just, unbiased, and non-racist. Social workers are also in a position of power, which limits their ability to determine whether racist acts have transpired in their sessions (Sue et al., 2007). The inherent power dynamics in the relationship further obscure this issue as helping professionals are in a position of power to influence the development of treatment. Hence, the harm committed against their clients of color is either unidentified or diminished significantly.

In clinical practice racial microaggressions not only oppress and damage, but they consequently put clients of color into a catch-22. This leads to clients being less likely to confront or disclose to their social worker and to doubt their own perceptions in the event of a microaggression (Sue et al., 2007).

The result is low utilization of social and mental health services by marginalized ethnic groups. The relationship between a social worker and client who differ along racial lines in a clinical practice may reflect the unsettled race relations in the United States. Although some believe that racism is no longer a big concern and that the helping profession has erected safeguards against bias and prejudice, the reality is that these issues manifest throughout the healing process (Sue et al., 2007). This does not imply that positive changes have not occurred recently, but that racial microaggressions are still likely to occur in interactions.

Relationship with client

Over the past twenty years, calls for cultural humility in the helping professions have emphasized two objectives correlated with effective service delivery to racially oppressed clients: (a) to become conscious of an individual's identity as a racial being and of the prejudices, stereotypes, and beliefs that impact worldviews and (b) to understand the worldviews of culturally diverse clients (Sue et al., 2007). These two objectives are impeded when social workers fail to comprehend how issues of race impact the empowerment process and how racism likely taints the delivery of services to clients of color. For effective healing, empowerment, and guidance to happen, an establishment of rapport must occur. In other words, a working alliance/therapeutic relationship must be cultivated (Sue et al., 2007). Social workers interacting with clients of color must increase their awareness of the influences of social concerns that affect their clients' ability to practice wellness.

The relationship between client and social worker is enhanced when the

client views the social worker as trustworthy. Sue and colleagues (2007) stated that “helping professionals are trained to listen, to show empathetic concern, to be objective, to value the client’s integrity, to communicate understanding, and to use their professional knowledge and skills to aid clients to solve problems” (p. 280). Although this may be true, the task of establishing a sufficient relationship applies to the entirety of the helping professions and working with individuals who differ from the social worker in race, culture, gender identity, and sexual orientation presents unique issues.

The major common aspect of all helping relationships is a successful outcome. Sue and colleagues (2017) noted that the client’s perception of an accepting and positive relationship is a better affirmation of successful outcomes than the same perception by the social worker. As a result, when clients do not regard their social workers as credible and feel misunderstood and underestimated, there is less likely to be a positive aftereffect. The failure of a social worker and client relationship possibly stems from the client declining to self-divulge, deciding to dismiss the healing process early, or frequently missing scheduled visits.

Under the category “alien in own land,” Sue and colleagues (2007) describe a situation from one of the nine distinct microaggression themes:

A female Asian American client arrives for her first session with her social worker. Her social worker asks her where she is from, and when told “Philadelphia,” the social worker further probes by asking where she was born. In this case, the social worker has assumed that

the Asian American client is not from the United States and has imposed through the use of the second question the idea that she must be a foreigner. Immediately, a barrier is created in the helping relationship because the client feels invalidated by the therapist (she is perceived as a foreigner, not a U.S. citizen). Unfortunately, the Asian American client is unlikely to question her social worker or point out the bias because of the power dynamic, which causes her to harbor resentment and ill feelings toward the social worker (p. 281).

In this example the client did not receive the assistance she needs and might have left the session feeling worse than she had initially.

There are countless ways for social workers to channel their biases toward clients of color, such as by minimizing symptoms of Asian Americans in support of a distorted belief in the “model minority” or by emphasizing symptoms such as paranoid delusions and substance abuse in Native Americans and African Americans, who are considered to be subject to these problems (Sue et al., 2007). Overall, many clients of color continue to be misunderstood due to a lack of cultural humility.

Several Effects of Racial Microaggression

How one reacts to a racial microaggression will likely lead to various results, not only for the perpetrator but for the person of color as well. Estacio & Saïdy-Khan (2014) state that “some clients of color experienced feelings of anger, frustration, and even

paranoia.” This could very well lead to social workers imposing such feelings on clients of color by rejecting their experienced reality. Clients of color also respond by (a) being uncertain about whether a microaggression has happened, (b) being too troubled to respond, (c) being afraid of the ramifications, (d) rationalizing that “it won’t do any good anyway,” and (e) being entrenched in self-deception through denial (in other words, “it didn’t happen”) (Sue et. al., 2007). Despite there being some validity to these responses from people of color, they could exact a psychological and physical toll on the client and a loss of the client’s worth and integrity. For example, in the case of African American clients, reacting furiously to a white social worker could lead to the assumption that the client is hostile and impulsive, which can result in greater hostility by white social workers toward people of color. This situation prevents white social workers from viewing a different racial reality and construct barriers to harmonious race relations (Sue et al., 2007). It might also lessen white social workers’ social consciousness of racial microaggressions and reinforce a lack of accountability for their behavior.

Future Approaches for Social Workers

Estacio and Saidy-Khan (2014) assert that “passive acceptance of injustice could arise when abuse is swept under the rug. And one of the ways to tackle microaggression is to make the ‘invisible’ “visible” (p. 6). Although social workers can intentionally or unintentionally commit a microaggression against a client, social workers can still empower and work on assisting individuals or communities who

are targets of microaggression. According to Ross-Sheriff (2012), this can be done by developing a comprehension of the concept of microaggressions and their particular abilities to:

- (a) recognize that a microaggression is debilitating for the client;
 - (b) understand causes and effects of the behavior;
 - (c) communicate this understanding to the client;
 - (d) help the client to develop and implement strategies for preventing the microaggression, for mitigating its debilitating effects, and if necessary take action to resist and take action to combat microaggression; and
 - (e) examine their own behaviors for microaggressions
- (p. 235).

Social workers can also cultivate and support trainees in overcoming their fears and resistance to talking about race by promoting safe and productive learning environments. This is significant because trainees need to be implored to explore their own racial identities and their emotions about other racial groups. For white social workers, this examination entails asking the question “what does it mean to be white?” and being fully cognizant of their own white racial identity development and how it may impose itself upon people of color (Sue et. al., 2007). Thus, this level of self-awareness allows probable prejudices and biases that illuminate racial microaggressions to surface.

Additionally, for mental health propositions, it would be effective to explore the coping mechanisms utilized by people of color. People of color encounter daily racial microaggressions and have constantly maintained their

dignity in the face of such spite as a proof of their resiliency. A greater comprehension of responses to racial microaggression, both long term and short term, and coping strategies would be beneficial in equipping children of color for the life they will face. Proposing a taxonomy of racial microaggressions may make it possible to probe other social psychological questions as well (Sue et al., 2007).

Conclusion

The social work profession has an important responsibility to conduct research and publish findings in order to enhance social and political consciousness of microaggressions. Evidence that can be disseminated can contribute to the education of practitioners, policy makers, and society

as well as establish concentrated endeavors to advocate for those negatively affected by microaggression (Ross-Sheriff, 2012). Students studying to become social workers must be required to learn about microaggression and its presence in the helping process when working with clients of color. However, it should not be assumed that racial microaggressions can be eliminated instantly, especially because they stem from this society's history of severe maltreatment of numerous cultural and racial identities. As social workers, the first step in improving services toward clients of color is becoming cognizant of the relations among power, race, and oppression for clients of color.

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The Importance of Multidisciplinary Collaboration between Social Workers and Lawyers in Working with Immigrant Clients

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Abstract

Legal service agencies in the United States aim to improve one aspect of an immigrant's life: their legal status. Though obtaining legal status is a significant priority for migrants settling in the United States, finding services such as comfortable housing, accessing public transportation, obtaining food security and others, contribute to the multifaceted needs of immigrant communities. An attorney working on an individual's legal immigration case cannot usually address these multilayered needs. Public interest attorneys are often only funded to provide legal services and representation for the clients they serve. For this reason, collaboration with social workers is crucial for providing holistic services to immigrant's seeking assistance. This paper examines the significance of multidisciplinary collaboration between social workers and attorneys when working with immigrant clients. A social worker's intersectional and strength-based approach validates the client's experiences understanding that migration neither starts nor ends with an individual's journey. This approach encourages transparency between clients and organizations while attending to legal concerns from the client that can arise from distrust, confusion, and misunderstanding of legal proceedings in the United States. Alternate roles of advocacy within a team of advocates, allows providers to address the various levels of needs exhibited by clients,

thereby creating pathways for healing and growth for immigrant communities.

Keywords: multidisciplinary, collaboration, social workers, attorneys

Introduction

Holistic service delivery is often a central objective for direct service providers around the nation. However, few organizations draw from models of multidisciplinary and collaborative work. There is a large gap between the distinctive roles of advocates within a team, which can ultimately be detrimental to the client's understanding, level of engagement, and overall satisfaction with legal assistance. Immigrant clients, in particular, may encounter cultural and linguistic barriers that may prevent them from comprehending the intricacies of legal systems in the United States. Through collaboration, social workers and attorneys can provide more effective and culturally sensitive services by understanding their clients' cultural background, the multidimensional socio-emotional impact of migration, and actively supporting clients through their legal cases. A social worker's understanding of clients' environmental risk and protective factors along with an attorney's understanding of legal proceedings and systems can provide immigrant clients with comprehensive assistance that addresses multiple needs at once.

Basics of the Collaboration

Collaboration between social workers and attorneys is essential to working with immigrant-identifying persons. Staff attorney Mara Tencer Block and social worker Andrya Soprych (2011) describe three models of collaboration between social workers and lawyers: interdisciplinary collaboration, agency collaboration, and multidisciplinary collaboration. The interdisciplinary model views the collaboration as integrated, arguing that social workers are subject to the same rules, professional conduct, and attorney-client confidentiality. The agency collaboration model bridges the gap between legal aid organizations and social service organizations by formalizing referral arrangements on behalf of specific clients. The multidisciplinary model, which is an effective approach to working with immigrants, features collaboration in which social workers and attorneys are employed by the same organization but work independently. This organizational structure allows for effective communication, both between social worker and attorney, and service provider to client.

Systems of oppression create difficult barriers for immigrants to overcome, not only because migration requires an adaption into a new lifestyle, but because of the implicit expectation for migrants to assimilate into idealized America norms. Moreover, a migrants' legal status directly causes disenfranchisement in employment, health care, housing, and other areas of everyday life. An attorney's focus on the legal aspects of the case can preclude focusing on the multidimensionality of immigrant clients' lives. This is normally

due to the organizations specific funding and time constraints. For example, if an attorney is submitting a U-visa for a mother who is a survivor of domestic violence, the attorney may only have the capacity to work on mother's U-visa filing, and may not put in resources towards helping the mother also fulfil housing needs of relocating to a new apartment closer to her work. Thus, a social worker's person-in-environment perspective can further support the complex client needs that stem from larger oppressive systems. This focus on the environmental components of clients' lives guides social workers in finding secure housing options, school-related programs for children, and mental health services for clients. In the example mentioned above, the social worker can invest their time helping the U-visa applicant find stable housing close to her job and her children's schooling. The social worker can inform clients of the housing application process, and the complexities of what moving can entail for families in the specific city. Discussing clients' rights in the United States along with informing them of sociopolitical events that directly affect their lives is a role social workers can take in the attorney-social worker relationship.

Collaborative work is especially effective when immigrant clients have difficulty understanding the complexity of their legal cases. Social workers can serve as mediators between attorneys and clients so that they can work together more efficiently. Cultural differences, language barriers, education levels, the impact of migration on mental health stability and other factors can contribute to clients' misunderstanding of their legal cases. When there is confusion or misunderstanding of a legal matter, the social worker can provide both clarity

and extra support to the client. Social workers can clarify legal cases by following-up with clients and answering their questions. Whether this takes the form repeating answers to questions that have already been addressed by attorney's or creating visualization that break down the legal process to them, social workers can serve as reinforcement of this information. Accessibility to multiple services and systems of support within one organization can help immigrant communities whose insecure employment status often leaves little time for contact with social service agencies. Organizations that provide both legal assistance and case management offer better solutions for immigrants who may already have difficulty seeking services. Multidisciplinary work is accessible, effective, and a better method for serving immigrant clients.

Immigration as a Process

The multidisciplinary approach encourages collaboration in working constructively with immigrant populations that tend to experience multifaceted problems. As immigrants embark on the ever-changing journey of migration, they leave behind family, friends, and sometimes cultural traditions to enter lifestyle drastically different than their life in the country of origin. Immigration does not start or end at the time of arrival in the new country but is instead a process that begins with the immigrant's decision to leave the country of origin and ends with successful adjustment to the societal norms of a new country (Foster, 2007). In ensuring that immigrants feel externally validated and supported in their new community, social service providers must encourage the acceptance of new societal norms, but not

the internalizing of self-hate that can derive from assimilation. In other words, social service providers should emphasize strength and power in the act of migration, affirming clients of their rights to autonomy and the preservation of their cultural and ethnic roots. Successfully adjusting to a new society means the migrant feels supported enough to uphold their own customs and ideas in a society different than their own. To best serve clients who identify as immigrants, clinicians must be aware that migration is not a single event but rather a process consisting of many stages.



"Immigration" by Wendy (flickr)

The idea of *peri-migration trauma* coined by Perez-Foster (2005) recognizes the risk for trauma to occur at multiple levels and different points in an immigrant's journey. Hilado and Lundy (2018) describe three elements of the migration experience: premigration experiences, migration experiences in transit, and resettlement experiences. Each element of migration poses hardship and risk to immigrants. Premigration is rooted in an immigrant's experience in the country of origin (Hilado & Lundy, 2017) and is thus defined by push factors that contributed to the individuals' decision to emigrate. The transit experience depends on the individual's

immigration status documented, protected, undocumented, or refugee and is directly influenced by travel documentation that is available prior to departure and upon entry. Understanding that obtaining travel documentation is a privilege that comes with financial capital in one's country of origin and is a result of political relations between the United States and the corresponding country is pertinent this categorization of immigration status. The last element of migration is known as resettlement or readjustment into the new country (Hilado & Lundy, 2017). Because resettlement can be challenging, social service providers working with immigrants arriving in a new country must know the best practices for supporting this population. Best practices for supporting immigrant groups during resettlement involve a multidisciplinary approach that allows clients to seek both legal counsel and referrals to direct service-providing agencies in their communities.

Resettlement in the United States

The resettlement process in the United States is certainly a challenging one, requiring intentionality from social service providers around creating safety, stability, and security for newly arrived immigrants. An individual's legal status in resettlement can result in new struggles deriving from the need to adapt into a new society. Individuals who faced persecution in their countries of origin may find it difficult to understand and trust the intricacies of U.S. immigration court processes. U.S. Immigration law, which is subject to the values of the current administration, is historically known for its volatility. Under the current political administration, many

individuals are seeking asylum at U.S. ports of entry, but U.S. Customs and Border Protection officers at a number of border ports are turning them back before they reach the official crossing, forcing them to wait days, weeks, or even months in Mexico before they can return to apply for asylum (Chishti, Pierce, & Jacks, 2018). This is just one example of the unpredictability of immigration law in the United States. Individuals and families migrating into a new country with different laws and regulations can find this experience both confusing and emotionally draining. For this reason, social workers and public interest attorneys must be willing to collaborate in exploring the needs and questions of their immigrant clients.

Enhancing Communication, Providing Resources, and Supporting Mental Health

The uncertain nature of immigration law creates great potential for confusion and anxiety with regard to immigrants' current and future legal status. For many immigrant-identifying clients, information regarding deadlines and timelines can seem unclear due to the ambiguity of immigration law. Clients may often think that their attorneys (a) have the answers to why their application for legal relief is an extensive process, (b) have the power to dictate outcomes regarding their immigration cases, or even (c) have information that they are unwilling to share with them out of distrust. Thus, clients may struggle in understanding the attorney's role in the case, the case itself, and potential outcomes of the case. A lot of this uncertainty can stem as a result of past experiences with law and authority in their country of origin or from an overall

lack of understanding of U.S. immigration law. These worries and accumulated feelings of anxiety can prevent clients from fully engaging with their attorneys regardless the attorney's attempts to clarify any confusions. As mental health issues rise, frustration can grow, creating inferiority complexes where individuals receiving legal services start feelings hopelessness regarding their immigration cases.

Providing direct clinical services to address the mental health needs of immigrant-identifying clients would be ideal in a legal service providing setting. The notion that systemically oppressed clients should fully understand the protocols and systems, which often times further alienate and oppress these communities is senseless. Thus, the perspective that social workers bring to the client-attorney relationship is crucial. Social workers can work to address issues of mental health, which indirectly affect a client's understanding of their legal proceedings. Galowitz (1999), a clinical professor of law at NYU, argued that lawyers can spend much of their time trying to resolve the non-legal problems that are inextricably entwined with a legal issue. A social worker's ability to connect clients with resources in their communities can help clients find balance in their lives, which can in turn positively affect their understanding of their legal situation. When clients connect with services in their community, they receive access to communal forms restoration, healing, and support. Mental health issues can improve and through group therapy options where they may meet other individuals who share similar experiences as them. In other words, caring for mental health concerns of clients who identify as immigrants remains an important component of legal

aid practice. Attorneys working cooperatively with social workers can both ease clients' mental health concerns and ideally improve clients' mental health.

I first began to realize the importance of social workers collaborating with attorneys during my first-year internship at the Legal Assistance Foundation, a nonprofit legal service provider in Chicago. At the Legal Assistance Foundation, there is a referral system whereby attorneys can refer their clients to social worker/social work interns for extra support on their legal cases. Many clients I worked with were applicants for U-visas (U.S. Citizenship and Immigration Services, 2019), which are special visas for crime victims who have suffered mental or physical abuse and have been helpful to law enforcement or government officials in the investigation or prosecution of criminal activity, as well as others who had divorce cases in court. Both groups had multifaceted issues arising from their legal status. Issues with transportation were frequently addressed because many clients did not have access to cars or public transportation. Language barriers, cultural differences, discrimination that people of color face when integrating to American society, and other factors heavily contributed to the everyday stresses of my clients' lives. Many these clients were mothers of families and their own primary sources of income.

After conducting an initial assessment of the client's economic stability, access to food, housing and employment status, support systems, and mental health, I would check in with my supervisor for potential referral options. As an intern, my responsibility was to refer clients to clinical mental health services and other social services that

could provide them with comprehensive assistance in their communities. Unfortunately, the lack of resources for undocumented immigrants in Chicago left many of my clients with unresolved issues and me on the lookout for assistance options that could help them. Mental health services and housing options have proven to be the most difficult resources to find for undocumented individuals in the Chicagoland area. Finding resources for my clients was crucial in order for them to receive adequate assistance from mental health care professionals that could improve their overall stability and help them understand their legal situations.

Many anxious high-functioning clients had difficulty connecting with mental health clinics in their communities, which is part of a larger systemic issue of health care access for immigrants. Attorneys were focused on clients' legal issues but my goal as a social work intern was to help clients achieve stability. On behalf of my clients, I called various mental health clinics for direct assistance because in some instances clients had an easier time obtaining appointments when social workers or interns directly contacted agencies. This speaks to the larger issue of the marginalization of undocumented clients who seek assistance and are not taken seriously.

The benefits of collaboration were seen in an intake interview I observed that was conducted by a social worker and an attorney. There was a noticeable difference in the language and direction of questions being asked by the attorney and the social worker. The social worker understood the client's decision-making ability with regard to the client's legal case and reframed the language

used in the intake interview to encourage self-determination. Asking questions such as "what do you think is best?" and making statements such as "whatever you feel comfortable with—these are your options and consequences" moves away from advice giving and hierarchical interactions. Rather, it meets clients where they are and encourages active participation. The social worker emphasizes safety planning and considers risks that can result from a decision in court. Asking clients whether they fear or have worries regarding their immediate safety after a court decision is established remains a crucial component of a social worker's role within the team of advocates. Safety planning falls under the scope of services in which social workers are trained and can better address the needs of the client. Decision-making moments can invoke passionate reactions from clients; therefore, identifying and assessing fears can help the client to adjust to the legal decision. This is especially relevant to work with immigration/Violence Against Women Act cases of domestic violence.

Social workers understand the complexities of cultural humility and can help attorneys to understand why clients may have certain concerns. In fact, within a social work framework, there are three key components of culturally sensitive care (McPhatter, 1997):

1. An awareness of and sensitivity to one's own values, biases, and power differences with patients (that is, having a grounded knowledge base involving a critical analysis of the gaps and weaknesses in cultural knowledge and reformulating new knowledge while incorporating

- information that involves culturally diverse communities)
2. Knowledge of the practice environment, including an understanding of patients' culture and values
 3. Effective communication with patients, including valuing others' worldviews, using cross-cultural communication skills, moving toward acceptance, and engaging a culturally diverse population (Lindsay, Tétrault, Desmaris, King, & Piérart, 2014).

For instance, when discussing options for child support benefits with a client, Juliana, it is important to understand that Juliana's hesitation in receiving child support in her divorce derives from the fear associated with her undocumented husband's legal status. In more complicated situations a social worker understands that a survivor's hesitation to file an order of protection against an abusive partner stems from not wanting to increase the risk of deportation for the partner. Often to avoid separating children from the other parent, an abused parent is unwilling to file for an order of protection needed to ensure their own safety. However, some states have initiated state-level due process protections. For example, in Illinois the TRUST Act restricts local law enforcement from collaborating with federal immigration enforcement agents to detain anyone without a judicial warrant (Cullen, 2017). Without this protection, any sort of contact with police authorities can place a partner at risk for deportation. In addition, an order of protection against a petitioner adversely affects the good moral character component of an

application for legal relief. Social workers understand why clients may fear breaking up their families through deportation and why clients feel guilty about reporting abuse to the authorities because of the negative impact on the legal case of their partners. This perspective allows social workers to reshape conversations around clients' experiences of abuse and can encourage clients to view their personal safety as a priority. Understanding the multifaceted lives of clients outside of their legal cases can provide some context to concerns raised within the case and can subsequently lead to productive dialogue in which advocates are not acting as experts but as listeners.

Not all attorneys are equipped to navigate mental health concerns with clients, and social workers can provide clarity in more complex situations. The following is a real-life case example involving an immigrant client who claimed to be living with bipolar disorder, schizophrenia, depression, anxiety, and posttraumatic stress disorder. Confused about the diagnosis, the attorney contacted the social worker, who was able to explain the diagnosis and how it could potentially impact the legal case. The social worker had insight into the case based on her understanding of the client's mental health history, which can be particularly helpful during the referral process. A broader understanding of what the client is encountering in everyday life can build context for the team of advocates and serve as a preventative measure to ensure that both the client and the team maintain clear communication patterns.

Social Work's Role in Legal Advocacy

Madden discussed the need for social workers to become knowledgeable about the legal field (as cited in Albert, 2000). He encouraged social workers to commit to influencing the legal system through education, advocacy, and proactive legal policy development, and he stated that social workers have neglected opportunities to influence the legal system and thereby improve outcomes for clients and practitioners. Not only does this redefine the role social workers occupy in nonprofit organizations that provide legal services, but it also refocuses social workers on their code of ethics. The ethical standards of the National Association of Social Workers state in section 6.04 that social workers “should be aware of the impact of the political arena on practice and should advocate for changes in policy and legislation to improve social conditions in order to meet basic human needs and promote social justice” (NASW; 2008). Holding social workers accountable for their commitment to advocate at the legislative level remains a challenge in today's world of social service. By providing access to resources, informing clients of their rights, social workers should work to empower clients to their fullest potential also encouraging them to advocate for themselves and their families. Thus, advocacy and legislative change includes the voices of social workers and community members directly impacted by laws and policies.

Often the idea that advocacy at a macro level falls under the realm of responsibility for attorneys in public interest can prevent direct service administrators from using their platform for larger systemic level advocacy such as litigation. Though an important form

of advocacy remains the responsibility of attorney's who are knowledgeable of the law, arguing that social workers, medical doctors, nurses, and other professions should also stand in comradery with oppressed identities allows social workers to use their capital to invest in empowering marginalized communities to obtain services and opportunities in their community. Chang-Muy and Congress (2009) addressed the many ways in which social workers can individually advocate for immigrant clients by educating these clients about their rights, educating others about immigration issues, providing input on legislation and policy, and creating an effective advocacy strategy. Social workers can facilitate better services to immigrant communities by being familiar with current policies and remaining educated on issues affecting immigrant communities (Chang-Muy & Congress, 2009). It is imperative for immigrant communities to become civically engaged and stay informed on current immigration policy. Civic engagement and political involvement in one's community often stems from connectivity, access to resources and information that build capital for individuals to feel confident enough to advocate for themselves.

Among other factors, the immense fear of deportation and lack of exposure to networks and support groups can contribute to immigrant's hesitation to engage civically. Social workers can work with clients to navigate these hesitations since they are often the only class of administrators accessible to immigrants, and for this reason, they can be of greater assistance by staying informed on current immigration policy and sharing that information. Educating immigrant clients about their rights in the

areas of housing, social services, health care, labor, and other policies can help these clients function more effectively in their communities (Chang-Muy & Congress, 2009). Social workers have access to networks and connections that can help disseminate this information. When immigrant families' lack knowledge of their community's social services, it prevents groups of people from executing daily tasks. In other words, the extreme challenges experienced by some immigrant-identifying individuals can be eased by support and connection to social service agencies in their own communities. Social workers can serve as information distributors, making it easier for individuals to build community with and gain support to empower leaders within their own communities to take up space and uphold pos

Implications of Merging Two Different Perspectives into One Team

There is an inherent tension between attorney and social work guidelines of ethical responsibilities (Galowitz, 1999). The attorney's responsibility is to advocate zealously for the client's best interests whereas the social worker's role is to safeguard the client's personal desires. Attorney problem-solving methods that consider the client's best interest may differ greatly from the social worker's client-centered approach that considers the client's desires. This differing foundation of the two professions can lead to ethical principles that sometimes conflict. The vagueness surrounding a social worker's role within a legal aid firm can discredit the social worker's experience, whereas the outcome-oriented perspective of an attorney can neglect the cultural

complexities of immigration cases. For social workers who have a wide range of roles and tasks within an organization, clearly defining these roles and acknowledging their purpose in facilitating conversations with high-needs clients remains a challenge to be overcome.

The social work curriculum tends to lack policy-based law-oriented classes that would better inform students about regulations that complicate their clients' daily lives. Policy-based classes can complement the theoretical, interpersonal, and experiential learning that are all fundamental components of social work curricula in universities. By taking courses that focus directly on policy and legal issues, social workers can be an additional resource for clients and aid in clarifying more complex issues that may arise in legal proceedings.

Conclusion

Although many legal aid service providers lack funds to hire social workers, the collaboration of social workers and attorneys is powerful and benefits every party in the interaction. A clinician's use of intersectional and strength-based approaches in work with immigrant clients helps to develop the client's autonomy and sense of understanding within a legal case. Multidisciplinary work allows the attorney to focus on the legality of the case, the client to better understand the case, and the social worker to use their socioemotional conceptualization of the client to enhance the client's self-sufficiency. In cases as specific as immigration, attorneys are responsible for drafting, preparing, and filing documents related to the clients' legal case but often do not have the capacity to

process court outcomes with clients. Social workers can make legal cases more manageable for clients by providing clinical and supportive spaces to reflect on judicial outcomes along with referrals to social services in the community. With

frequent communication and client-centered services, social workers and attorneys can effectively work together to best serve the multiple needs of immigrant clients.

Melanie Minuche recently graduated with my bachelor's in social work from Loyola University. Throughout my undergrad years I worked for various non-profits in the Chicagoland area, specifically in providing services to migrant communities. I served as a mentor for first-generation/students of color in a mentorship program under the Student Diversity and Multicultural Affairs at Loyola and held leadership roles in UNICEF and the department of residence life. I served as Provost fellow where I collaborated with a professor in the department of Social Work and researched the effects of mentorship in adolescents in the foster care system. In May of 2019 I spent a month at the U.S./Mexico border working with various organizations who provide humanitarian aid and case management to migrants crossing the desert and asylum seekers. Most recently I was hired as a legal assistant at the National Immigrant Justice Center where I work with unaccompanied immigrant children, providing them information regarding their rights in detention, the immigration court process, and later conducting legal screenings with them to assess for legal relief. I am passionate about working with immigrant groups and analyzing the effects of intersectionality, race, class, and gender in the act of migration.

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“Three Strikes and You’re Out” Legislation

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Abstract

This article will explore the “Three Strikes and You’re Out” legislation introduced in the 1990’s by the Violent Crime Control and Law Enforcement Act. This legislation was implemented as a way to recognize and combat the perceived rise of violent crime in the United States. The “Three Strikes” law specifically targeted habitual offenders and intended to practice general deterrence by introducing stricter consequences for repeat offenders. Hence, this law aimed to discourage offenders from engaging in further criminal activity. The “Three Strikes” legislation was adopted by 24 states between 1993 and 1995 but tended to differ in the way it was practiced from state to state. This article will provide a general analysis of the development and implementation of the Three Strikes legislation, specifically focusing on the way it was adopted by the state of California. It will also analyze the various factors that influenced the way “Three Strikes” was implemented in California and the impact this legislation had on California’s crime rates.

Introduction

The “Three Strikes and You’re Out” legislation introduced by the Violent Crime Control and Law Enforcement Act was a response to the perception of overwhelming violent crime in the 1990s (McCollum, 1995). This legislation attempted to address the public misconception that rising crime

rates were due to a lack of punitive measures, specifically those addressing habitual offenders (Dickey & Hollenhorst, 1999). According to Datta (2017), the intention of this policy was to achieve general deterrence by assigning longer sentences to criminal acts, using confinement to isolate repeat offenders from the community. This legislation essentially highlighted the concept of three chances, emphasizing that offenders would be deterred from engaging in further criminal behavior once they were aware of the severe consequences of their actions. Datta also noted that the legislation ensured that repeat offenders would be incarcerated for longer sentences that would prevent them from engaging in any other criminal activities that could be harmful to society.

Overwhelming support from both Republican and Democratic parties and the increased public concern about criminal behavior led to a quick acceptance of this bill on the state level. The “Three Strikes” legislation was adopted by 24 states between 1993 and 1995 (Karch & Cravens, 2014). This article will provide a general analysis of the development and implementation of the Three Strikes legislation, focusing on its adoption and impact on crime rates in the state of California.

Three Strikes Background

According to McCollum (1995), the Violent Crime Control and Law Enforcement Act was enacted by Congress in 1994, spearheaded by President Clinton’s efforts to address the

rising crime rates in the country. This crime bill consisted of funding for various government entities, including law enforcement agencies and prisons. McCollum noted that federal funding was provided to instill crime prevention measures and included policies such as the Federal Assault Weapons Ban, Federal Death Penalty Act, and the Three Strikes and You're Out law. While this bill was being broadcasted on the national level, the increase in criminal behavior was also sparking conversations at the state level.

Washington was the first state to pass the Three Strikes and You're Out ballot measure in 1993. As noted by McCollum (1995), this ballot measure was passed swiftly in Washington State and met with support on both the state and national level. California and 12 other states followed this trend in 1994 (Sutton, 2013); however, the application of the law in each state varied. For instance, Georgia's Three Strikes policy, passed in 1994, identifies seven crimes that receive a minimum sentence of 10 years upon the first conviction and a life sentence for a second conviction (Dickey & Hollenhorst, 1999). Dickey and Hollenhorst (1999) further explained that these crimes, known as the "seven deadly sins of Georgia" are murder, kidnapping, rape, aggravated sexual battery, aggravated child molestation, aggravated sodomy, and armed robbery.

Washington State's Three Strikes law is known as the Persistent Offender Accountability Act. Under this law, an adult offender convicted of three "serious" felonies receives a sentence of life without parole (Columbia Legal Services, 2018). Serious felonies include all class A felonies and some class B felonies that are a result of sexual motivation. On the other hand,

Connecticut did not implement mandatory life sentences for a third conviction but instead "upgraded" sentences for felony convictions (Dickey & Hollenhorst, 1999). For instance, after two strikes, individuals convicted of a class B felony receive a punishment that is usually applicable to a class A felony. Dickey and Hollenhorst (1999) explained that some states, such as Washington, Georgia, and Connecticut, vary in sentencing practices, specifically in identifying which felonies are considered strikes or the number of strikes needed to enact the policy. Over time, some states attempted to reduce the severity of this law by either eliminating certain sentences or introducing range in the type of crimes that would need to be committed in order to impose the Three Strikes legislation (Karch & Cravens, 2014).

Existing Policies

Although Three Strikes is widely known as the first broadcasted effort to strengthen penal response to crime, it is not the first attempt made by states to address habitual offenders. Existing policies addressing repeat offenders indicate that this is not a new social problem. Rather, it was a social problem that was heavily emphasized and recognized in the 1990s, leading to a countrywide attempt to increase punitive measures.

Policies enforcing stricter punishments for habitual offenders were implemented on the state level well before Three Strikes was developed. According to an article by Beres and Griffith (1998), the Persistent Felony Offender Law was implemented at the state level in New York in 1978. This policy allowed courts to issue stricter

sentences to repeat offenders, particularly offenders who had been previously been convicted of felonies. However, Beres and Griffith noted that this statute was amended in 1995 to reflect the federal Three Strikes legislation. New York's adoption of Three Strikes in 1995 involved imposing severe punishments primarily for violent offenses.

The Illinois Habitual Offender Act, created in 1978, sentences offenders to life without parole upon a third conviction of a Class X felony (Moran, 1982). Class X felonies in Illinois include aggravated battery, kidnapping, sexual assault or armed robbery. Florida's Habitual Offender Law was passed in 1988. As of 1998, nearly 20 percent of Florida's prison population had been convicted under this law (Dickey & Hollenhorst, 1999). Florida's law was amended in 1995 to include Three Strikes legislation. Maryland implemented a policy in 1975 that sentenced individuals convicted of their third felony to 25 years of incarceration without parole. This law was successfully utilized in 250 cases before it was amended in 1994 to reflect the Three Strikes policy (Dickey & Hollenhorst, 1999). Maryland's amended Habitual Offender Law sentenced individuals convicted of their fourth strike to life without parole, illustrating yet another variation of the Three Strikes legislation at the state level.

California's Three Strikes Legislation

California's original version of the Three Strikes legislation was not applied exclusively to violent offenders (Datta, 2017). Instead, any crime described by the legislation as "serious" could be counted as a strike, whether it was violent or nonviolent (Romano, 2010). According to Datta (2017),

"Three Strikes' led to a doubling of sentences on the second strike, and to a dramatic increase in sentence lengths on the third strike" (p. 226). In other words, an individual who committed a second felony received a doubled sentence (Males & Macallair, 1999). Additionally, an individual who had committed two felonies that were either serious or violent would serve a mandated sentence of 25 years to life for their third felony conviction (Karch & Cravens, 2014).

Influence of a Populist Government

California's implementation of the Three Strikes law was heavily influenced by the state's populist government, which decentralizes power by granting citizens a major role in the development of legislation (Barker, 2006), and the violent events that were being recognized in the public sphere. Populism has strong historic roots in California, having emerged when social groups began to push back for more control and were able to win influence through the ballot box. This initiative expanded in the 1960s when California's citizens were given direct power to influence their state's legislation. With a dramatic rise in state crime rates, citizens began to advocate for stricter crime laws.

In 1967, an anti-crime penalty package was passed in California that ultimately increased sanctions for offenders who committed crimes in which victims were significantly injured or harmed (Barker, 2006). This initiative exemplified a shift in California's perspective on crime by imposing punishment that was heavily influenced by the victim or the people affected by the crime. Another initiative passed by the California legislature was Proposition 8 (the Victims' Bill of Rights), which made

prosecution of offenders easier (Barker, 2006). This policy was yet another step that California took to solidify its stern stance on crime and punishment. Similarly, the adoption of Three Strikes in 1994 supported California's severe anti-crime movement that had been building for decades.

California's form of governance played a large role in the development and implementation of the Three Strikes legislation. Populist governments reduce the complexity of an issue by limiting citizen's choices to yes or no (Barker, 2006). According to Barker, by voting against stricter crime legislation, citizens may believe that they are contributing to the increasing crime rates. On the other hand, voting for stricter crime legislation can mean that they are not advocating for the defendants. Barker inferred that this can lead to individuals feeling that neither side represents their beliefs, causing them to refrain from voting altogether. Additionally, it can create potential for conflict in public life by forming distinct social groups that can isolate citizens outside those groups. Barker further stated that this isolation can lead to lack of voter participation in a state that is highly dependent on civic engagement.

Populist governments' dependence on citizens plays a large role in the way policy is developed and implemented at the state level. By leaving power to the citizens, decisions are based on public sentiment rather than empirical data (Barker, 2006). Although public sentiment has a necessary role in this country's governance, there are many cases when political sentiment is correlated with what is portrayed in the media. Social problems may be exaggerated or emphasized by the media, instigating a sense of urgency and influencing the way the public decides to

address an issue. Voters may focus on what they see on the media or hear from government officials, which may influence their decision-making with regard to policy initiatives. In this case, the general consensus on the upsurge in crime and the media's urgency in addressing this social problem played a role in swaying votes. Hence, the public leaned toward severe punishment and increase in imprisonment rather than other solutions.

Media and Government's Portrayal of Crime

Although California's historical dependence on populism played a role in the adoption of the Three Strikes legislation, portrayal of crime rates by media and the government also heavily influenced California's crime bill. In 1992, 18-year-old Kimber Reynolds was leaving a restaurant when she was murdered by a career criminal during an attempted robbery. Kimber Reynold's murder became the motivation behind the adoption of the Three Strikes legislation in California (Vitiello, 1997). Her father spearheaded the drafting of this legislation, insisting that California needed stricter penalties for habitual offenders. However, it was not until the kidnapping and murder of Polly Klaas in 1993, by a repeat offender on parole, that the legislation received a push on the public level. Polly Klaas became the poster child of rising crime rates and the lack of criminal justice policies addressing the problem of repeat offenders (Vitiello, 1997).

Although the flaws in the Three Strikes legislation may have been recognized during its development process, the public's outcry for action pushed it through with majority support

(Vitiello, 1997). California had seen an increase in violent crime rates in the 1960s and in response it had become strict in its sentencing (Barker, 2006). As a result of these events, confinement and punishment became the overlying theme of California's governance (Barker, 2006). In view of the rising crime rates, the underlying voter distrust of the state government, and the rising public concern about increasing crime rates (Vitiello, 1997), it is not surprising that the state passed the Three Strikes legislation with very little opposition.



"Crime Scene Tape" by Brandon Anderson (flickr)

According to Barker (2006), "when citizens participate in public life, they may be more likely to keep a check on the repressive powers of the state" (p. 6). In other words, confinement and punishment are connected to the way states exercise and maintain power. Hence, the way citizens participate in their respective state can influence the state's use of confinement. The Three Strikes legislation in California is an example of policy for which the outcomes and effects are seen over time (Barker, 2006). Three Strikes increased prison length for habitual offenders, which played a significant role in the increased incarceration rate and offender population in California (Barker, 2006). According to the Bureau of Justice

Statistics, California in 2004 had an incarceration rate of 455 incarcerated individuals per 100,000 people in the state, which is higher than the national average of 429 incarcerated individuals per 100,000 people in the state (as cited in Barker, 2006). This rise in incarceration rate was due to the increased reliance on imprisonment in California from the 1960s through the 1990s.

Attempts to Reform Three Strikes Policy

Once the original law was passed in 1994, there were many attempts to reform its strict and arguably unfair guidelines (Karch & Cravens, 2014). These reforms originated from two distinct judicial cases that led to the recognition that the law could result in excessive prison sentences. Individuals who committed seemingly low-risk crimes were eligible for a life sentence due to the technicalities of the bill. In the first court case, *Lockyer v. Andrade* (2003), Andrade had two strikes of nonviolent crimes that were considered serious because they were residential burglaries (Romano, 2010). After his third strike for shoplifting, he was eligible for life in prison. In another case discussed by Romano (2010), *Ewing vs California* (2003), Ewing was serving a life sentence for attempting to steal golf clubs.

In both cases, the defense argued before the court that the decision was a violation of the Eighth Amendment. According to Romano, the defense argued that the use of Three Strikes in these cases represented cruel and unusual punishment because the crimes committed were not proportionate to the punishment. The court upheld

California's law and determined that the rulings did not violate the Eighth Amendment (Romano, 2010). These were landmark cases in California because they attempted to highlight the inherent flaws in California's Three Strikes law by arguing that it violated the Eighth Amendment in non-capital cases.

Lockyer vs. Andrade (2003) and *Ewing vs. California* (2003) were two of several cases that recognized the use of the Three Strikes law as a way to impose life sentences for minor crimes. However, they did not lead to an immediate change in the way the law was implemented. In 2004, Proposition 66 was introduced at the state level. This proposition attempted to ease the guidelines of the Three Strikes bill in California but was rejected by the voters (Romano, 2010).

The rejection of Proposition 66 may have been influenced by opposition from interest groups. The California District Attorneys Association (CDAA) consists of prosecutors who are tasked with leading special interest groups that "advocate for and against propositions" (Center on Juvenile and Criminal Justice, 2011, p. 3). The CDAA publicly lobbied against Proposition 66 and "its endorsement carried considerable weight" (Center on Juvenile and Criminal Justice, 2011, p. 4). The CDAA may have opposed Proposition 66 because of the authority district attorneys are given under the guidelines of the Three Strikes policy (Chen, 2014).

According to Chen, "most of the discretion in the implementation of California's 'Three Strikes' law is exercised by prosecutors" (p. 262). As an example, the Three Strikes policy was implemented inconsistently by different counties in California. Conservative counties tended to have district attorneys who were supportive of Three Strikes and

more inclined to implement the policy. On the contrary, liberal counties had district attorneys who were less disposed to charge offenders with Three Strike penalties, especially for nonviolent crimes (Chen, 2014). These discrepancies in practice could be seen in the "uneven application of the law throughout California" (Dickey & Hollenhorst, 1999, p.14). For example, more than 60 percent of the cases filed under the Three Strikes legislation originated in Los Angeles County, which was known to be represented by a fairly conservative district attorney. On the other hand, San Francisco's district attorney did not utilize this penalty and openly advocated against its practice. Hence, the authority bestowed upon prosecutors in terms of sentencing may have motivated influential interest groups such as the CDAA to oppose Proposition 66, which could have led to restrictions on prosecutorial discretion.

It was not until 2012 that California passed Proposition 36, which was another attempt to modify the Three Strikes law. Proposition 36 intended to restrict the life sentence penalty associated with Three Strikes to individuals who had prior convictions of rape, murder, or child molestation (Karch & Cravens, 2014). It also offered the opportunity for third strike offenders to appeal the courts for resentencing and to allow the judge to decide whether a lesser sentence for the offender would jeopardize public safety. This proposition gave thousands of inmates an opportunity to appeal their life sentences for potential reduction (Karch & Cravens, 2014). As a result, thousands of prisoners appealed their sentences, both independently and with the help of public defenders (Mills & Romano, 2013). Inmates in counties that do not provide defense resources to

inmates could file petitions with the help of interest groups such as the Stanford Three Strikes Project (Mills & Romano, 2013). The Stanford Three Strikes Project is a student-run organization developed by Stanford Law School (n.d.). This program attempts to provide legal aid to individuals sentenced for minor crimes as a result of California's Three Strikes policy.

Effectiveness of Three Strikes: Crime Rates and Deterrence

The effectiveness of this law has been widely researched and debated among both supporters and critics in California. In most cases, the success of this law is evaluated on the basis of its impact on crime rates, deterrence, and the targeted population and other agencies. In 1998, California's attorney general stated that the Three Strikes law contributed to the "largest overall drop in crime over any four-year period in [California] history" (Beres & Griffith, 1998, p. 102). The attorney general's report based its argument on a comparison of crime rates between 1990–1993 and 1994–1997. The report indicated that between 1994 and 1997 the crime rate dropped more than 30 percent and the violent crime rate decreased by 26.9 percent. According to the report, although a slight decrease in the crime rates was noted between 1990 and 1993, the crime rate dropped "dramatically" after the state enacted the Three Strikes law in 1994 (Beres & Griffith, 1998).

Although this report may not be completely inaccurate in its interpretation of the crime rates, it is imperative to consider other factors and analyses. For instance, further scrutiny of the trends in crime rates compared to previous years indicates that the crime rate in California

began to drop a year before the Three Strikes law was implemented (Beres & Griffith, 1998). Furthermore, the drop in crime rates was a trend that was taking place not only in California but also on the national level. This indicates that, although the information provided by the attorney general may not have been untrue, it did not accurately reflect the variety of other factors that could have influenced the reduction in crime rates.

The interpretation of the crime rate data for California can also be reevaluated relative to the crime reduction rates in other states. New York was among three states that experienced an exponential drop in crime rates from 1993 to 1996 (Beres & Griffith, 1998). New York had a persistent offender statute since 1978 that was later revised to include stricter penalties for individuals who committed multiple violent felonies. However, despite a change in the existing policy, New York did not experience a drastic change in crime rates. Instead, New York's crime rate had been steadily decreasing since 1991, before the stricter policies were implemented (Beres & Griffith, 1998). Additionally, New York's crime law was much more lenient than the law enacted in California. Unlike New York's law, which specified harsher punishments for violent offenders, California's law included strict penalties for nonviolent offenses (Beres & Griffith, 1998). Hence, it can be argued that New York's reduction in crime rates can be attributed to other factors that were changing in the law enforcement environment including reforms in policing practice (Beres & Griffith, 1998).

A study conducted in 1997 compared the crime rates in states that did not have the Three Strikes law to the crime rates in California. The study

determined there was no difference in the declining crime rates between states that adopted a version of Three Strikes and those without a similar policy (Males & Macallair, 1999). These comparisons to other states indicate that there may have been other practices or policies that influenced the crime rate in California.

In addition to increasing incarceration, the Three Strikes law intended to deter repeat offenders. Because this law's emphasis on strict guidelines was highly publicized on both the state and national level, the law could have had a deterrent effect on crime. It can be argued that the deterrence aspect of the law may have been more impactful (Beres & Griffith, 1998). This argument is further supported by the analysis of crime rates in California. The crime rates examined by the state included those for the year the law was enacted and the next three years. Because of the time span of the data, it can be concluded that the decrease in crime rates cannot be fully explained by the incarceration rates (Beres & Griffith, 1998). Several inmates may have been sentenced before the Three Strikes legislation was completely enacted in California and these numbers could have been overrepresented in the data (Beres & Griffith, 1998). This supports the argument that the bill's deterrence aspect may have played a larger role than its emphasis on longer imprisonment.

Impact of the Three Strikes Bill on Individuals and Institutions

The Three Strikes law strived to target repeat offenders; however, there were several weaknesses in its implementation, which failed to consider the age and crime of the offenders who were being affected. Critics argue that the

law targeted older nonviolent offenders because they are perceived to have a higher probability of having previous offenses (Beres & Griffith, 1998). This is problematic considering existing data that suggest that offenders may not be committing as much crime at an older age (Males & Macallair, 1999). As stated by Sampson and Laub (2005), only a "small group of offenders continue to commit crimes at a persistently high rate as they grow older" (p. 13). In other words, a regression of serious criminal behavior can be seen in individuals near the age of 28, which is followed by a continual decline of criminal behavior at an older age (Males & Macallair, 1999). Therefore, this law would be more effective in its practice if younger offenders convicted of violent crimes were incarcerated at an early age as a preventative measure to ensure that they do not commit crimes in the future (Beres & Griffith, 1998).

As indicated by the court cases that ensued after the implementation of this policy, the guidelines seemed to target individuals who convicted serious but nonviolent felonies. It was found that 37.3 percent of the offenders sentenced under Three Strikes in California were convicted of property offenses and 30.4 percent were convicted of drug offenses (Males & Macallair, 1999). Only 21.6 percent of the convictions were for violent crimes including murder, kidnapping, robbery, rape, manslaughter, robbery, felony assault, and child sexual assault. These statistics indicate that the larger percentage of convictions were for nonviolent offenses rather than the more serious offenses that this law originally intended to address.

Offenders who committed a violent felony for the third time would probably be given a longer sentence even

without the Three Strikes law (Beres & Griffith, 1998). This suggests that the offenders most affected by this bill were individuals who committed nonviolent felonies as they were given a harsher sentence under the provisions of the law.

The Three Strikes policy implemented in California did not identify specific offenses that could be considered a third strike. Instead, any serious felony could qualify as a strike. This inadvertently targeted offenders who committed low-risk felony crimes instead of the violent repeat offenders the policy intended to punish. According to the California Department of Corrections data from 1996, the number of offenders sentenced under Three Strikes for marijuana possession was more than the combined number of offenders convicted of rape, kidnapping, or murder (as cited in Dickey & Hollenhorst, 1999). This trend continued into 1998, when it was further noted in data obtained from the California Department of Corrections that second or third strike cases involving individuals convicted of property crimes and drug crimes outnumbered those involving crimes against persons (as cited in Dickey & Hollenhorst, 1999). These data indicated that California's implementation of Three Strikes legislation was inadvertently targeting less serious or nonviolent crimes.

The disproportionate sentencing based on offense type could also be reflective of the racial disparity in sentencing resulting from the implementation of the legislation. According to the California Department of Corrections report in 1997, although African Americans accounted for 7 percent of the state's population, they constituted 43 percent of individuals sentenced under the Three Strikes legislation (as cited in Dickey &

Hollenhorst, 1999). Similar findings could be seen in the 1998 report published by California's Department of Corrections: 36.8 percent of second strike convictions and 44 percent of third strike convictions involved African American offenders (as cited in Dickey & Hollenhorst, 1999).

The longer terms and limited chances of early release extended the time of incarceration for offenders convicted under Three Strikes. This not only increased prison populations, but also contributed to the increasing rate of older adults confined in prisons. According to data provided by the Bureau of Justice Statistics, the recorded number of prisoners 55 years and older was 9,500 in 1980 (as cited in Dickey & Hollenhorst, 1999). However, the number of the elderly prisoners rose to 30,000 in 1998, a significant rise in this population (Dickey & Hollenhorst, 1999). The rise in incarcerated older adults leads to an increase in prison costs because the cost per older prisoners is nearly twice that for younger prisoners due to health care and other services.

Prison crowding is also a long-term expected outcome associated with the Three Strikes policy. Upon the implementation of California's Three Strikes legislation, the California Legislative Analyst's Office estimated that "the prison system will exhaust all available space by late 2000 and there will be a shortage of more than 70,000 beds by 2006" (Dickey & Hollenhorst, 1999, p. 15). Although California's strict Three Strikes policy aimed to deter future crime, it also increased the sentencing lengths for individuals convicted of any serious crime, which was inclusive of nearly all federal crime. This broad implementation and practice of the law, coupled with the relatively slow

sentencing process in the criminal justice system, increased overcrowding in both the county jails and state prisons (Dickey & Hollenhorst, 1999). Furthermore, the rise in convictions based on Three Strike sentencing was expected to increase both the number of individuals incarcerated per year and the time convicted individuals spent in prison. This hindered the prison turnover rate because the number of sentenced individuals was disproportionate to the number of individuals released from prison (Dickey & Hollenhorst, 1999). The costs associated with confining older adults and building new facilities to accommodate prison overcrowding are major drawbacks of the implementation of Three Strikes.

Costs of Implementing Three Strikes

Three Strikes also led to an increase in prison system costs due to decreased use of plea bargaining and hence an increased need to process cases through the justice system. Plea bargaining is a “common practice . . . that is justified to preserve time and resources” (Dickey & Hollenhorst, 1999, p.16). However, the strict guidelines of Three Strikes sentencing led offenders to take their cases to trial rather than participate in plea bargaining. According to the California State Judicial Council, in the first year after the implementation of Three Strikes there was a 13-percent increase in trials; in the second year there was another 4-percent increase in trials (as cited in Dickey & Hollenhorst, 1999). The decrease in plea bargaining and rise in processed cases led to an increase in costs associated with court proceedings, including the costs associated with holding hearings, compensating lawyers

and personnel involved in trials, and holding defendants awaiting trials.

Beneficiaries of the Three Strikes Policy

The Three Strikes policy played a strong role in increasing prosecutors’ discretion with regard to sentencing (Chen, 2014). Hence, it can be argued that prosecutors and district attorneys stood to benefit from the Three Strikes policy. Additionally, the overcrowding in prisons resulted in more prison facilities, creating more job opportunities for individuals interested in working in the prisons system (Dickey & Hollenhorst, 1999). There was a 47-percent rise per \$1,000 of personal income for prisons from 1984 to 1992, which may indicate that prison workers benefited greatly from the implementation of the Three Strikes policy. Furthermore, the reduction in plea bargaining and increase in court proceedings led to a backlog in criminal court that motivated offenders to utilize private courts if applicable. Compared to criminal courts, private courts were less costly and less time consuming (Dickey & Hollenhorst, 1999). Hence, it can be inferred that private courts benefitted from the implementation of Three Strikes.



"Supreme Court" by Matt Wade (flickr)

Conclusion

The adoption of the Three Strikes Law and its development in different states, specifically in California, is an important example of the evolving policymaking and policy modification process. It was not until public recognition of certain acts of violence that the country decided to advocate for a specific policy addressing repeat offenders. The Three Strikes law was popularized through the Violent Crime Control and Law Enforcement Act of 1994. It was intended to act not only as a deterrent but also as a preventative measure limiting criminal behavior. This was not a new concept; in fact, the notion of restrictions and harsher penalties for habitual offenders has existed for many years in many states, including New York and Illinois. Nonetheless, Three Strikes was adopted by several states as a way to address rising crime rates on a state level.

The implementation of this policy on a state level did not reflect the policy's original intentions. As a result, the law was tweaked and enhanced to ensure that the policy's application addressed serious or violent acts of criminal behavior. This policy-making process was demonstrated by California's adoption, implementation, and amendment of the Three Strikes Law. California adopted this policy in 1994 and after several years began to see the effects of this policy. After landmark cases such as *Lockyer v. Andrade* (2003) and *Ewing v. California* (2003), the state slowly began to realize its drawbacks, specifically, that it was inadvertently targeting individuals who were not the violent criminals this policy originally intended to apprehend and deter. As a result of the arguments in these cases, as well as many other examples of the prejudicial effects of this

legislation, Proposition 36 was passed in California. This initiative was the first of many to be passed, and it aimed to improve upon the weak points of the Three Strikes legislation.

The development and use of the Three Strikes policy in California and its consequent modifications present a clear example of the policy-making process in the United States. Policies are created to address certain social problems, but it is impossible to determine whether these policies will accomplish their intended goals until years after their implementation.

Social Worker's Role in Policy

The creations of policies such as the Three Strikes law can alter the existing social justice structure, affecting the lives of many people, including groups and individuals whom the policy does not intend to target directly. Subsequently, through various empirical studies and active advocacy, a policy can be changed. This process addresses the policy's weaknesses and evolves its guidelines so that it accurately reflects present thinking. This form of advocacy plays a strong role within the field of social work. As stated in the NASW Code of Ethics (2017), "Social workers pursue social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people."

The Three Strikes legislation intended to target violent crime, yet it inadvertently affected the populations served by social workers, specifically those individuals with lower income or minority backgrounds. It is imperative not only to serve vulnerable populations through direct practice but also to understand how general policies can disproportionately affect the populations

social workers serve. Professionals and advocates of social justice can effectively combat and reform imbalanced policies by gaining a thorough understanding of the various factors that play a role in their development. As stated by Jenkins and Patashnik, law making is “a complex process of governance in which the

policy content and societal impact of legislation unfold over time” (as cited in Karch & Cravens, 2014, p. 462).

Mirrat Moloo recently obtained her graduate degree in Clinical Social Work from Loyola University Chicago with a sub-specialization in Forensic Mental Health. Mirrat’s interest in the justice system started during her time as an undergraduate student at Florida State University. Mirrat was involved in several studies as an undergraduate, ranging in topics such as Intergroup Relationships and Biosocial Criminology. As a graduate student, Mirrat completed a field placement at the Federal Defender Program. At this placement, Mirrat worked with individuals involved with the justice system as well as their loved ones to create mitigation reports. This afforded her the opportunity to collaborate with attorneys and mitigation specialists. Currently, Mirrat continues to provide mitigation services as an assistant at HKS Mitigation Services. She would like to continue advocating for individuals involved in the justice system as a social worker.

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Impacts of Neoliberalism on the Clubhouse Model

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Abstract

Community-based services provided to those with serious and persistent mental illness often struggle for funding. The move from institutionalized care to community-based care resulted in large funding gaps that were never filled and continue to impact services provided to this population. These gaps are currently and have been historically influenced by neoliberalism, a political agenda designed to privatize the government and focus on cost effectiveness. Although evidence-based practice is important, it can easily fall in line with neoliberal agendas, causing funders to support only programs that are explicitly evidence based. Further, under neoliberalism, evidence must focus on cost effectiveness instead of quality of life. This article will provide the overall framework of the Clubhouse Model, culminating in an examination of the constraints neoliberalism imposes among the effectiveness of these types of programs.

Keywords: Clubhouse Model, community mental health, evidence-based practice, neoliberalism, serious mental illness

Neoliberalism: Definitions and Implications on Practice

Neoliberalism is a political agenda that pushes for a liberal market (Hyslop, 2018). Neoliberalism allows for an open market where all aspects of

government are privatized, shifting effectiveness and outcomes based on monetary gain or savings. It views paid work as synonymous with self-worth, which is central to American society. Neoliberalism is connected to globalization due to the notion of the free market adopted throughout Europe as well as the United States (Hyslop, 2018). This viewpoint assumes that funding for human services can advance through philanthropic efforts targeted to meet the needs and interests of funders. Program funding then becomes dependent on the preferences of philanthropists rather than distributions through taxes according to state law. This political structure is designed to promote flexible capitalism and diminish government sponsorship in community programs aiding marginalized populations (Hyslop, 2018).

Social work is bound by this neoliberal system because of the way social services are provided in the United States. In the United States, social services rely on government grants, philanthropic fund-raising efforts, and reimbursement from health insurance. Social workers must adapt to this system in order to continue to provide services. Each of these social service funding streams has its own agenda and specific expectations of results. Social workers are required to shape practice and research efforts to accommodate the system.

One notable way that social work adheres to the neoliberal system is through evidence-based research and

practice. The term *evidence based* refers to practices that are scientifically proven to have quality outcomes. Ideally, evidence-based treatment helps mental health providers serve their clients or patients with the most effective services. However, neoliberalism determines the types of outcomes that organizations evaluate. Evidence-based evaluations focus on the effectiveness of only certain aspects of programs, largely aiming to mold persons with disabilities into contributing members of the economy. Frequently, community mental health programs are often evaluated in terms of employment or vocational outcomes, lowering incidents of incarceration, service dependence, and hospitalization (McKay, Nugent, Johnsen, Eaton, & Lidz, 2018). The cost of incarceration, hospitalization, and service dependence is extremely high; therefore, it is in the interest of neoliberalism to reduce the need for these services unless there are other economic benefits, such as privatization of prisons and hospitals. Of course, it is optimal to have lower rates or incidents of incarceration and hospital usage but other outcomes such as quality of life should be examined.

A Brief History of Deinstitutionalization

Deinstitutionalization allowed neoliberalism to emerge into the field of mental health. Deinstitutionalization was seen as a step forward in human rights that incorporated the least restrictive environment into the mental health policy narrative. At first, due to the long-time failings of psychiatric institutions, the neoliberalist model of mental health reformation appealed to mental health advocates, families, and consumers. The injustices, poor living conditions, abuse,

and neglect that had been going on for decades are only now emerging in public discussion. Using the term *consumer* to replace *patient* appealed to advocates and individuals because it alluded to a sense of empowerment and self-interest in the person receiving services (Raeburn et. al., 2014). The term *consumer* was also utilized under neoliberalism though with the intent to envision health care as a transaction (Gooding, 2016). This facade led persons seeking services as consumers to believe they would have power over the type of services they received and even their ability to access services.



"Bon appetit" -Pictures of Money (flickr)

In the United States, mental health reform under the Reagan Administration disguised care for persons struggling with mental illness with neoliberal motives, designing a reformation system that would lower taxes and move the responsibility of care for citizens out of the government's jurisdiction (Gooding, 2016). The subsequent initiatives in mental health reform did not allow for proper transitions and alternative systems. Many alternatives for psychiatric institutionalization have been adopted in community mental health, born out of the push for psychiatric patients to become clients (Jackson, Purnell, Anderson, & Sheafor, 1996).

The continued effects of the neoliberal deinstitutionalization of mental health services can be seen in a phenomenon called transinstitutionalization (Gooding, 2016). A current example of transinstitutionalization is the role of nursing homes and prisons that house many persons with serious mental illness. To further neoliberal measures, the vast majority of nursing homes and prisons are for-profit institutions in which revenue is generated by the numbers served, thereby removing mental health services from the purview of the American government's checks and balances and transitioning to a capitalist agenda that is guided by the invisible hand of the free market.

The Clubhouse Model

Recovery Model Oriented

The Clubhouse Model allies itself within the recovery model in that it believes that people who are in recovery from serious mental illness (SMI), such as depression, bipolar disorder, and schizophrenia-spectrum disorders, have the capacity to live healthy and meaningful lives. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), *recovery* is defined as “a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential” (as cited in Lynsen, 2014). The U.S. surgeon general and the Institute of Medicine are advocates of the recovery model (Raeburn et. al., 2014). Unlike clinical recovery, which is based on the medical model focusing on remission of symptoms and improvement of social functioning, personal recovery

is a subjective process. Recovery-oriented organizational practice generally involves fostering hope, acceptance, supportive relationships, and empowerment through self-determination.

The use of the word *member* instead of patient or client is also based on the recovery model, in which clients are seen as individuals who have a say in their treatment (Raeburn, et al., 2014). This reduces practitioner's own stigma among members as its use eliminates the “us versus them” mentality. In the recovery model, members are treated as actively engaged participants rather than consumers of services.

Social roles in recovery are crucial because isolation is one of the most common triggers of symptom relapse. Infrequent social connection and social isolation are associated with higher rates of mortality and psychological disturbances (Pernice-Duca & Onaga, 2009). Those who experience SMI are at particular risk of social isolation due largely to stigma. Therefore, treatments focused on reducing isolation among persons with SMI and incorporating opportunities for socialization are particularly important.

According to the interpersonal theory of suicide, thwarted belongingness and perceived burdensomeness are identified as the two largest psychological factors among those who attempt and complete suicide (Ma, Batterham, Calear, & Han, 2016). Fostering a sense of belongingness has many implications and is underrepresented as an outcome variable among those living with SMI. Reinforcing meaningful social roles fosters a sense of belonging and attachment to the community (Pernice-Duca & Onaga, 2009). Social integration

and connectedness can be empowering, particularly for those with SMI, who are frequently stigmatized. Inclusion in society for people with SMI helps fight against deadly isolation and further marginalization (Herman, Onaga, Pernice-Duca, Oh, & Ferguson, 2005). An important aspect of the recovery model is participation in meaningful social relationships. Social roles are largely under-researched within this context, even though they are one of the central aspects of the recovery model. Further, many studies show the importance of social networks in increasing emotional well-being and self-advocacy among those with SMI (Herman et. al., 2005).

What is the Clubhouse Model?

The Clubhouse Model is defined as a nonclinical, strengths-based, voluntary community-based program (McKay et al., 2018) that is co-managed by members and staff who provide a variety of services for adults with serious and persistent mental illness (Kinn, Tanaka, Bellamy, & Davidson, 2018). Serious mental illness is most frequently defined as a diagnosis of schizophrenia or bipolar disorder but can apply to long-term mental health treatment and/or psychiatric hospitalization (Floyd & Lorenzo-Schibley, 2010). Clubhouse services can be categorized as vocational, educational, and social. Clubhouses operate during the workday, from 9:00 am until 5:00 pm. The Clubhouse Model aims to promote employment, reduce hospitalizations, and improve quality of life (McKay et al., 2018). McKay and colleagues state that “fundamental elements of the Clubhouse Model include the right to membership and meaningful relationships; the need to be needed;

choice in type of work activities; choice in staff selection; and a lifetime right of reentry and access to all Clubhouse services” (2018, p. 29).

The Clubhouse Model offers three types of employment services: transitional, supported, and independent. Employment services meet the federal definition of competitive employment and provide at least minimum wage earnings (McKay et al., 2018). Vocational assistance generally begins with clubhouse’s relationships with local employers. The clubhouse helps link members to employers and continues to provide assistance throughout the process. Assistance from clubhouse staff is reduced at each level of service—transitions, supportive services, and then independent services.

The Clubhouse Model was developed in the 1940s in New York City. It began with a small group of people who had experienced SMI and several psychiatric hospital stays. This group started meeting at the library and eventually went on to start the first clubhouse called Fountainhouse (Kinn et. al., 2018). Now, there are over 320 clubhouses in 34 countries around the world (Clubhouse International, n.d.). The official organization for the Clubhouse Model is Clubhouse International. This organization aims to uphold standards through accreditation of all clubhouses (McKay et al., 2018). Although there are many clubhouses that operate outside of Clubhouse International, most strive to be accredited. Clubhouse International also provides evidence-based evaluation and keeps track of statistics and outcomes of accredited clubhouses. In 2018, Clubhouse International reported a 42-percent employment rate, reduced incarcerations, and fewer hospital stays.

In terms of finance, Clubhouse International reported that one year of services through a Clubhouse costs the same as two weeks in a psychiatric hospital (Our Impact, n.d.).

The Clubhouse Model and Neoliberalism

Much research on the Clubhouse Model reported higher quality of life, lower rates of hospitalization, and better overall vocational outcomes (Kinn, Tanaka, Bellamy, & Davidson, 2018; McKay et al., 2018; Battin, Bouvet, & Hatala, 2016). Further, several studies found that those diagnosed with schizophrenia and actively involved in a clubhouse had a decrease in negative symptoms pertaining to isolation and anhedonia (Battin, Bouvet, & Hatala, 2016). However, there are studies suggesting that more research is needed in order to validate the Clubhouse Model as evidence based (Battin, Bouvet, & Hatala, 2016). Kinn (2018) identified two main critiques of the Clubhouse Model. One critique suggested that the Clubhouse Model has the potential to create a dependence on services. The second critique noted the lack of overall community integration outside of the clubhouse, suggesting that the clubhouse members participate only within their own community rather than in society at large.

Another critique of the Clubhouse Model noted the failure to provide onsite psychiatric services. This is likely true of many clubhouses; however, some are extensions of mental health agencies. One mental health agency in Seattle, WA, has a clubhouse on its campus that offers case management, psychiatry appointments, psychological testing, and even an onsite pharmacy. This clubhouse

is available to clients who receive services at the mental health agency. Further collaboration in this interdisciplinary manner is noted as lacking and implementation is recommended (Raeburn et al., 2013).

Several studies conducted on the Clubhouse Model include or focus entirely on the cost-benefit analysis (Plotnick & Salzer, 2008; McKay, Yates, & Johnsen, 2007; Akiba & Estroff, 2016). This is an example of how evaluation research operates under the influences of neoliberalism in the funding of mental health programs. Funding for the Clubhouse Model in the United States comes largely from the state, second to Medicaid. Only 1.7 percent of clubhouses in the United States are funded by national grants (McKay, Yates, & Johnsen, 2007). Outside of the United States, state or provincial mental health funds are also the largest financial contributor to clubhouse funding, followed by local or municipal sources (McKay, Yates, & Johnsen, 2007).

Overall, the cost to run clubhouses is substantially lower than that of partial hospitalization programs. A recent analysis reported that the average cost per member per year is \$4,776 at accredited clubhouses. The average number of active members per clubhouse is 162; therefore, it costs approximately \$773,712 to serve 162 people. The average member to staff ratio is 19.5 to 1. Similarly, a meta-analysis of research on the effectiveness of the Clubhouse Model found that rehospitalization of clubhouse members was very low at 6-month, 9-month, 1-year, 2-year, and 5-year intervals. Further, several studies showed that clubhouse members spent less time on average in the hospital than those not affiliated with a clubhouse (McKay et al., 2018).

One example of the Clubhouse Model's struggle to survive under neoliberalism occurred with the implementation of health care reform in North Carolina. In North Carolina in 2001, local management entities (LMEs) were implemented to ensure that agencies that provide mental health, substance use, or developmental disability services are held accountable. However, this initiative created a larger barrier to accessing resources as well as contributed to the growing gap between agency services. Technocratic compliance, such as using time that could have been spent on providing services to input data for billing, has become embedded in many organizations (Hyslop, 2018). Clubhouses struggle with reimbursement for services including low priced meals, social activities, political advocacy, volunteer work, member transportation, case management, and mobile outreach (McKay, Yates, & Johnsen, 2007).

In order to continue receiving state-sponsored funding, which accounts for the majority of its income, one clubhouse in North Carolina had to hire a full-time staff member simply to be the liaison with the LMEs. Navigating LMEs and billing Medicaid for services have become major hurdles in continuing to secure funding for this model.

At that same clubhouse in North Carolina, Medicaid claims were denied at higher rates after introduction of the LMEs. Medicaid reimbursement represented 54 percent of the clubhouse's income, and 20 percent of its budget had to be set aside for services for which it was not reimbursed. In addition, the hourly rate for clubhouse services, if they were accepted for reimbursement, decreased from \$12.13 per hour to \$10.76 per hour, representing an average 10-percent decrease in Medicaid-generated

income. Reducing the Medicaid reimbursement from 54 percent to 44 percent of its income forced this particular clubhouse to recover the missing 10 percent from other funding venues. Thus, the focus became simply staying in business, and service delivery was neglected (Akiba & Estroff, 2016).

Even in countries like Australia that provide universal health care to all citizens and permanent residents, funding for community mental health services is a struggle. One study from Australia describes how funding reimbursements from the government take approximately two months and do not utilize computer technology (Raeburn et al., 2015). Countries that provide universal health care are still constrained by austerity measures, such as the need to incorporate several funding sources outside of government medical reimbursement rates. This forces agencies to develop philanthropic opportunities, private donations, and other fund-raising efforts in order to continue providing services.

One of the most important and ethical outcomes for those experiencing serious and persistent mental illness is quality of life. Frequently, social work research or grant research is focused on outcomes pertaining to decrease in symptoms, hospitalization, service dependency, and ultimately cost. On a consumer level, the only important factor is quality of life. Several studies have focused on quality of life and found that clubhouse members reported greater quality of life, specifically with regard to social and financial aspects (Battin et al., 2016; Kinn et al., 2018; McKay et al., 2018).

Most evaluations of the Clubhouse Model have focused on employment and the effectiveness of this model in getting members back into the

workforce. This is a very neoliberal idea of recovery. It also feeds in to a specific ideation of what success really looks like. Social workers' goals are to improve an individual's quality of life and self-agency. However, social workers' goals are also to help the person to fit into society's expectations of a citizen based on his or her ability to contribute to the economy; hence there is a focus on a program's effectiveness and ability to improve vocational outcomes.

Discussion

In a society that is still suffering from the aftermath of the neoliberal deinstitutionalization and lack of replacement services for psychiatric hospitals, social workers are affected in their attempt to provide community-

based long-term care. The Clubhouse Model is one example of an evidence-based program that continues to lack adequate funding because of neoliberalism. Community mental health agencies are increasingly being forced to compete for funding due to a decrease in overall government aid. Social workers are in a difficult position in which their central role is acting as an advocate and liaison for the marginalized within the climate of neoliberalism. The field of social work is identified as a leader in social justice. As a profession, we need to challenge these systemic models that operate under neoliberalism and advocate for systemic change that starts with the awareness and understanding of how these systems operate.

Margaret Ann Pauw graduated with her master's in social work in 2015 from Loyola University Chicago. She returned to Loyola one year ago as a PhD student at the School of Social Work. Her research interests are community outreach, persons with serious and persistent mental illness, and library social work. She is also a peer reviewer for Loyola's social work journal, Praxis, and enjoys reading about what types of research Loyola students are engaged in.

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