

# PRAXIS

Where Reflection & Practice Meet

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# PRAXIS

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The School of Social Work at Loyola University Chicago created Praxis: Where Reflection & Practice Meet to give voice to 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 and the priority deadline for the annual Fall publication is the last day of January editorial board and edits accepted papers with permission from the authors. Papers should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc). 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

### Advocating for Social Justice in the Social Work Profession

Social work practice occurs in a variety of domains. Social workers practice on micro levels as individual practitioners, as program administrators on mezzo levels and in the policy arena on macro levels. However, all areas share a common goal of advocating for individuals and issues that serve to improve the wellbeing of the underserved. This is social justice. I have found that some social workers do not identify themselves as advocates, as they do not engage in traditional advocacy activities in community organizing. However, I remind these social workers that every time they write a paper, submit a manuscript for publication, make a phone call on behalf of a client or even partner with a client in the development of a treatment plan, they are advocating for social justice.

My experience in the social work profession has provided me with an unique experience of being able to practice on multiple levels (micro, mezzo, macro) as well as instruct budding social workers in a bachelors program. I am encouraged by the energy and commitment that younger social workers have regarding advocacy and social justice issues. However, I have also witnessed this energy become subdued in the practice world, energy that somehow transforms into complacency. Social workers must not forget our roots and must not forget the pillar of our profession—advocating for social justice. Because even seemingly small tasks—such as writing notes and treatment plans are activities that can either promote or dilute social justice. Every time we shine a light on an injustice, whether it be through a publication or even by voicing concerns to our supervisor we are advocating for social justice.

Social justice is certainly a wide topic. Social justice, in its simplest terms, can be understood as advocating for the rights or wellbeing of others. This may include a social worker helping their client get food stamps or assisting another client with accessing affordable housing. Social justice helps define and frame

social work practice. Social workers must seek out social justice for our clients and are already equipped with the specialized person-in-environment framework to advocate for such.

Throughout my experience as a direct practice social worker I have found that every client I served had a common theme that included a lack of access to resources. These resources may be tangible such as income or housing but also intangible, such as emotional support or validation. Regardless, the services I provided always included some component of advocating for social justice. As my experience transitioned to mezzo level practice and at times, macro practice, the theme of advocacy and social justice remained. In essence, my experience has taught me that social work practice is inextricably intertwined with social justice. We cannot discuss social work practice without acknowledging social justice and advocacy. In fact, this is a defining characteristic of the social work profession and I encourage all social workers to embrace this and make their voices and the voices of their clients be heard.

In the Fall 2013 edition of Praxis I am impressed as to the diversity of topics and their common themes of social justice. Some authors chose to address social justice on micro levels that included discussions regarding individual practice, while others broadened their view and addressed macro level issues such as health care policy. Regardless, all of the articles contained in this issue embody the theme of advocating for social justice, whether it be advocating for particular diagnostic definitions, using more effective practice methods with particular populations or by recognizing our own racial attitudes. The articles in this edition embody the concept that advocating for social justice occurs on all levels in the social work profession.

Elizabeth Morgan, LCSW  
 Doctoral Candidate  
 Editor-in-Chief

## THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

### Changing the Face of American Health Care: The Patient Protection and Affordable Care Act

Christine Demos

#### Abstract

*The paper begins with a brief history of national health care policy in the United States, starting at the beginning of the twentieth century. This is followed by a presentation of recent data on the state of American health care that illustrates the need for health care reform policy. The text then provides an overview of the law, focusing on the main elements: Medicaid expansion, state health insurance exchanges, consumer rights and industry regulation, and spending containment measures. The next section narrates the political and legislative process that produced the Patient Protection and Affordable Care Act (PPACA), including a timeline. The final section describes the importance of social workers as advocates and service providers for the PPACA, including National Association of Social Workers' policy statements and the possible impact of the law on the social work field. Next, the various legal challenges to the law are reviewed, including repeal efforts by Congressional Republicans and ongoing court cases regarding contraception benefits. Finally, the text provides data on the impact of the law as of 2013, and speculates on future health care policy.*

**Keywords:** Patient Protection and Affordable Care Act, health care policy

#### Introduction

Since the passage of the Social Security Act in 1935, lawmakers have attempted to pass legislation to ensure universal access to health care in the United States. The Patient Protection

and Affordable Care Act (PPACA), voted into law in 2010, is a first step towards this goal. This paper will provide historical context for health care policy and the need for systemic reform, illustrate the legislative and political process behind the law, provide information on the main elements of the law, clarify the role of social workers in advocating for reform and implementing new services, and provide data on the law's impact as it is implemented.

#### Historical Background

Forging effective health care policy has been a priority for administrations and a national concern among American citizens for almost a century. The Kaiser Family Foundation (2009) stated that there are “many reasons why national health insurance proposals have failed, including complexity of issues, ideological differences, the lobbying strength of special interest groups, a weakened presidency, and the decentralization of Congressional power” (p. 1). These elements can be seen in the decades' long attempts to legislate health care policy at the national level.

#### *A New Century and the New Deal Era*

The first proposals for health care policy were seen in the early 1900s when President Theodore Roosevelt and the Progressive Party campaigned for national health insurance in 1912. More than two decades later, Franklin D. Roosevelt's administration put forward widely encompassing proposals at a time when people were rallying together and calling for government relief from Depression-era hardships (Kaiser Family Foundation, 2009). These people included workers, unemployed

Americans, veterans, ethnic groups, and the elderly. The Social Security Act was put in front of Congress in 1935 with the goal of ensuring retirement benefits and unemployment insurance for millions of Americans. Within the original bill, each state could choose whether to participate in state-run, mandatory insurance systems with the help of federal subsidies.

The American Medical Association, businesses and labor groups, and private health insurance companies all opposed the bill, and despite the clear need, President Roosevelt excluded the health insurance portion in the Social Security bill in order to gain the votes needed for its passage (Kaiser Family Foundation, 2009; Palmer, 1999). Although national health insurance was not included, the Social Security Act did provide funding to states to expand public health programs and provide maternal and child health services.

### ***The 1940s***

After World War II, President Truman proposed a single insurance system to provide health care to all Americans as part of his 'Fair Deal' agenda. The government would also provide public subsidies to low income Americans. Cold war perspectives caused many to label the single, comprehensive health insurance plan as part of a socialist movement and well-funded opposition came from the American Medical Association, the American Hospital Association, and the American Bar Association (Palmer, 1999), as well as the growing number of businesses providing their employees with health care benefits and pensions (Kaiser Family Foundation, 2009). Subsequently, Truman lost political support for this legislation and his initiative failed. Truman did manage to pass the 1946 Hill-Burton Act that funded hospital construction and expansion. In return for these funds, the facilities were obligated to provide care to community residents, including free or reduced fee services for those without means to pay.

### ***The 1960s and 70s***

Major health care reform efforts took place during the 1960s, starting with the 1960 Kerr-Mills Act that established a system of federal grants to states to cover health care for the elderly poor. This law failed when only half of the states participated and many were not budgeted sufficiently (Kaiser Family

Foundation, 2011). Soon after, Medicare was proposed, along with two other programs to expand the Kerr-Mills Act and to make federal subsidies available to purchase private coverage. These elements were merged into one bill with three elements: Medicare Part A, optional Medicare Part B, and Medicaid.

Medicare Part A paid for hospital care, limited skilled nursing, and home health care for individuals 65 and older or with certain disabilities. The optional Medicare part B helped pay for physician care and outpatient medical costs. Medicaid was a separate program that assisted states in providing health insurance coverage for certain classes of low-income and disabled individuals. However, the bill did not provide private coverage for services like prescription drugs, long-term care, and eyeglasses. Lyndon B. Johnson signed Medicare and Medicaid into law as part of his 'Great Society' legislation, and these two programs were incorporated into the Social Security Act.

In 1974, President Nixon pushed for the Comprehensive Health Insurance Plan (CHIP), which called for universal health care coverage, voluntary employer participation, and a separate program for the working poor and unemployed to replace Medicaid. However, the bill was derailed by Nixon's illegal activities and eventual departure from the White House (Kaiser Family Foundation, 2011). Nixon was able to impose cost controls on health care as part of his sweeping government cost control effort, but this was later lifted in 1975 when the health care industry promised to keep costs down voluntarily.

In the late 1970's, President Carter proposed legislation to control health care costs when hospital costs rose steeply in the absence of previous cost regulation. This bill stalled when the hospital industry lobbied against it, once again pledging to keep costs down without government ordinance. Eventually Carter's successor, Ronald Reagan, passed cost containment legislation with the 1983 Medicare Prospective Payment System that created a predetermined pricing system based on patients' diagnosis (Davis & Stremikis, 2009). The new law effectively decreased Medicare hospital costs while encouraging hospitals to provide more efficient treatment (Millenson, 2010).

### ***The 1990s and 2000s***

During the 1990's, President Clinton promised to bring universal health care coverage

to the country. His plan would instill employer and individual mandates, stimulate competition between private insurers offering coverage through regional alliances, and regulate policies to ensure lower costs (Kaiser Family Foundation, 2009). Once again, the bill faced well-funded, media savvy opposition by lobbying groups from the health care and health insurance industries as well as Republicans in Congress, and did not pass (Cutler & Gruber, 2001). Instead, the Children's Health Insurance Program was enacted to provide insurance for low-income children.

George W. Bush succeeded in passing the Medicare Modernization Act in 2003, which created the Medicare Part D program allowing Medicare enrollees to buy private prescription drug coverage. Unlike the Veterans Administration and other government programs, the law mandated that Medicare Part D would not be able to negotiate lower drug prices for consumers. As the economy went into recession and the 2008 elections loomed, new calls for health care reform appeared amidst the Democratic presidential primary candidates competing for their party's nomination.

### **The Need for Health Care Policy**

The lack of access to health care had been a significant and increasing problem in the US for many years, but was exacerbated by the growing recession. Because American health insurance is linked to employment, both increasing layoffs and the decreasing number of employers offering health insurance benefits brought the already existing problem to a head. Millions of Americans found themselves without employer-subsidized health insurance, yet unable to qualify for Medicaid benefits. Many more had health insurance, but found themselves to be underinsured with such limited coverage that the out-of-pocket costs caused financial ruin. This section will provide information on the need for far-reaching health care policy to address the issues of systemic expense and efficacy, access and affordability, and the rights of health insurance consumers.

### **National Health Care Spending and Outcomes**

In a recent study, the World Health Organization evaluated the current health care

system in the United States, ranking it 37th in the world based on level of population health, inequalities, distribution of resources to the population, and health system responsiveness (Riedel, 2009). Garber and Skinner (2008) compared the percentages paid by the United States and other developed regions, demonstrating that the United States spent a higher percentage (15%) of their Gross Domestic Product on health care than Germany (11%), France (11%), Canada (10%), and Japan and the United Kingdom (each spending 8%). A Commonwealth Fund study (2012) found that a major cause for higher health care prices in the US was the lack of price negotiation or fee setting by the government; all other industrialized countries have regulatory power to keep health care and pharmaceutical prices lower (Squires, 2012, p. 1). The way health care is billed in the United States also creates high costs and encourages costly interventions. The fee-for-service system charges for each individual service so that payment is based on quantity of services rather than the quality of those services (Barnes, 2012). This fragmented system, with payments coming from many different private insurance companies, is costly and inefficient as a Commonwealth Fund study illustrates. The study found that American medical practices spent \$82,975 annually per physician interacting with private insurance payers, with nursing staff spending an average of 13 hours a week securing prior authorizations for treatment. In contrast, in Canada's single payer government insurance system, physicians spent \$22,205 on these administrative tasks (Morra, Nicholson, Levinson, Gans, Hammons & Casolino, 2011).

Hospitals that are required by law to provide medical care to individuals regardless of their coverage status accumulate debt load because of this uncompensated care. To cover this debt, the federal government gives states disproportionate share hospital funds meant for those hospitals that serve a high number of unfunded individuals. In addition, the costs of providing this unpaid hospital care are passed on as higher service rates for those who do have health insurance coverage, or pay out of pocket (Sinner, 2012).

The United States is spending much more on health care than other countries, yet its health care outcomes rank below most other industrialized nations (U.S. Census Bureau, 2009). This is most noticeable in the area of chronic illnesses; the United States had the

highest rate of hospital admissions for chronic conditions such as asthma and congestive heart failure, as well as the highest rate of lower-extremity amputations from diabetes complications (Squires, 2012). In fact, half of current health care spending goes towards individuals with three or more chronic conditions (Collins, 2011). The study identifies access to preventative care as well as effective care coordination as important factors in successful management of these illnesses, two areas of weakness in the US health care system.

### Access to Health Care

According to the 2012 Census Bureau, 49.9 million Americans are uninsured, and an additional 29 million Americans who have health insurance are underinsured, with policies that leave the holder responsible for substantial health care costs not covered by the insurer (Riedel, 2009). According to a study by the Institute of Medicine, those without health insurance have a 25% greater risk of dying and less access to preventative care (Commonwealth Fund, 2011). A public health study found that “lack of health insurance is associated with as many as 44,789 deaths per year, more than those caused by kidney disease” (Wilper, Woolhandler, Lasser, McCormick, Bor & Himmelstein, 2009, p. 2294). Individuals who do not have medical insurance, or those whose insurance policies include high deductibles and co-pays, must pay out-of-pocket for expensive doctors’ appointments and prescription medicines. A 2013 Commonwealth Fund survey found that “more than one-third (37%) of U.S. adults went without recommended care, did not see a doctor when they were sick, or failed to fill prescriptions because of costs, compared with as few as 4 percent to 6 percent in the United Kingdom and Sweden” (Schoen, Osborn, Squires & Doty, 2013, p. 1). The same survey reported that nearly one fourth of American respondents had serious problems paying medical bills, and almost 40% of both insured and uninsured Americans had paid more than \$1,000 in out-of-pocket medical care in addition to premium fees.

While many Americans cannot afford to go to the doctor for medical care, many others fall into debt and bankruptcy due to insufficient insurance policies or lack of insurance when a medical emergency strikes. The share of

bankruptcies attributable to medical problems rose by 50% between 2001 and 2007 (David, 2009). Most individuals declaring bankruptcy for medical debt were well educated and middle class, and three quarters had health insurance but were underinsured. Today, medical care expense is one of the most common reasons for Americans to fall into bankruptcy; 62.1% of all bankruptcies have a medical cause (David, 2009).

### Consumer Rights and the Insurance Industry

Insurance industry practices such as searching for mistakes on policyholders’ application in order to rescind their policies and avoid paying for expensive treatments, in addition to putting caps on annual expenditures, left some insurance consumers without insurance or without sufficient coverage for necessary treatments (New York Times, 2009). During the 1980s, the health insurance industry shifted from being majority non-profit to publicly held for-profit entities focused on providing value to shareholders (Austin & Hungerford, 2009). The average amount of policyholders’ premium dollar going towards medical care (known as the medical loss ratio) averaged less than 70%, as profits went towards marketing and administrative costs.

### A Look at the Patient Protection and Affordable Care Act

The main purpose of the PPACA is to make health care accessible to all Americans while reining in health care costs and enforcing new consumer protections. Former Speaker of the House, Nancy Pelosi, summarized these goals as affordability, accessibility and accountability (Pelosi, 2009). It contains provisions to reduce costs, combat fraud and abuse, and research innovative programs to improve the quality of health care under Medicare and Medicaid (Medicare Trustee’s Annual Report, 2010). This will be accomplished by gradual, comprehensive changes to the way health insurance is handled in the United States. These changes started on March 23, 2010, and will continue until January 1, 2015 (U.S. Department of Health and Human Services, 2011).

There are too many changes brought on by the PPACA to discuss individually, so only the most significant ones will be touched on here. Some of the major provisions include the creation of state insurance exchanges and premium subsidies, the largest expansion of Medicaid in its history, new rules to protect health insurance consumers, and innovations to reduce costs of health care delivery and strengthen Medicare (U.S. Department of Health and Human Services, 2011).

### ***Expanding Access to Health Care***

There are two elements in the law that will provide coverage for almost 32 million currently uninsured Americans (Congressional Budget Office, 2010): the premium subsidies for state health insurance exchanges and the Medicaid expansion. The state insurance exchanges, known as the Health Insurance Marketplace, will allow individuals without access to insurance through their workplace to purchase coverage, with premium and cost-sharing credits available to individuals and families with income between 133 - 400% of the federal poverty level. For example, a family of three with an income of \$73,240 will fall within the 400% range of eligibility for subsidy assistance. Maximum out-of-pocket expenditures for these policyholders will be limited to 2% of income for those at the low-income range to 9.5% at the top of the range (Gabe & Peterson, 2010).

Starting March 31, 2014, most individuals will be required to have health insurance or pay a fee to offset the cost of providing care for uninsured Americans (U.S. Department of Health and Human Services, 2011; Alonso-Zaldivar, 2013). This fee is either \$95 or 1% of the individual's income, whichever is greater, and will go up to \$695 or 2.5% of the individual's income starting in 2016. This fee will apply to every uninsured adult in the household, but will not exceed \$2,085 a year (Berry, 2010).

The 'Individual Mandate', as this requirement is called, is necessary to ensure that the insurance risk pool is diverse enough to be sustainable. Without such a mandate, those individuals least inclined to purchase health insurance coverage, such as the young or those without current medical problems, will not form part of a risk pool until they get sick and are in need of medical services. As health insurance

providers are required to insure those with pre-existing conditions under the PPACA, it is necessary to have a broad-based risk pool, with a mix of healthy and in-need individuals. Those exempt from paying a fee for not being insured include those whose income is so low they do not have to file taxes, if the cheapest insurance plan costs more than 8% of the individual's income, those who demonstrate financial hardship, American Indians, individuals in jail, and individuals who qualify for religious exemptions (Berry, 2010).

The Medicaid expansion will for the first time allow access to all non-Medicare eligible individuals under 65 with incomes up to 133% of the federal poverty level, including childless couples and individuals. Until now, the groups eligible for Medicaid have been low-income parents and children, the elderly and the disabled. States, whose participation in the Medicaid program will continue to be voluntary, will receive 100% federal financing for 2014 through 2016, with increasing financial responsibility culminating in states being responsible for 10% of expansion funding by 2020 (Kaiser Health Foundation, 2009).

### ***Ensuring Accountability***

Before the PPACA, insurance companies could deny coverage to anyone with pre-existing conditions (for example, a history of cancer). Now, children under 19 with pre-existing medical conditions cannot be denied coverage or given limited benefits because of the condition, and in 2014, no one can be denied coverage or given limited benefits because they have a pre-existing medical condition. During the interim, state and federally run programs called Pre-Existing Insurance Plans will provide benefits to people who have been denied insurance because of a pre-existing medical condition and have not been insured for at least six months (US Department of Health and Human Services, 2011)

Coverage for young adults has also changed. Before the PPACA, insurance companies could discontinue coverage of children on their parents' insurance plans as soon as they turned 19 years old. Now, children can stay on their parents' plans until they are 26 years old, even if they are married, not financially dependent on their parents, not living with their parents, attending school, or are eligible to enroll on their employer's plan (U.S.



Department of Health and Human Services, 2011). Insurance companies will no longer be able to set lifetime or annual limits to the amount of money policyholders can receive for health care. Limits are slowly being phased out, and by January 1, 2014, no limits will be allowed. However, insurance companies can still put a limit on how much they will pay for services that are not considered essential (U.S. Department of Health and Human Services, 2011). Terminating policies when someone needs medical care, called ‘rescission’, is no longer allowed unless that policyholder committed fraud when applying for coverage (Carey, 2012).

Health insurance companies will have to comply with new medical loss ratio percentages. The medical loss ratio is the amount of each premium dollar that goes to health care, rather than administrative costs or profit. In the last decade, many insurance companies spent as little as 65%, and in some extreme cases less than 50%, of each premium dollar paid on health care for policy holders (U.S. Department of Health and Humans Services, 2010). Starting in December 2011, the rate will be 80% (85% for the largest companies) that must be directed to actual health care for the members that pay the premiums (U.S. Department of Health and Human Services, 2011).

### ***Addressing Affordability and Efficiency***

Medicare and Medicaid will establish pilot programs to develop and evaluate using a bundled payment system for services, rather than the current fee-for-service system. If the pilot program achieves its stated goals of better health outcomes and lower costs, a plan for expanding the program will be implemented. A pilot program for home health care, which is much less expansive than institutional care, will be implemented and evaluated for possible expansion. In addition, a program to base hospital payments on quality measured performance will be established (Kaiser Health Foundation, 2009).

### ***How the PPACA Will Be Funded***

The total cost of the PPACA over just the next ten years is expected to be roughly \$940 billion, according to the Congressional Budget Office (CBO). Most of this money is expected to come from taxes and industry fees (Sahadi, 2010).

High-income households will pay an increased Medicare tax, and an excise tax will be placed on insurers offering high-cost policies starting in 2018. Taxes from the latter are expected to bring in \$32 billion over the next ten years. Funding will also come from penalties placed on those who do not purchase coverage and employers who do not provide enough coverage to their employees, which will bring in \$17 billion and \$52 billion, respectively, over the next ten years. Because of the new business expected to come their way due to the policy, new fees will be placed on the health industry, bringing in \$107 billion over the next ten years. Finally, various health-related tax breaks will be trimmed, to provide an additional \$29 billion over ten years (Sahadi, 2010). The CBO estimates that the law will reduce the deficit by \$124 billion over ten years (Congressional Budget Office, 2009).

The PPACA is fully funded through a combination of revenue streams contained within the law and the savings accrued through its implementation. As the Congressional Budget Office report states, “enacting the PPACA would result in a net reduction in federal budget deficits of \$130 billion over the 2011-2019 period.... Over the 2010–2019 period, the net cost of the coverage expansions would be more than offset by the combination of other spending changes that CBO estimates would save \$491 billion and other provisions that JCT and CBO estimate would increase federal revenues by \$238 billion” (Congressional Budget Office, 2009, p. 4).

More extensive legislation will likely be necessary to both curb expenses and meet growing health care needs. Medicare will need to be adjusted to address the needs of an aging population. The PPACA includes pioneer programs to incorporate home care into Medicare benefits and to study the high costs of treatment in the final months of life and what can be done to curb those costs while making quality of patient care a priority.

### **The Legislative Process: Patient Protection and Affordable Care Act**

This section will begin with a timeline of the bill’s passage into law, followed by a narrative outlining the political process that underscored the legislative process.

### ***Timeline of the Passage of the Patient Protection and Affordable Care Act***

*March 2009:* The White House held a Health Care Summit with lawmakers, health care professionals and hospital groups, pharmaceutical makers, and consumer organizations to begin forming a road map for legislative reform.

*July 2009:* The Senate Health, Education, Labor and Pensions Committee was the first Congressional panel to pass a preliminary version of health care reform legislation (The Affordable Health Choices Act). This version included a public option government-run insurance program, Medicaid expansion, premium subsidies and consumer protections. The House Energy and Commerce Committee passed its own version of a health care reform bill, with a public option. The House adjourned for August recess.

*October 2009:* The Senate Finance Committee passed their health care reform bill, with only one Republican vote from Senator Olympia Snowe (R-ME). This version did not contain a public option, but did include state insurance exchanges, Medicaid expansion and consumer protections.

*November 2009:* The House passed its bill, the Affordable Health Care for America Act, with all Republican representatives and 39 Democratic representatives voting against passage. This bill contained a public option as one of its provisions.

*December 2009:* Because of the Senate Republican filibuster threat, 60 votes were needed for the bill to pass. The Senate passed their bill (The Patient Protection and Affordable Care Act) after intense negotiations with conservative Democrats whose votes were needed to overcome the Republicans' filibuster. As a result, the bill no longer contained a public option government insurance plan.

*March 2010:* Senate Democrats lost one of their seats in a special election, thereby reducing their number to 59 and depriving them of the 60 votes needed to overcome a Republican filibuster. Because of this, House Democrats agreed to abandon their House bill and pass the Senate's bill without the usual amendment process, as a newly amended Senate bill would face a Senate filibuster threat. In return, Senate Democrats agreed to pass an amending bill with Congressional provisions using the parliamentary maneuver of 'reconciliation' that

required a simple majority of 51 for passage. The Senate's Patient Protection and Affordable Care Act bill HR 3590 passed along with the House's reconciliation bill, the Health Care and Education Reconciliation Act (Stolberg, Zeleny & Hulse, 2010).

On the 23<sup>rd</sup>, President Barack Obama signed the Patient Protection and Affordable Care Act (HR 3590) into law. The next day, President Obama issued the Executive Order that ensured federal funds will not be used for abortion services as has been demanded by conservative Senate Democrats whose votes were needed for passage.

### **Political Process**

By the time campaigning for the 2008 Democratic presidential nomination began, all candidates were running on a platform that highlighted the promise of passing health care reform. The fact that Barack Obama campaigned specifically on the need for health care reform and won by the largest majority since Ronald Reagan's 1984 win, was a strong sign that the climate was ripe for health care policy reform.

As historical advocates for health care reform, Democrats in Congress wrote and promoted the bill with the support of the Obama administration. Many professional groups supported the bill, including groups that had traditionally fought against reform, such as the American Medical Association. Another foe of health care reform, the pharmaceutical industry, gave its support after negotiating a deal wherein the bill would limit savings on drug pricing to \$80 billion, rather than directly negotiating prices for Medicare prescription drugs (Time, 2009). Unions, including the AFL-CIO and several nursing unions, worked hard to gather support for the Act. The National Association of Social Workers (NASW) supported the bill, and outlined specific programs that would positively affect the social work field, including social work professional education and training grants, public health loan repayment programs, and geriatric education and training grants and career awards. (NASW, September 20, 2010).

Since the days of Medicare and Medicaid being debated in Congress, the Republican Party has opposed health care reform. Republicans have voted to pass health care legislation in the past, but the party's platform has been against a federal health care

policy. Unlike the 1935 Social Security vote, all Republicans in both houses of Congress voted against the PPACA. Industries that profit from the status quo also opposed the bill, headed by America's Health Insurance Plans, the for-profit health insurance industry's member group. Heavily funded by the conservative political action committees FreedomWorks and Americans for Prosperity, the ostensibly grassroots Tea Party groups mounted protests against the bill and went to their representative's Town Hall meetings to vent their anger and prevent its passage (Mayer, 2010).

House Republicans drafted a bill of their own that did not contain programs to increase access, limiting reform to allowing consumers to buy private insurance across state lines, allowing insurance companies to escape state regulations if they are based in other states and allowing small businesses to join together to buy insurance (New York Times, 2009). In 2011 Representative Paul Ryan (R-WI) released a Republican budget plan that would eliminate the current Medicare program by 2024 and replace it with a voucher premium subsidy for seniors to buy private health insurance, while raising the eligibility age to 67 by 2022 (Kaiser Family Foundation, 2011). The CBO states that this change would result in seniors paying 68% of their health care costs, rather than the 25% they pay under the current Medicare program. These plans correspond with the Republican preference for "free market, federalist" solutions (Romney, 2012, p. 3) rather than what Senator Chuck Grassley (R-IA) called: "...increasing government control of health care" (Grassley, 2009, p. 2). The specter of 'death panels' was raised by Republican lawmakers, referring to a program within the law to allow for free consultations with health care providers regarding the end-of-life wishes of Medicare recipients, and this fear of rationing of health care by the government formed a theme of Republican opposition to the law (Rutenberg & Calmes, 2009). These end-of-life counseling provisions were later removed from the final version of the law.

Governmental regulation of industry and universal social welfare programs have often been controversial in the United States. The anti-government, free market-based ideology spearheaded by Ronald Reagan had become pervasive, serving as a backlash to the New Deal era in which Social Security was enacted. This anti-government doctrine was so strong that it

resulted in jarring inconsistencies, such as this town hall incident reported by the Washington Post:

At a recent town-hall meeting in suburban Simpsonville, a man stood up and told Rep. Robert Ingliss (R-S.C.) to 'keep your government hands off my Medicare.' I had to politely explain that 'Actually, sir, your health care is being provided by the government,' Inglis recalled. But he wasn't having any of it. (Rucker, 2009).

As with any far-reaching legislation, the PPACA was shaped by legislative negotiating from its original form to a bill that could garner the votes needed for passage. There were critics on the left that found some compromises unacceptable, including the exclusion of a public option from the final bill because conservative Democrats refused to support it. The Republican's use of the filibuster, which had increased to historic highs in unified opposition to the Obama administration, forced the need for 60 votes rather than a simple majority for passage in the Senate (New York Times, 2012). The Social Security Act was also compromised to gain passage, and did not include coverage for millions of Americans in its original form, specifically people of color and women. Given the historical record of that program, which was subsequently amended until it became truly universal in scope, it is reasonable to expect a similar process will be seen with the PPACA.

Polls show opinions on the PPACA being directly linked to political orientation: Democrats overwhelmingly support it, while Republicans oppose it (Gallup, 2011). The general public does not seem to have much information on what the law contains and how it will impact them (Kaiser Family Foundation, 2011). A March 2013 poll by the Kaiser Family Foundation found that 57% of respondents felt they did not have enough information to know how the law would affect them, but the majority were in favor of specific provisions such as expanding Medicaid, allowing young adults to stay on parents' policies, and closing the Medicaid 'donut hole' (Hiltzik, 2013).

### **Social Work's Role in The Affordable Care Act**

Social workers have been strong advocates for a national health care policy to address the issue of disparities in access to healthcare. In November 2009 NASW published a letter of support for the Democratic health care reform bills before Congress stating

The NASW and its members are long-time advocates for major health care reform. We have carried the vision of former Secretary of Labor Frances Perkins, a pioneer in the social work profession, who included universal health care on the 12-item agenda she brought to President Roosevelt. This was the only item on her agenda that did not pass into law and social workers have actively sought health care reform since that time (NASW, 2009, para. 2).

The letter highlighted strong support for the bill's provisions, including increased access through the Medicaid expansion and state insurance exchanges, health insurance reforms, parity for addiction and mental health care, improvements in care coordination, free preventative care, and the addressing of ongoing inequities in health care (NASW, 2009).

Social workers will be directly involved in providing many of the services created through the PPACA. There is a need for social work intervention, input, and collaboration to ensure that Americans receive the full benefits entitled to them, especially in regards to five sections of the PPACA: Hospital Readmissions and Reduction Program (Section 3025), Community Based Care Transitions Program (Section 3026), Independence at Home Demonstration Program (Section 3024), Patient Centered Medical Homes and Interdisciplinary Community Health Teams (Section 3502), and Accountable Care Organizations (Section 3022) (Golden, 2011).

To ensure social work involvement, the NASW published a letter to the Department of Health and Human Services in 2011 strongly recommending that social workers be included in government plans for the Accountable Care Organizations (ACOs) and Medicare Shared Savings Program because of their experience and specialized skills in providing both clinical mental health care, medical case management, discharge planning, and care coordination. The letter stated the benefits of social work involvement in reduction of hospital

readmissions, delays in nursing home placement, reductions in avoidable emergency room visits, and improved adherence to treatment plans (NASW, 2011).

As the PPACA is implemented, social workers will be essential to its success in connecting Americans to new health care options through the new 'navigator' programs funded by the PPACA to educate and enroll eligible individuals in appropriate health plans through the state insurance exchanges or Medicaid expansion (Andrews, Darnell, McBride & Gehlert, 2013). The demand for social workers will increase as millions of Americans become eligible for Medicaid and coverage through the state insurance exchanges, and the inclusion of behavioral health and rehabilitative health as part of the minimum health benefits mandated by the law will give millions more access to clinical services. The new bundled payment system for Medicaid and Medicare services will rely on social workers to provide discharge planning and transitional care to avoid hospital readmissions, and the increasing numbers of Community Health Centers will need social workers to provide services.

### Challenges to the Law

As with the other universal social welfare programs, the health care law was challenged as unconstitutional and eventually a case was brought before the Supreme Court. The main elements in contention were the 'Individual Mandate', which will require that all Americans have health insurance policies, and the expansion of Medicaid (New York Times, 2011). The mandate was challenged as being an invalid use of congressional power according to the Commerce Clause, which outlines Congress' ability to regulate interstate commerce, and the Medicaid expansion was opposed as an invalid exercise of Congress' spending clause power (Kaiser Family Foundation, 2012). In June 2012, the Supreme Court upheld the constitutionality of the Affordable Care Act in a 5-4 vote. The decision found the 'Individual Mandate' to be legal under the federal government's power to collect taxes, viewing the fee for non-compliance as a form of tax. The Court found the Medicaid expansion to be coercive and unconstitutional, since it mandated that any state rejecting the expansion would have its Medicaid funding cut. Instead, the court allowed the expansion to

remain as an option for those states that chose to adopt it (Just, 2012). As of September 2013, many state legislatures had chosen not to accept the Medicaid expansion, including several states with the highest numbers of uninsured individuals in the country. Hospital industry lobbying groups are pushing for Medicaid expansion, as this program will cover many of those without current insurance coverage whose uncompensated care creates hospital debt. Although federal, state and local government funding has covered approximately 75% of this hospital debt, the federal funding program is being decreased in response to the new PPACA programs that will cover millions of previously uninsured individuals. States that refuse Medicaid expansion will find their federal uncompensated care funding lowered without the subsequent PPACA revenues that were planned to offset this decrease, resulting in more pressure on state and local coffers to cover uncompensated care and avoid facility shutdowns (Sinner, 2012).

Religious institutions have challenged the law as well. The PPACA mandates that preventative care be covered without co-pays or deductibles, including contraception. The Catholic Church and other conservative religious groups claimed that this was an attack on their religious freedom to decide what services their employees have access to. In response, the Obama administration amended the law to allow contraception coverage to be offered directly from the private insurance company to any employees, rather than through the religious institution. In this way, the institution would not have a role in the provision of birth control. The Catholic Health Association (national trade group for Catholic hospitals) has stated that they are satisfied with the compromise (Zoll, 2013). The United States Conference of Catholic Bishops and other Catholic and Protestant organizations refused this accommodation and stated that the policy still infringes on the religious freedom of their institutions. As a result, in May 2012 several Catholic and Protestant organizations filed lawsuits to fight compliance with the law. The mandate for birth control coverage took effect for religious institutions in August 2013 (New York Times, 2012).

The 2012 Republican presidential candidate, Mitt Romney, represented the continued Republican Party commitment to repealing the PPACA, saying, “President

Obama’s program is an unfolding disaster for the American economy, a budget-busting entitlement, and a dramatic new federal intrusion into our lives” (Romney, 2012, p. 2). As governor of Massachusetts Mitt Romney implemented health care reform similar to the PPACA, including mandated coverage, a Medicaid expansion, and a state insurance exchange with premium subsidies that increased the coverage rate to 98% of the state’s residents (New York Times, 2011). In their opposition to the law, Republicans have repeatedly attempted to defund the program through legislative means (Kenen, 2011). By September 2012, Congressional Republicans had made their 40<sup>th</sup> attempt to repeal the health reform law, and had amended a government-spending bill to include a delay to the law’s implementation as well as allowing employers to deny contraceptive coverage to female employees. This led to a shutdown to many government services, as the spending bill’s passage was needed before government funding could continue (Weisman & Peters, 2013).

## Implementation and Future of Health Care Policy

The PPACA has begun to take effect and its provisions will be rolled out through 2014. Although many worried about the costs of state exchange policy premiums, a recent study shows that premiums are at or below market prices (U.S. Department of Health and Human Services, 2013). In addition, the creation of the state exchanges has actually brought down premium rates in many states (New York Times, 2013).

As Americans incorporate elements of the law into their lives, the PPACA may become more difficult for Republicans to repeal. Much like the Social Security Act, this law and its benefits to average citizens will likely become part of peoples’ lives and expectations from their government, and repealing popular provisions such as ensuring coverage for those with pre-existing conditions may prove politically difficult.

Some of the results of the PPACA since its implementation include:

- 2.5 million uninsured young people gained coverage through their parents’ policies.

- 54 million Americans have access to free preventative care through their private health insurance plans, without co-pays or deductibles, including contraceptives.
- More than 50,000 Americans with pre-existing conditions have gained coverage through the Pre-Existing Condition Insurance Plan. By January 2014 these individuals will be eligible to buy their insurance through the Online Marketplace (state health insurance exchanges) without denials or high premiums.
- Parents of over 17.6 million children with pre-existing conditions cannot be denied insurance coverage.
- Drug manufacturers must provide a 50% discount on brand-name drugs to Medicare recipients. Over 7.1 million Americans on Medicare saved over \$8.3 billion on prescription drugs (Centers for Medicare & Medicaid Services, 2013).
- Community Health Centers have increased the total number of clients served annually by 2.4 million, treating more than 21 million people in 2012 (White House, 2012; Health Resources and Services Administration, 2012).
- So far, 19 states have chosen to accept funds for Medicaid expansion. If all states participate in the Medicaid expansion, an estimated 21 million uninsured Americans would gain health insurance coverage (Holahan et al, 2012).
- Medical loss ratio standards require insurers to spend 80-85% of each premium dollar on direct medical care instead of administrative costs, marketing or profits, or pay rebates to customers. So far, consumers have received \$1 billion in rebates as insurers start compliance with this new rule (Kaiser Family Foundation, 2013).

Outlines for a potential national health care system can be found in both the state insurance exchanges and the Medicaid expansion. One model of national health care system, found in the Netherlands and other countries, involves a private/public hybrid with a heavily regulated private health insurance industry providing coverage to citizens with subsidization from the government for those below a certain income level. The state insurance exchanges may be seen as a pilot program for this type of national system, with its premium subsidies and regulated

private policies. The seeds of a Canadian-style single-payer system, where the government is the insurer while health care provision remains in private hands, can be found in the Medicaid expansion or the Medicare program. In Vermont, the state legislature has decided to use the federal funding provided for the creation of a state insurance exchange to develop its own single payer system (Kaiser Health News, 2012).

With the passage of the PPACA, millions of previously uninsured Americans will have access to health insurance, millions will become eligible for Medicaid, and millions more will no longer be in danger of economic disaster if they become ill. All policyholders will have access to preventative care and other basic services. Societal views on health care are shifting from a historical stance that saw health care as a service for those who could afford it to a contemporary perspective claiming access to health care as a basic human right. As the NASW stated, the PPACA is “a monumental legislative achievement of our time” and “a significant step toward a comprehensive and universal healthcare system for our nation”(Gorin, 2010, p. 22).

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## RACE WORK IN SOCIAL WORK

### The Continued Journey of Race Work in Social Work from the Theoretical

#### Perspective of Foucault

Adrienne M. Fletcher

#### Abstract

*A historical account of the African slave and white slave-owner in the United States from the fifteenth century onward provides the backdrop for this conceptual article. A resultant factor of the United States slave system is an inherently racist and discriminatory child welfare system as manifest by the theoretical perspective of power as defined by French philosopher Michel Foucault. Foucault argues that power is always met by resistance. Hence, resistance in the form of Race Work/Social Work will be discussed as a means of challenging Foucaultian defined power and its manifestation in United States child welfare system. Lastly, current race work/social work trends and implications will be discussed*

**Keywords:** Race, race work, slavery, social work, settlement house, charity organization societies, NAACP, NASW, NABSW

#### Introduction

Over the last twenty years Child Protective Service agencies have seen a rise in the number children of color in out-of-home placement (Baird, Ererth & Wagner, 1999). As the number of children of color is out of proportion to their number in the population, this trend has come to be known as disproportionality. Billingsley and Giovannoni (1972) were one of the first to write about the number of children of color in the child welfare system. Over four decades ago they proposed that the very existence of slavery ensured an inherently racist child welfare system. Further,

Grimmer and Cobbs (Boyd-Franklin, 1989) believed that the culture of slavery had not been undone even after one hundred years of emancipation. They stated, “The civilization that tolerated slavery dropped it[s] slaveholding cloak but the inner feelings remained...the minds of our citizens have never been freed” (Grimmer & Cobbs as cited in Boyd-Franklin, 1989, p. 32).

The following paragraphs lay a history of the African-American experience in the United States as it relates to social up-lift or Race Work which is part of the social work tradition. Foucaultian theory provides the theoretical lens through which to view race work and the African-American journey. Further, race work will be discussed as a form of resistance, and as part of the historical social work movement. Lastly, this paper will conclude with current race work trends, and implications for social work practice.

#### Foucaultian Power

French philosopher Michel Foucault introduced the idea of Power as a force; he viewed power not simply as a relationship between partners, but as a way that some act on others (Rainbow and Rose, 2003). As a set of actions Power does many things, “...it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more acting subjects...” (Foucault as cited in Rainbow and Rose, 2003, p. 138). Foucault argued that created institutions freeze certain relations of power so certain people are advantaged while others are

disadvantaged (O'Farrell, 2007). Foucault further explained that people do not possess Power, but rather, Power is exercised. This Power was initially exercised via Sovereign Power. Sovereign Power involves abject obedience to the law but is often gradually taken over by Disciplinary Power. Disciplinary Power works to regulate behavior and is enforced by a complex system of surveillance. Another form of Power introduced by Foucault was Biopower. Biopower appeared at the end of the eighteenth century and as a way of managing populations. Biopower is a means of managing birth, death and reproduction of a population. It should be noted that Power operates on both micro and macro levels of social relations. Lastly and most importantly, Foucault outlines the idea of Power and Resistance. Foucault believed that Power always has the potential to be met with criticism and resistance no matter how oppressive (O'Farrell, 2007). The following paper will discuss resistance of the historical and present forms of Power as defined by Foucault via the ongoing tradition of Race Work within social work in the United States.

### **Foucaultian Power and the African-American Journey**

Historically, Foucault may have suggested that slavery of imported Africans, an overt form of Sovereign Power, marked the body by way of Biopower. The black skin of the African served as a personal marker from which neither the vanquished nor the vanquisher could escape. Slavery as a form of Sovereign Power and Biopower had its intended effect on the physical body and the mental psyche of African-Americans. A template of Power was imposed by racism on the psyche of individuals within the minority and majority group. As a result of this grotesque imposition, the privileged group--like the oppressed group--assimilated by "...equating power with goodness and powerlessness with badness" (Simon, 1994, p. 13). However, as Foucault would suggest, confrontation in various forms--including slave mutinies, mass suicide, insurrections and social and political movements--occurred as forms of resistance. Race Work thus began its journey.

### ***African-American History 1440-1900***

During the fifteenth century Europeans entered Africa, first for gold and then for people

(Thomas, 1997). The Portuguese led the charge in establishing trading posts on the coast of Senegal in the mid-fifteenth century. The trade of ivory and spices and the spread of Christianity characterized the changing world. Colonization and plantations were on the developmental horizon. Antam Gonclavez was the first to return from Africa with ten 'black ones' in 1441 (Thomas, 1997, p. 4). Delighted by the 'black ones,' Gonclavez returned from Senegal with another 235 enslaved Africans. Soon after in 1445, the Pope, authorized Portugal to reduce servitude to all "infidel" people (Thomas, 1997). This authorization began the trajectory toward Foucaultian power.

With the 'discovery' of the New World by Columbus the trade of slaves grew. Enslaving the Arawak Indians decimated their population, hence the Spaniards turned to Africa for cheap and a plentiful supply of labor. Slave trade from the continent of Africa lasted for over four hundred years. "It disrupted cultures, depopulated the continent and evoked wars. Slave Trade took the strongest and the brightest" (Thomas, 1997, p. 4).

### ***Race Work/Social Work in the form of Resistance***

Munities, slave revolts, scholarly essays, speeches, collective movements, the work of the Settlement House and Charity Organization Societies movements, the Freedmen's Bureau and the Civil Rights movement might all be considered forms of racial up-lift or Race Work in which social workers often took part.

The resistance in opposition to Foucaultian Power began during the Middle Passage, the fifty-day journey to the New World in the form of mutinies. Thomas (1997) notes that more than fifty-five mutinies were recorded with at least one hundred other attempts. The most noted slave mutiny is that of the Amistad led by the West African, Cinque. The Africans revolted and sailed the Amistad to New York. Former president John Quincy Adams, who eventually won their freedom in this landmark Supreme Court case, defended them.

By 1663, with slavery well established, the first serious slave revolt occurred in Gloucester, VA. Toussaint L'Ouverture, a former slave, led the slave revolt that eventually led to Haitian Independence in 1791. In 1800 Gabriel Prosser attempted a well-planned resistance with

arms and over 1,000 slaves, but was betrayed and hanged for his defiance toward the Sovereign Power of slavery. In 1822, Denmark Vesey led another well thought out slave revolt similar to that of Prosser, but with several more slaves willing to resist. He too is betrayed and hanged for his crime of resistance. In Southampton County, Virginia in 1831, Nat Turner led the most successful slave insurrection. By the time Turner was captured, sixty whites had been killed. Turner was also hanged for his resistance. With Race Work gaining momentum, the work of Harriet Tubman began; from 1831-1863 she led approximately 75,000 slaves to freedom with the help of Abolitionists on what came to be known as the Underground Railroad. Fredrick Douglas escaped from slavery in 1838 and resisted Foucaultian Power with the authority of his pen. In 1859, the Harper's Ferry revolt led by Abolitionist John Brown hastened the advent of the Civil War, which began two years later (The Encyclopedia Britannica Guide to Black History, 2011). Resistance demonstrated in the form of speeches:

- Charles Lenox Remond, an agent of the American Anti-Slavery Society was the first Black Abolitionist speaker to address large audiences. Speaking directly against Biopower, Remond stated, "Complexion can in no sense be constructed into a crime, much less be rightfully made the criterion of rights" (Foner, 1975, p. 95).
- Henry Highland Garnet's speech was considered radical for its time as he called 'rebellion' the surest way to end slavery. John Brown (Harper's Ferry martyr) had Garnet's speech published at his own expense (Foner, 1975, p. 104).
- Sojourner Truth, Fredrick Douglas, and John S. Rock: Their writings and speeches attempt a loosening of Sovereign Power and the beginnings of Disciplinary Power soon to be manifest by way of Jim Crow, Share Cropping, Ku Klux Klan activities, as well as other formal and informal surveillance systems.
- Henry McNeal Turner (1868) delivered a speech to his colleagues, who voted to unseat him and several other state senators because they were African-American. Turner stated, "...Never in the history of this world, has a man been arraigned before a body clothed with legislative, judicial or

executive functions, charged with the offense of being a darker hue than his fellow men...never has a man been arraigned, charged with the offense committed by the God of Heaven Himself (Foner, 1975, p. 388-398).

- Hiram R. Revels, the first Black man to be seated in Congress, pled for the desegregation of schools.
- Robert Brown Elliot delivered a speech in support of the Civil Rights Bill introduced by Senator Charles Sumner in the fall of 1871. Within this speech Elliot apologizes that his darker hue might lead one to believe that his motivation is merely driven by his skin color. Elliot points out that such thinking is narrow and reductionist. He states that he pursues equal rights and privileges simply because it is right.

With the sudden and unplanned emancipation of approximately four million Black slaves, the Freedmen's Bureau was established by an act of Congress in the spring of 1865 (Billingsley and Giovannoni, 1972). W.E.B. Du Bois referred to the Freedmen's Bureau as, "the most extraordinary and far-reaching institution of social uplift that America ever attempted," (Du Bois, 1935, p. 219). The Freedmen's Bureau assisted newly freed slaves and white war refugees. Billingsley and Giovannoni (1972) assert that the bureau presented a model of comprehensive social welfare planning as it included a combination of the Department of Labor, Justice and Health, Education and Welfare, as well as a component for Veterans.

At the beginning of the Post-Civil war period, Fredrick Douglas stated in his address entitled, *I Denounce the So-Called Emancipation as a Stupendous Fraud*, "the love of power is one of the strongest traits in the Anglo-Saxon race" (Foner, 1975, p. 553). He also argued in this essay that if Anglo-Saxon power remained unchecked, they would remain masters of the South and soon become masters of Congress, and eventually masters of the nation. Douglas unknowingly described the current state of American affairs and the everlasting tension between Sovereign Power and Disciplinary Power described by Foucault.

## Race Work within Social Work

Before the close of the nineteenth century Charity Organization Societies (COS) and the Settlement House movement emerged as a means of providing aid to poor white families. Charity Organization Societies accepted the philosophy of individual responsibility for poverty, while the Settlement House movement worked in poor communities and stressed social reform rather than individual reform. Du Bois (1967) found that within these two movements, the 'Negro' population was further devalued. Agencies fell into one of four categories: "charitable agencies exclusively for blacks; those exclusively for whites; those that professed not to discriminate, but did in some cases; and those that made no statement, but usually were discriminating," (Du Bois, 1967, p. 357-358).

Organizations participating in Race Work during the COS and Settlement House movements were religious groups, including Quakers and Episcopalians. The Episcopal Diocese of Philadelphia established the House of Saint Michael and All Angles for Colored Cripples and the House of the Holy Child in 1887 and 1889, respectively. In New York City the Roman Catholic Church established Saint Benedict's, the Moor Church for the Colored in 1883 (Billingsley & Giovannoni, 1972).

The twentieth century was ushered in with the publication of W.E.B. Du Bois' *The Souls of Black Folk*, which continued resistance/Race Work. *The Value of Agitation* was a leading essay at the turn of the century. Denounced as an agitator, Du Bois embraced the title and with it the Niagara Movement, called "the first important Negro protest movement..." (Foner, 1975, p. 48). The Niagara Movement, created in response to Booker T. Washington's conciliatory policies toward whites, issued a manifesto calling for equal rights for Blacks. The movement, though it established thirty branches and achieved a few scattered civil rights victories, suffered financially and was dismantled. However, after the 1908 race riots in Illinois, the core group of Niagara members started the National Association for the Advancement of Colored People (NAACP) (Wormer, 2002). Ida B. Wells-Barnett delivered a speech called *Lynching, Our National Crime* at the National Negro Conference and was one of the founders of the NAACP. Ms. Wells-Barnett originated and led the crusade against lynching at the age of nineteen (Foner, 1975). On the other side of the coin, Booker T. Washington

advocated for Black people's ability to be calm and patient while enduring great wrong (Foner, 1975). Washington called for self-control among southern Blacks after ten Black people, including two women, were killed by a white mob which included police officers. He urged the Black people of the south to get rid of agitators and become law-abiding and law-respecting individuals. Washington's perspective fits squarely, under the Disciplinary Power of the valued group. The establishment of The Chicago Urban League by Black reformers and White Settlement and Charity workers occurred in 1911 after an unprecedented number of riots and lynchings rocked Black communities from April to November of 1911. That summer became known as the Red Summer.

### **Race Work within the Black Social Work Movement**

Race Work specifically engendered by Black social workers began to emerge with the works of Eartha White, Sarah Fernandis, and Victoria Matthews. White, a philanthropist, started the only African-American orphanage in Florida. Fernandis started several Settlements, including the first in Washington D.C. Victoria Matthews, born a slave and one of the founding members of the National Association for Colored Women, established the White Rose Industrial, which provided services for young Black women in 1897 (Simon, 1994). In 1899, The Smith Home, Chicago's first African-American charity for dependent children, was established. In 1892, Carrie Steele-Logan organized an orphanage in Atlanta. The Louis Home orphanage was founded in 1907 (Hasenfeld, 2010). Blacks were also involved as Friendly Visitors. Atlanta's Black women founded the Neighborhood Union in 1908. Women from this organization made home visits to address concerns within the Black community. Linda Gordon (1991) states, "Race up-lift work was usually welfare work by definition and it always conceived as a path to racial equality" (p. 580). The above are all instances of African-Americans working to carve their niche in the emerging social work field against the backdrop of Foucaultian Power.

In 1896, the existing Black women's organizations merged to form the National Association for the Advancement of Colored Women (NACW). Victoria Matthews, as

mentioned above was one of its founding members. Their motto was “Lifting as we Climb” (Thomas, 2001, p. 23). The NACW resisted Foucaultian Power as they worked to bring about women’s suffrage and human rights.

Marcus Garvey and the Universal Negro Improvement Association continued to carry the torch of Race Work, agitation, and resistance. Garvey stood for human rights, not just for Negroes, but for all races. Forming a united and universal group of four hundred million Blacks was the mission of the Universal Negro Improvement Association. The purpose was sole ownership: to build a civilization comprised of people of Negro descent from United States, Asia, the West Indies, Central and South America, and Africa. Garvey’s desire was to break the tether of Disciplinary Power tainted with remnants of Sovereign Power. He stated, “The Universal Negro Improvement Association seeks independence of government, while other organizations seek to make the Negro a secondary part of existing governments” (Foner, 1975, p. 137).

Race Work continued as Black social workers established schools of social work within black-run universities. Howard University followed Atlanta University in creating a school of social work. The foundation of these two schools of social work pushes against Foucaultian Power by the expansion of educational resources and opportunities. These resources transformed powerlessness into power. The collective experience of Black students, including needs, problems, and strength came to bear on the formulation of social work approaches and services to Black communities (Simon, 1994). By 1900, one hundred Black colleges, most of which admitted women had been established. Now called Historically Black Colleges/Universities (HBCU), Fisk, Hampton, and Biddle (Johnson C. Smith) are among the ranks with Howard University and Atlanta (Clark Atlanta University) (Thomas, 2000).

The Great Migration occurring after the end of World War I saw a steady stream of black Americans move north to take up jobs. Detroit, Cleveland, Gary, Chicago, St. Louis, Cincinnati, Pittsburgh, Buffalo, New York, Boston, and other urban hubs saw an explosion of black ghettos. Able to ignore black poverty while hidden out of sight in rural areas, social workers found themselves confronted with black underemployment, unemployment, poverty, and other societal ills. Suddenly, the messages

purported by Garvey and Du Bois became relevant (Simon, 1994).

## Race Work within Social Movements

Before the end of World War II, A. Phillip Randolph called for mass action via his conception and leadership of the March on Washington movement in 1941. Randolph voiced the need for self-empowerment and an end to the power belonging to the valued culture. It was his desire to see an end to discrimination within the nation’s national defense. With the expectation of over 100,000 marchers at the planned March on Washington, President Franklin D. Roosevelt encouraged Randolph and his comrades to call off the march. When this failed, President Roosevelt barred discrimination within the defense industries and Federal bureaus. Randolph’s Race Work had its intended effect, the increase of power of and within the devalued group (Simon, 1994).

According to Simon (1994), The March on Washington for Jobs and Freedom in 1963 inspired the Congress of Racial Equality (CORE), the organization that planned Freedom Rides. CORE worked in conjunction with NAACP and the Urban League in protests and educational and economic advocacy. Soon after, the Southern Christian Leadership Council (SCLC) along with the Student Nonviolent Coordinating Committee (SNCC) powered and empowered Blacks to seek equal rights and economic justice. This fresh sentiment of power is best summarized by Dr. King as a “...new sense of somebodyness’...” (Boyer 1984:12).

Concurrently, Malcolm X, founder of the Organization of Afro-American Unity, followed Garvey’s trajectory of nationalism and separation. CORE and SNCC shed their integrationist stance to assume a position of separation more in line with Malcolm X, who believed “efforts to achieve integration had only diluted and divided black people’s individual and collective strength...” (Simon, 1994, p. 143). Stokely Carmichael also belonged to this school of thought. King, social worker Whitney Young, and others believed that black separation would only lead to increased violence from official and unofficial whites. They also felt that separation would decrease the black community’s access to material resources (Simon, 1994).

Black women involved in important social movements include Mary McLeod



Bethune, who organized the Federal Council on Negro Affairs in 1936 under the presidential leadership of Franklin D. Roosevelt. Bethune and Mary Church Terrell organized the National Council of Negro Women (NCNW). While working in Washington, Bethune remained focused on non-government supported Race Work by supporting the work of A. Phillip Randolph and other activists. Following closely behind Bethune and Terrell, social worker Dorothy Irene Height eventually became president of the NCNW (Lyman, 1999).

The National Black Association of Social Workers (NABSW) was founded in 1960, five years after the foundation of the National Association of Social Workers (NASW) in 1955. The NABSW was started in California by a group of black social workers. “Black liberation and improved social work service delivery” (National Association of Black Social Workers, 2011) were among their initial goals. The theme of liberation falls under efforts to resist unwelcomed power of the valued or dominate culture. Between the years 1968 and 1969, the NABSW and NASW struggled and dialogued about racial and white supremacy behaviors within the NASW. Soon after these discussions, the NABSW focused their energies on developing their organization to its fullest. In the late 1960s, Whitney M. Young Jr. became the first Black president of the NASW (National Association of Black Social Workers, 2011).

Simon (1994) points out that movements including the civil rights movement impacted empowerment social work in the United States. She believes these movements had a profound effect on “...the social work profession’s conceptions of power, justice, self-determination, equity...” (p. 141). Simon (1994) also notes that social work professionals joined Race Work efforts by listening, observing, reading about, discussing and in some cases directly participating in civil rights and black liberation activities. Between 1962 and 1968, a flurry of articles regarding racism and its impact on the social institutions in the United States were published.

### Race Work Current Trends

Race Work continues its journey via the work of black social workers, black organizations, grass-roots movements, and the increased authorship of scholarly writings.

While “disproportionately employed in human service work...black social workers constituted a *fourth* of those determining eligibility for public programs” (Hasenfeld, 2010, p. 321). Relative to their proportion in the labor force, Blacks represent 17.9% of counselors, 22.7% of social workers, and 23.9% of other social service specialists in the United States (Hasenfeld, 2010, p. 321). Accordingly, Hasenfeld (2010) also notes black social workers participate in Race Work within their respective organizations. Their motivation for Race Work is due to allegiance and commitment to black people, self-help, race consciousness, pride, interconnectedness, and a sense of social responsibility (Simon 2010).

Currently, the NABSW is addressing issues of disproportionality within the foster care system specifically and the child welfare system in general, as well as securing reparations for people of African ancestry. Liberation of the black community remains a major theme of the NABSW (National Association of Black Social Workers, 2011).

The National Fatherhood Initiative (NFI), founded in 1994, seeks “to improve the well-being of children by increasing the proportion of children growing up with involved, responsible, and committed fathers. President Roland C. Warren presents a perspective on father involvement in education, faith-based outreach to fathers, juvenile delinquency, and work-family balance (National Fatherhood Initiative, 2011).

Scholarly works impacting the undercurrent of Foucaultian Power include: *Shattered Bonds* and *Killing the Black Body* by Dr. Dorothy Roberts, *Root Shock* by Dr. Mindy Thompson Fullilove, *Medical Apartheid* by Harriet A. Washington, *The Immortal Life of Henrietta Lacks* by Rebecca Skloot, and *The New Jim Crow* by Michelle Alexander. These works focus on child welfare, housing, incarceration, and medicine; all struggles faced by the devalued group.

### Implications for Social Work

Since the existence of the welfare state over this past century, social problems have not decreased, but have increased (Mullaly, 2010). Mullaly (2010) asserts that traditionally disadvantaged groups have found themselves further disadvantaged in light of globalization.

As noted above, the last twenty years have seen a disproportionate rise in the number children of color in out-of-home placement, denoting the trend of disproportionality. While the causes of disproportionality are still under investigation three causes come to the fore as likely contributors: parent and family risk factors, community factors and organizational and systemic factors (Hill, 2006). The trend of disproportionality may be considered as damaging as the atrocities of slavery and Jim Crow.

As social work practitioners are key players within 'the organization' and 'the system', they are faced with the need to examine their role in changing the trend in increased social problems, including disproportionality. Conventional approaches that support personal change may no longer be helpful as people of color find themselves further disadvantaged in light of globalization. Approaches that are progressive and radical, which support social transformation on a larger scale, must be discussed as future social work interventions. Approaches must be empirically-tested means of social up-lift which evaluate the ongoing undercurrent of the power exercised by 'the organization' and 'the system'. Further, approaches must empower those who are disadvantaged. Such approaches and interventions must no longer be considered radical, but necessary and normal. Though antediluvian in its connotation, Race Work in social work is a cry for survival, the survival of those who remain disadvantaged. As long Foucaultian power exists in the form of disproportionate and disparate treatment, Foucaultian resistance will also exist.

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**ATTENTION DEFICIET- HYPERACTIVITY DISORDER IN ADULTS**

## Controversy in Diagnosing Adult Attention-Deficit/Hyperactivity Disorder: Implications for Social Work Practice

**Mallory R. Gamer, MSW**

### Abstract

*When people think of Attention-Deficit/Hyperactivity Disorder (ADHD), they think of symptoms including hyperactivity, impulsivity, and poor concentration manifesting in childhood. While it is important for social work practitioners to consider the implications of working with a child or adolescent experiencing the debilitating symptoms of ADHD, there is one population suffering from this disorder that is often overlooked: adults. Though research on adult ADHD is relatively new, it has been proven by specialists that while ADHD symptoms tend to lessen overtime, it is likely that the disorder will persist throughout one's adulthood. In this narrative, I will be exploring the controversy behind diagnosing adult ADHD as well as implications for social work intervention. Along with prescribing and monitoring central nervous stimulants to reduce the symptoms of adult ADHD, it is beneficial for individuals to engage in cognitive-behavioral therapy with a professional social worker to help with social and occupational functioning impairments.*

**Keywords:** Attention-Deficit Hyperactivity Disorder, Cognitive-Behavioral Therapy

### Introduction

Attention-deficit/hyperactivity disorder is a common diagnosis for children and originally its symptoms were thought to significantly lessen to nonexistence by adulthood. As defined by Sadock and Sadock (2007), "Attention-deficit/hyperactivity disorder (ADHD) is characterized by a pattern of diminished sustained attention and higher levels

of impulsivity in a child or adolescent than expected for someone of that age and developmental level" (p. 1206). It is only until recently that researchers and medical professionals are recognizing the symptoms of ADHD as continuing into adulthood, or symptoms presenting themselves not until later in adult onset ADHD.

There are three different subtypes of symptoms of ADHD as described in the American Psychiatric Association (2013), Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which include inattentiveness, hyperactivity-impulsivity, and combined (p. 59). To be diagnosed with ADHD, a client must present either 6 or more inattentive symptoms, such as (a) often fails to give close attention to details or makes careless mistakes in school work, work, or other activities, (b) often has difficulty sustaining attention in tasks or play activities, and (h) is often easily distracted by extraneous stimuli (Criteria A) (DSM-5, 2013, p. 59).

It is possible for a client to not present any of the Criteria A inattentive symptoms, but to present 6 or more Criteria A symptoms of hyperactivity-impulsivity. These symptoms include (a) often fidgets with hands or feet or squirms in seat, (f) often talks excessively, and (h) often has difficulty waiting his or her turn (Criteria A). These symptoms must have been recognizable in patients before the age of 12 (Criteria B), and must be present in two or more settings (Criteria C). Along with the symptoms causing the client significant social and occupational impairment, they must not be better accounted for by a different mental disorder, nor be present during the course of a psychotic disorder (Criterion D & E).

## Controversy in Diagnosing and Treating Adult ADHD

There is controversy in diagnosing an adult with ADHD for multiple reasons. To start, the DSM-IV-TR (2000) emphasizes that symptoms be present prior to age 7 (Criteria B). This calls for an adult client to be able to have a clear recall on symptoms of inattentiveness and/or hyperactivity-impulsivity they displayed in childhood. McGough and Barkley (2004) refute many of the DSM-IV-TR criteria for ADHD in regards to being able to diagnose adults in their article “Diagnostic Controversies in Adult Attention Deficit /Hyperactivity Disorder.” The authors explain that, “Adults may have limited recall of the exact time course and nature of symptoms as well as impairments related to those symptoms” (p. 1951). This can cause complications in assessing an adult for ADHD. This barrier in diagnosing ADHD appropriately in adults holds the same with the recent publication of the DSM-5 (2013). The diagnostic criterion has changed from some inattentive or hyperactive-impulsive symptoms being present prior to age 7 to being present prior to age 12 (DSM-5, 2013, p. 60). It is still necessary for an adult to be able to cite instances in his or her childhood in which symptoms of inattentiveness and/or hyperactivity-impulsivity were present and debilitating.

Along with the age of onset of symptoms as specified by the DSM-5 (2013), the Criteria A symptoms are based around the notion that ADHD is a childhood disorder. McGough and Barkley (2004) elaborate on the inappropriateness of the symptom descriptions in diagnosing adults with ADHD. For instance, the use of wording such as, “has difficulty playing...quietly,” and “runs and climbs excessively” are not necessarily synonymous for diagnosing an adult with ADHD (p. 1950). Knutson and O’Malley (2009) discuss how ADHD symptoms manifest differently in adults by stating that, “Some of the symptoms that led patients to seek medical help include poor concentration, disorganization, the inability to follow through on a job to completion...and problems related to inattention, impulsiveness, and temper” (p. 595). Because the symptoms mostly seen in adult ADHD do not commonly include hyperactivity or overtly disruptive behaviors, many are inclined to deny the legitimacy of the diagnosis in adulthood. This

causes practitioners to look toward alternate explanations for one’s behaviors, seeking one more suitable for adults.

There is a clear discrepancy in the diagnosis of adult ADHD because of current criteria and symptoms specified for the disorder focusing on childhood onset and diagnosis. This often leads to an under diagnosis of adult ADHD, thus, resulting in a lack of treatment for those adults who are suffering from ADHD symptoms. Along with the complications in translating adult ADHD symptoms, there are many social factors leading to the under diagnosis of adult ADHD. It is because adults are perceived as capable of controlling their impulses that the symptoms of ADHD tend to be seen as mere laziness or other personal shortcomings when manifested in adulthood (Knutson & O’Malley, 2009, p. 595-596). Kessler, Adler, Ames, Barkley, et al. (2005) found in a sample study that in a pool of adults who were identified as suffering from ADHD, only 16% were receiving treatment to address the disorder. Furthermore, 32% of the adults in the sample had sought help for various emotional problems (as cited in Patton, 2009, p. 131). This is an example of how medical professionals tend to look towards other psychiatric disorders before considering adult ADHD based off the nature of how symptoms are manifested.

Based on the perceived notion that adults are capable of controlling their ADHD symptoms, many adults are deterred from seeking treatment because of the stigma that ensues with the diagnosis. According to Goffman (1963), the characteristics of stigma possess three common features that all apply to ADHD (as cited by Canu, Newman, Morrow, et al., 2013, p. 701). In the article, “Social Appraisal of Adult ADHD: Stigma and Influences of the Beholder’s Big Five Personality Traits,” stigma features are defined as overt characteristics that are often misunderstood by the public and thought to be controllable. Additionally, existing literature notes that when stigma is seen as “controllable,” onlookers are likely to be less sympathetic to those who are suffering. Lastly, the article states that, “disorders that are misunderstood are more likely to be stigmatized” (Canu, Newman, Morrow, et al., 2013, p. 701). It is for these reasons that a disorder such as ADHD that exhibits noticeable symptoms and carries the perception of being controllable is likely to be stigmatized by society.

The first step to eradicating the stigma associated with being an adult with ADHD is to educate medical professionals on the realness of the diagnosis and its prevalence in adulthood. The need to raise awareness of ADHD in adulthood is asserted by the following statement: "In a 2003 Harris poll, 77% of doctors reported that ADHD in adults is not understood by the medical community" (Patton, 2009, p. 331). This shocking statistic implies that ADHD in adulthood will continue to be stigmatized as long as it remains to be misunderstood by medical professionals. By raising awareness of adult ADHD in the medical community, many adults suffering from the disorder will find solace in the fact that their symptoms are a result of an actual mental illness that has implications for treatment and respite.

The etiology for adult ADHD is the same as for ADHD diagnosed in childhood; there are genetic factors, developmental factors, neurochemical factors, neurophysiological factors, and psychosocial factors that can be associated to the onset of ADHD symptoms (Sadock & Sadock, 2007, p. 1206-1207). The symptoms must cause significant social and/or occupational impairment; which can be subjective depending on the individual's biopsychosocial makeup. According to Sadock and Sadock (2007), the persistence and remitting of symptoms vary regarding an individual's genetic history and life events, and 50% of childhood ADHD cases persist into adulthood (p. 1214). It is likely that an adult who is experiencing symptoms of ADHD has actually had the disorder since childhood, but the symptoms were not debilitating to the point of impairment in functioning. Adults usually seek medical treatment for ADHD symptoms based off of self-report of social and occupational impairments, adding to the complications in making an accurate ADHD diagnosis.

#### Problems Associated With Under Diagnosis of Adult ADHD

With there being such controversy in diagnosing an adult with ADHD, many individuals suffer severe consequences because they are not receiving the treatment they need. The implications of not treating an ADHD diagnosis in adulthood are explored in the article, "ADHD: Not Just a Childhood Disorder." It is discussed that adults living with undiagnosed ADHD are more likely to be unemployed, suffer from a substance use disorder, have been arrested, have trouble

managing finances, sustain serious injuries, to divorce, and to engage in risky sexual behaviors (Dodson, 2008, p. 75). It is time for medical professionals to be aware of the validity of adult ADHD and to be prepared to help clients connect with the resources necessary to manage their symptoms. Though adults are seen as capable of controlling their impulses, ADHD symptoms make this increasingly difficult when left untreated.

As recent research shows an increase in recognizing adult ADHD as a valid diagnosis, it is important for social work practitioners to be prepared to treat an influx of adults with ADHD symptoms. Dr. Susan Okie conceptualizes this increase in her article, "Adults with ADHD," published in *the New England Journal of Medicine*. According to her research, "Data from U.S. Pharmacies...indicate that the number of prescriptions given to people 19 years of age or older for eight drugs commonly used in ADHD increased by 90 percent between March 2002 and June 2005" (p. 2638). Okie goes on to explain how while these drugs are sometimes prescribed for other ailments, adults are currently the recipients of one third of all ADHD medication prescriptions. While about 50 percent of adults that are currently being treated for ADHD have been receiving treatment since childhood, many adults are learning for the first time that their personal and occupational difficulties are attributed to the diagnosis (Okie, 2006).

#### Treating Adult ADHD with Cognitive-Behavioral Therapy

Using central nervous stimulants is the most commonly used treatment in combating ADHD symptoms in both children and adults. Sadock and Sadock (2007) discuss that, "Signs of a positive response [to medication] are an increased attention span, decreased impulsiveness, and improved mood" (p. 1215). While stimulant medication helps decrease the symptoms of ADHD, it is beneficial for adults to engage in a cognitive-behavioral approach to therapy (CBT) with a social work practitioner to ensure a good prognosis. In the article, "CBT for Adult ADHD: Adaptations and Hypothesized Mechanisms of Change," it is stated that, "Although medications may provide desired symptom improvements, these gains may not necessarily result in normalization or adequate

improvements in domains of daily functioning” (Ramsey, 2010, p. 38). Using CBT with an adult individual who is experiencing ADHD symptoms will help the client to develop the coping skills necessary to improve social and occupational functioning.

CBT emphasizes a partnership between the social work practitioner and the client in order to alter existing behaviors through behavior reinforcement. In Coady and Lehmann’s (2008) text, *Theoretical Perspectives For Direct Social Work Practice*, Cobb highlights the benefits of using CBT with clients. He states that, “All human beings...can unlearn problematic thoughts and behaviors and learn more adaptive thoughts and behaviors” (p. 223-224). Interventions commonly used through CBT that would be helpful to use with adult patients with ADHD include psychoeducation, environmental engineering, and cognitive modification.

The purpose of using CBT with adult clients with ADHD is to promote positive change in their everyday behaviors by making alterations to existing routines. Psychoeducation helps by providing the client with training in skills that will create change in behaviors (Cobb, 2008, p. 236). Through gaining an understanding of how ADHD affects their lives, clients will be able to identify situations that cause distress and learn the skills needed to cope more easily in these situations. Ramsey (2010) elaborates on the use of psychoeducation through CBT with ADHD clients by emphasizing the importance of education in environmental engineering as well as executive functioning. By understanding the benefits of environmental engineering, clients will learn to eliminate distractions in their environment to reinforce productivity while training in executive functioning will help clients learn essential skills such as time management and organization (p. 42).

Along with psychoeducation, it is important that social work practitioners use cognitive modification while working with adult clients with ADHD. Using cognitive modification addresses the assertion that, “Individuals with ADHD are likely to put off dealing with an issue that is not imminent, minimize its importance, or make a rash decision...in order to avoid facing a stressful topic” (Ramsey, 2010, p. 42). Adults suffering from ADHD are likely to have negative expectations of their own capabilities when it comes to following through on certain tasks

based off of previous experiences. Murphy (2005) elaborates on this assumption by explaining the possibility that, “Perhaps the most insidious consequence of ADHD for adults is a chronic sense of underachievement, frustration, disappointment, and disillusionment.” (as cited by Patton, 2009, p. 330). Using CBT interventions with clients that center on the issue of the individual’s self-esteem can be beneficial in addressing the aforementioned cognitive distortions in ADHD individuals (Knutson & O’Malley, 2009, p. 600). Social work practitioners can work with clients to alter their negative conceptions of their abilities through using cognitive modification by helping clients to see their potential and creating new, rational beliefs.

## Conclusion

Though commonly thought of as strictly a childhood disorder, ADHD continues to affect individuals well into adulthood, and symptoms may have gone unnoticed until adulthood. Research validating this is very recent, meaning that an influx of adult ADHD cases is bound to surface with more medical professionals becoming aware of its prevalence in adulthood. Okie (2006) highlights this by not only citing the 90% increase of adults receiving prescriptions for ADHD medication between 2002 and 2005, but also how at Massachusetts General Hospital in Boston, the average age of individuals receiving treatment for ADHD is 40 years old (p. 2638). It is pertinent that medical professionals are aware of the debilitating consequences that undiagnosed and untreated ADHD has on the adult individual, and are prepared to provide the services necessary to ensure a strong prognosis. Through combining central nervous stimulants with CBT, adult clients with ADHD will be able to manage their symptoms as well as develop the skills necessary to cope with presenting social and occupational impairments brought on by the disorder.

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## Using Touch in Health Care Social Work

Leigh Huston

### Abstract

*Touch is a fundamental form of communication and can be extremely beneficial to the recipient. Although the information in this paper explores the modality of comforting touch as it relates to social work practice in the healthcare field, touch is important in all areas of social work. For the purposes of this paper, this type of touch is represented by simple actions such as hugging, squeezing of the arm, or holding of a hand. Studies have shown the multitude of benefits of comforting touch such as helping establish a relationship, communicating information, and decreasing anxiety levels. However, social workers can be reluctant to incorporate it into their practice due to concerns regarding misinterpretation. Those that do use it have had little or no formal education on the practice. Guidelines are discussed to provide a framework for social workers to understand how to use touch with their clients.*

**Keywords:** Touch, healthcare social work, benefits of touch, cultural touch

### Introduction

Touch can mean a tremendous amount to the recipient and is a vital form of communication between two people. Touching provides a variety of positive benefits that seem to be lost in its absence. As long as it is implemented appropriately, the benefits of touch often outweigh the concerns associated with it. To fully meet clients where they are, health-focused social workers should incorporate positive touch with their patients as one more way to make a connection and provide comfort. This article focuses particularly on touch within a case management context; however, the dynamics discussed here are also relevant to therapeutic, social work settings. For those

interested in exploring touch within a counseling setting, the reader is referred to Horton, Clance, Sterk-Elifson & Emshoff (1995), McKinney & Kempson (2012) and Lynch & Garrett (2010).

Each social worker and client has his or her own comfort level with touch that needs to be respected during the working relationship. The recommendation that health-focused social workers should become both comfortable and effective with touch must be tempered with consideration for the culture of the client, the benefits of touch in different situations, some strong concerns about touch, and different ways to integrate touch in to client interaction.

### Focus

This paper focuses on touch that is specifically related to non-procedural, or comforting, touch. It is represented by simple actions such as hugging, squeezing the arm, or holding of a hand.

Touch can be important to any vulnerable individual; however, much of the research in this area is focused on opposite ends of the life continuum: the elderly in nursing situations (Gleeson & Timmons, 2004; Weisberg & Haberman, 1989; McCann & McKenna, 1993; Routasolo, 1996) and sick children (Peterson et al, 2007; Vannorsdall, Dahlquist, Pendley, & Power, 2004; Lynch & Garrett, 2010; McKinney & Kempson, 2012; McNeil-Haber, 2004). The research above was primarily driven by the nursing profession rather than the social work profession, as the elderly, sick and young children frequent health facilities more than other populations. Furthermore, there are many different types of touch used both in and out medical treatment.

### Benefits of Touch

Touch is a fundamental form of communication and can be extremely beneficial to the recipient. Touching someone can help establish a relationship, communicate information, decrease anxiety levels, and increase compliance of a person. Many things can be shared through a simple touch including empathy, rapport, encouragement, caring, trust, affirmation, and interest (Davidhizer, 1991). Touch can also communicate calmness, Davidhizer (1991) expands on this by saying, “For patients under stress, touch is the most effective means of comforting and quieting a patient” (p. 15).

Research has shown that people are more likely to have success with a request if they incorporate touch into the request (Field, 2009). “People are more likely to give someone something if they are touched at the same time that the request is made... For example, when passengers touch a bus driver while requesting a free ride, they are more likely to get a free ride” (Field, 2009, p. 372). This compliance can be found in the medical realm as well. Based on research of older adults, “more healthful food including more protein was consumed following touch” (Field, 2009, p. 372).

In the nursing profession “it has been found that touching increases the patient’s attention, comfort, relaxation and verbal interaction, that it induces positive changes in their attitudes towards nurses and that it lengthens the duration of interaction” (Routasalo, 1996, p. 905). Another benefit of touch is it can lower anxiety. One research project studied anxiety in children undergoing lumbar punctures as part of their cancer treatment. The authors found non-essential touch by nurses before and during the procedures decreased the amount of anxiety the children experienced (Vannorsdall, Dahlquist, Pendley, & Power, 2004).

In another study, Moon & Cho examined the relationship between touch and anxiety in adult cataract surgery patients, which requires the patient to be awake during the procedure (2001). The authors sought to understand whether there was a difference in patients who had their hand held during the cataract surgical procedure versus those who did not. Of those having their hand held, 73.3 percent reported less anxiety. The hand-held group also had significantly lower epinephrine, norepinephrine and cortisol levels than the non-hand-holding control group, supporting the patient’s feelings of the decrease in stress levels

(Moon & Cho, 2001). The multitude of benefits demonstrated in research clearly show touch is a helpful element to social workers relating to clients.

### Concerns With Touch

Based on the studies researched, the most significant concern with using touch in social work practice was misinterpretation by the client, more specifically, misinterpretation of a sexual intent that could lead to a lawsuit. The potential for misinterpretation of a sexual intent is one reason that children and the elderly are the most touched of all populations, rather than adolescents and adults, as there is less concern regarding misinterpretation with these age groups (Davidhizer, 1991).

In social work, attention is paid to the verbal and non-verbal cues coming from clients during interactions with them; this attention must also be carefully applied when utilizing touch in the relationship. Adjustments to or elimination of touch should be determined by the observations made and feedback received from the client. Strozier, Krizek, & Sale (2003) performed an exploratory study of social workers’ use of touch within therapeutic practices and the results were surprising even to the researchers. According to their data, 95 percent of the respondents used touch within their practice in some manner. This included shaking hands, hugging, touching arms, or holding hands (Strozier et al., 2003, p. 54).

In the Strozier et al. study, the researchers also asked why those that did not use touch chose not to do so. As predicted, many mentioned concern over touch leading to legal issues and/or sexual feelings; however, most were primarily concerned that touch might feel threatening to the client (Strozier et al., 2003, p. 56). Other potential concerns included transference issues, touching to satisfy a need within the therapist, and concern over interrupting processing that the client may be doing. These therapists reported feeling that by avoiding touch, they establish firm boundaries between themselves and the client (Strozier et al., 2003, p. 56). The concerns listed above are genuine and should be considered with each interaction. However, with guidelines, it is possible to limit misinterpretation and provide the client with another type of intervention.

The Strozier et al. (2003) study also showed the lack of education received by social workers with respect to touch. Of those responding to the study, 82 percent of respondents stated they had no education about trust during the Master of Social Work (MSW) academic process, including in both coursework and supervisory experiences. With 95 percent of the respondents using touch and 82 percent of them with no training in how or why to use it, how did they learn the skills needed to make the appropriate meaning of their touch?

## Touch and Cultural Differences

Culture dramatically affects individual acceptance of touch; therefore, before using touch, a social worker must understand a client's cultural background in order to gain insight into his likely acceptance and appreciation of touch. In an often quoted study "Jourard recorded how frequently people in cafes of different countries touché each other in a period of 1 h[our]. In Puerto Rico, two people touched 180 times; in Paris, 110 times; in Florida, two times; and in London, zero times" (Morales, 1994, p. 465).

Cultures are generally divided into two groups, high contact and non-contact (Dibiase & Gunnoe, 2004). High contact cultures include "Middle Eastern, Latin American, and southern European ones" (Dibiase & Gunnoe, 2004, p. 52). These cultures touch more, stand closer during interactions, and more often greet others with hugs or kisses than non-contact cultures (Dibiase & Gunnoe, 2004). Non-contact cultures include "northern Europe, the United States, and Asia" (Dibiase & Gunnoe, 2004, p. 52). These cultures behave in ways directly in opposition to high contact cultures by standing farther apart and by using handshakes more often than hugs or kisses.

While cultural guidelines are helpful indicators of the response of a client, it is still imperative for the social worker to look at each client as an individual and understand he or she may not fit into cultural generalizations. This need to further understand should not, however, preclude the use of touch. Social workers should strive to understand each individual regardless of whether touch is to be employed, as that understanding is a vital component in every client interaction.

## How to Use Touch

Before adding touch to every day client interaction, it is important to understand the National Association of Social Workers (NASW) view on the subject of touching a client. Section 1.10 of the NASW Code of Ethics states:

Social Workers should not engage in physical contact with clients when there is a possibility of psychological harm to the client as a result of the contact (such as cradling or caressing clients). Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact (NASW, 2008, p. 21).

While the NASW Code of Ethics does provide some guidance, it is sufficiently vague to allow different interpretations. It is clear in a helping profession, such as social work, that adding to emotional difficulties when a client is already likely to be in a delicate state of mind or situation is not appropriate. However, no definition is given for culturally competent boundaries (National Association of Social Workers, 2008) nor is it clear how to set them. Before one can appropriately touch another person, context must be understood. Since touch can have so many meanings, it is important to understand the situation prompting the desire for touch.

Per Davidhizer, "Touch by a health professional is more likely to be interpreted positively and viewed as supportive in a situation of high anxiety" (1991, p. 16). Most medical procedures and hospitalizations are cause for high levels of stress for both the patient and their family; therefore, touch is more acceptable in that environment. During high stress periods, the social worker will want to convey a connection to the client and provide reassurance. A simple touch can serve this purpose.

Due to the meager research regarding touch in the social work realm, learning about appropriate touch is easier done when looking through the lens of the nursing profession. Routasolo (1996) used body intimacy zones to categorize unnecessary touches between nurses and patients in a long-term care facility. These zones, designed by Ebersole & Hess (1996, p. 906), are as follows:

1. Social Zone includes the hands, arms, shoulders and back. Generally, no requirement is needed to ask permission to touch a person in these areas. These areas are the least sensitive and embarrassing.
2. Consent Zone includes the mouth, wrists and feet.
3. Vulnerable Zone includes the face, neck, and front of body. These areas are sexually highly charged.
4. Intimate Zone is the genitalia. These areas cause stress and anxiety when touched without consent.

Using this framework as a guide, social workers should touch within the patient's Social Zone to help avoid misinterpretation. Touching in the Vulnerable Zone may be appropriate in certain situations, but the social worker must use his/her best judgment to decide what is proper. Regardless of where the touch occurs, it is important that the professional does not use a touch that lingers as it could be interpreted as sexual in nature in the American culture (Davidhizer, 1991).

Dealing with clients who have been abused, either physically or sexually, adds more demand for mindfulness when employing touch. Some may eschew touching entirely as it could produce anxiety. However, the McNeil-Haber (2004) study has shown that adults with sexual problems or a sexual assault history can find touch "significantly more positive than those who endorsed other concerns" (McNeil-Haber, 2004, p. 134). One reason for this finding could be that the patient finds the touch has "greater restorative impact" than a patient without negative sexual histories (McNeil-Haber, 2004, p. 134).

More research is needed in regard to working with clients that are survivors of abuse; all clients are susceptible to projection but this population may be particularly so. Research that explores the use of appropriate comforting touch in the therapeutic relationship may find that touch proves to be a valuable asset in counseling survivors of abuse or violent touch. Because of significant differences in reactions, social workers must use judgment when using touch with members of this population.

Davidhizer (1991, pp. 16-17) puts forth three guidelines for nurses to use relative to touch which social workers can use as well.

1. Be alert of patients' attitude and values toward touch...The following questions can assist the nurse in evaluating the patient's potential reaction to touch:

- a. Does the patient provide nonverbal clues that more personal space is desired?
- b. Does the patient provide nonverbal or verbal clues of loneliness and the desire to feel close to someone?
- c. Will touch help the patient feel my concern and enable expression of feelings?
- d. Is this patient likely to be comfortable with touch?
- e. If I touch the patient will it be therapeutic?

2. Modify approach to meet patient needs...For many people the need for intimacy and support is so strong that the satisfaction of that need may be greater than the fears about touch being inappropriate. A momentary and yet sensitive touch may establish a bond between nurse and patient that allows the patient to tolerate discomfort, to become more compliant, to feel less anxious. Holding the hand of a dying patient can convey warmth, strength, and empathy.

3. Respect personal differences in use of touch. All cultural groups have rules about who touches who, when and where. The nurse needs to be cognizant of these cultural rules but also of differences that may exist between individuals in these cultural groups. It is essential for the nurse to communicate respect for the patient even though attitudes and values may differ. A nurse who is not touch oriented may find when touch is part of another's personality, personal preferences may be laid aside. This tolerance allows the other person freedom of expression. An unexpected effect is that the nurse may find touch enjoyable.

## Conclusion

Simple touching is an effective method of communication with significant mental and physical benefits to clients. There is a need for research that is designed and executed from the social worker's perspective to understand better how it can most effectively be integrated within a practice in any environment. It is also critical for all Bachelor and Master level social work

programs to teach the art and skill of compassionate touch. Most social workers using it in practice today are doing so using instinct rather than prior professional guidance. While instinct is important, guidelines are necessary to establish a positive and acceptable way to implement this valuable treatment. Research into the benefits of touch, as well as the establishment of appropriate guidelines for including touch in social work treatment, will assure that this valuable modality is available for those that will benefit most from it.

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**FIRST SUPERVISION SESSION AND SLSPQ**

**The Importance of Utilizing a Supervisee's Learning Style and Preferences  
Questionnaire (SLSPQ) during the First Supervision Session as the Foundation of  
the Supervision Alliance**

**Kathryn Krzykala**

**Abstract**

*Many clinicians wonder what would happen if a supervisor knew how to help the supervisee learn, grow professionally, provide administrative functions and, at the same time, offer guidance and emotional support while explaining ethics and values. Literature shows that supportive supervision should provide three functions: administrative, educational and emotional. This article proposes an interactive model developed to specifically address the needs of effective supervision: the Supervisee's Learning Style and Preferences Questionnaire (SLSPQ). It discusses the importance of using the SLSPQ in order to fulfill the three functions of supervision, as well as to establish a supportive supervision alliance. Suggestions for a valuable conversation using ten questions and one contract between a supervisor and supervisee as an opening to a more in-depth learning experience are offered in this article.*

**Keywords:** Supervision, social work

**Introduction**

Most health professionals and students consider supervision to be life changing, professionally transforming and emotionally supportive. Unfortunately, not all health professionals know how to define, offer and perform effective supervision. Clinicians who seek personal and professional growth and development often ask the following questions: How important is clinical supervision in the social work environment? Is it effective and transformational to know what to expect from supervision? What would happen if a supervisor knew how to help the supervisee to learn, grow

professionally, provide administrative functions and at the same time offer guidance and emotional support while explaining ethics and values? If all of that would be emphasized at every work environment, then professionals would make fewer mistakes, be more prepared to take on challenges and know how to resolve problems in order to be most effective with their clients. Kadushin and Harkness (2002) stated that in the past, supervision was viewed as a supplementary educational resource. Presently, literature shows that supportive supervision has three functions: administrative (good standard of work), educational (development of each worker), and emotional support (address feelings and emotions) to increase job satisfaction. If professionals who claim to know how to do supervision were familiar with those three functions, then complications and obscurities resolving from unclear expectations would be significantly decreased.

Unfortunately supervision is considered a luxury in many situations. For some agencies, it is too expensive and not seen as a benefit to offer appropriate supervision including the administrative, educational and supportive functions emphasized by Kadushin and Harkness (2002). According to Nerdentoft (2008), some individuals critique clinical supervision and disapprove of it because, in their opinion, supervision is nothing but an 'emotional outlet' in which people talk about and get relief from the emotional tension at work. The same source argued that professionals have a great need to talk about job-related thoughts and feelings in addition to receiving support and reassurance after experiencing emotionally demanding situations. Nerdentoft (2008) stated that understanding various emotions in health-related fields can be very important. In her opinion,

emotions are often articulated and negotiated in interactions; however, they are not controlled and let out under specific circumstances. Awareness of many different emotions and their functions is crucially helpful in a work environment. Consequently, with that explanation of emotions, social workers should protect the emotional function of supervision. Without knowing how to work with emotions, clinicians would lack the ability to work with clients' emotional states and their feelings. Moreover, talking about emotions in supervision can provide a great opportunity to mention ethics and what is appropriate and what is not with clients.

Supervision's educational function plays an essential role in professional development throughout the counselors' career (Schultz, Ososkie, Fried, Nelson & Bardos, 2002). The same source argued that, although the educational function of supervision was identified as a central activity and an essential method in the training of new counselors, it was largely neglected and ignored in rehabilitation counseling. Furthermore, educational clinical supervision should focus on counselors' development which includes: increasing competence, noticing continuous improvement, establishing expectations and accountability, and working towards goals attainment. Also, giving information and directive techniques should be emphasized (Schult et al., 2002). This study reported that supervisors should engage in regularly scheduled, proactive supervisory activities in order to fulfill the educational function of supervision (Schult et al., 2002).

Finally, the administrative function, which focuses on operations and enforcing the policies, was considered to be the most important task of supervision. Currently, this function is very important and it gives the supervisor the opportunity to talk about values and ethics as well as roles of the supervisee and supervisor in the particular setting. Professionals should have a clear understanding of what is expected from them and what are the agency rules, values and regulations. Without a detailed description, the supervisor and the supervisee can make mistakes resulting in legal actions or termination of employment.

The establishment of the supervisory alliance is a helpful tool whether the supervisory role is willingly assumed or forcefully thrust upon a clinician. The supportive relationship between supervisors and supervisees creates a

foundation for a successful, effective work alliance. Kadushin and Harkness (2002) argued that the first impression in supervision can have positive or negative effects by assuming that a supervisee is either a good fit or not well-fitted for a certain job. Perhaps, the 'halo effect' can result in strong a first impression. Kadushin and Harkness (2002) described the 'halo effect' as a human error that occurs when a supervisor thinks of the supervisee only positively because of a positive first impression. On the contrary, a supervisor can see the supervisee only negatively because of something negative that happened during their first meeting. To eliminate the halo effect, a supervisor can use a questionnaire called the Supervisee's Learning Style and Preferences Questionnaire (SLSPQ). This questionnaire is developed by the author of this paper and described below.

### **Supervisee's Learning Style and Preferences Questionnaire**

This tool should be given by the supervisor to the supervisee to reflect on before their first meeting. The questionnaire will include ten questions and one item. The questions will focus on the supervisee's learning style and preferences and the item will help develop a contract between the supervisor and supervisee. This tool will allow the supervisor and supervisee to develop the best way to enforce the three functions of supervision as well as establish a supportive supervision alliance. The SLSPQ will include the following items:

1. What do you understand by the term supervision, its functions, and theories?
2. How different is supervision from therapy?
3. What do you know about vicarious liability?
4. What do you think about being honest during supervision?
5. How do you feel about silence?
6. Would you say that you are more of an introverted or extraverted type in relations with other people?
7. In what ways do you think you learn the most? E.g. observations, role playing, discussing, reading, receiving feedback, video recording, audio recording, process recordings.



8. How do you feel about receiving feedback or constructive criticism during supervision?
9. Would you consider yourself more a dependent learner or independent learner and why?
10. What qualities should I have to promote and allow you to maximize your learning experience? E.g. patience, understanding, gentle way of giving positive and negative feedback, challenging and caring, approachability, willingness to share information, empathy, openness to supervisee's point of view and orientation, clear explanation of expectations.
11. Contract

This questionnaire will offer an opportunity to have a discussion with care, respect and professionalism. Supervisor and supervisee will be able to engage in a valuable conversation and every question will serve as a beginning to a more in-depth learning discussion.

The following will describe the reasons for choosing these particular questions:

### ***What do you understand by the term supervision, its functions and theories?***

The first question will invite the supervisee to either share his/her knowledge and/or experience about supervision by explaining the definition and purpose of that supportive service. This question will inform the supervisor of gaps and lack of knowledge that need to be discussed before the supervisory relationship develops. There are many ways to define the term supervision. According to Schultz et al. (2002), supervision is an intervention provided to a junior member of the same profession in order to enhance the professional functioning of that member, monitor his/her work with clients and serve as a gatekeeper for those who are to enter that particular profession. The same source also argues that supervisory practices should be based on theories and models. The supervision includes structure, phases and contracts (Schultz, et al., 2002). The structure is best understood in terms of power and involvement. A phase can be understood by establishing a working alliance (goals, direction and emotional bonds) and

accomplishing work through the supervisory process. The contract will be discussed later.

### ***How different is supervision from therapy?***

The second question assists in emphasizing the importance of knowing that supervision is not therapy. Marrow and Tatum (1994) simply summarized supervision as work focusing on support, growth, instructions and reflections which are what can be seen in therapy. Many people mistakenly think of supervision as therapy and, not wrongly so, many years ago therapists would supervise by applying therapeutic theories. Professionals would ask their therapist supervisory questions that blurred the fine line of difference between a supervisor and a therapist. With that in mind, the second question would clarify that misunderstanding. The biggest difference between therapy and supervision is understanding that supervision is teaching and therapy is treating (Kadushin & Harkness, 2002). The goal of supervision is to change professional identity while therapy changes personal identity. The supervisor should know that difference in asking the supervisee the following questions: "How can I help you?" which is asked in therapy and "How can I help you do your work?" which is asked in supervision (Kadushin & Harkness, 2002). It can be very comforting to know the difference between therapy and supervision in order to eliminate the supervisee's anxiety and unnecessary worry that something is personally wrong with him/her if the supervisor is correcting his/her behavior.

### ***What do you know about vicarious liability?***

The third question invites the supervisor to explain to the supervisee the importance of vicarious liability. The National Association of Social Workers (NASW) makes it clear that the supervisor is automatically responsible for the work that is assigned and delegated to the supervisee (Kadushin & Harkness, 2002). Moreover, the supervisor is responsible for the decisions and actions of the supervisee. Discussing the answer to this question could illuminate the importance of the supervisee's honest disclosure with the supervisor in order to resolve issues before any legal actions might have to be taken. Knowing that the supervisee is not alone and that he/she has a responsibility to

share everything about his/her work with his/her supervisor in seeking any support in a critical situation may put the supervisee at ease.

***What do you think about being honest during supervision?***

After discussing the third question, the fourth question regarding honesty is appropriate. The process of supervision relies upon counselors being able to disclose everything and anything which relates to the relationships with their clients (Webb & Wheeler, 1998). In order to have an honest relationship in supervision, a strong supervision alliance has to be developed. A strong supervisory working alliance predicts a lesser sense of role conflict in supervisees. Unfortunately, if a working alliance is not established, then discomfort, conflict and fear develop. If a supervisor's approach does not resonate with a supervisee's needs, then it is hard to expect honesty (Webb & Wheeler, 1998). Webb and Wheeler's (1998) study reported two dimensions related to perceived risk to self as a consequence of disclosure. One of them referred to fears of negative assessment of abilities, being thought of badly, of being disliked, of revealing personal vulnerability in a sensitive area or feelings of shame. The second dimension related to expectations of conflicting with the supervisor and, in particular, of a personality clash or of the supervisor recommending an approach to the client felt by the supervisee to be inappropriate. The disclosures of sexual attraction to a client, sensitive issues and countertransference can be brought up during the discussion to determine the level of the supervisee's comfort and competence in an uncomfortable situation. The fourth question can be discussed either in great detail or in general. However, avoidance of this topic can result in either the supervisee's discomfort in talking about personal or culturally-prohibited issues, such as touching the client, or in staying away from discussing the important feelings one can develop during sessions with clients.

***How do you feel about silence?***

The fifth question refers to silence in supervision. Using silence can be another helpful skill when using, perhaps, solution-focused questions (Knight, 2008). Silence provides time for clients and supervisees to process information and to think about what has been

asked of them. According to Knight (2008), silence is often threatening to clinicians and supervisors. Supervisors should assist the supervisees in becoming comfortable with silence and developing an appreciation for how it can be used to gather more useful information. New counselors often think that if they allow silence, then that would reflect on their lack of knowledge on what to say. However, if supervisors discuss the role of silence and practice it during supervision, then this can be a learning experience for the supervisee.

***Would you say that you are more of an introverted or extraverted type in relations with other people?***

The sixth questions can be refreshing during the first session and it can let the supervisee talk about his/her relations with others. The balance between how much to allow the supervisee to talk about his/her relationships should be controlled by the supervisor. Knowing if the supervisee is an introvert or extravert can be extremely important in helping the supervisee to be as effective as possible in the work environment. According to Myers Briggs (1985), the introverted type needs time, quiet and space for internal processing, while the extraverted type learns by talking things out and interacting with others. Knowing how people learn can facilitate taking different approaches instead of getting angry or disappointed in professional relationships. Understanding the uniqueness of individuals' personalities and learned behaviors can help change ways of thinking, learn new ways of thinking and appreciate differences. It is noteworthy to mention that adults learn most effectively, especially when approaching new or difficult topics, when they are given a variety of opportunities to use their most effective learning style (Myers & McCaulley, 1985).

***In what ways do you think you learn the most? E.g. observations, role playing, discussing, reading, receiving feedback, video recording, audio recording, process recordings.***

The seventh question can broaden the above discussion. Learning the supervisee's preferences of many different learning styles can add to how supervisors should plan and what should be used so the supervision time can be worthwhile. According to Marrow and Tatum

(1994), the information obtained from direct observation provides a richer picture of practice. Discussing the learning style and agreeing to what would be the most preferable style for the supervisee can be mentioned in the contract. Role playing or modeling certain styles might be a good practice for the supervisee.

***How do you feel about receiving feedback or constructive criticism during supervision?***

Most would agree that receiving feedback is very important in order to learn or unlearn techniques and dynamics. The eighth question invites a discussion of the most difficult part of receiving or giving feedback which is hearing the negatives versus the positives about the way someone does his/her job. This can be defined by understanding that what we do does not define who we are. Certainly having a discussion about feedback or constrictive criticism may ease this process. It can transform the idea that some people are wrong into the idea that these people are not wrong, but rather that they did something that needs modification.

Enyedy, Arcinue, Puri, Carter, Goodyear and Getzeman (2003) reported five points to use in supervision regarding feedback. They include the following points. In early group sessions, positive feedback exchange should be emphasized. However, during the middle and later sessions, encouraging a balance of positive and corrective feedback should be the focus. Moreover, positive feedback should accompany corrective feedback and feedback messages should cite specific and observable behaviors. Furthermore, when giving corrective feedback, be sensitive to the readiness and openness of the recipient. In addition, during group supervision, group leaders should model feedback-giving while encouraging other members to actively engage in thoughtful feedback exchange (Enyedy et al., 2003). Likewise, the supervisee should be allowed to give feedback to his/her supervisor. Although it may be difficult to provide honest and direct feedback to a supervisor when there are problems, this feedback is an important component of the success of the supervision experience (Enyedy et al., 2003)

***Would you consider yourself more as a dependent learner or independent learner and why?***

The ninth question refers to dependence and independence as learning issues. In the United States culture, dependence and independence serve as central organizers for our models of development. Independence, autonomy and self-sufficiency are assigned to a mature and healthy person. On the contrary, dependence is negatively valued and linked with immaturity. In general, dependence is considered a problem and a failure of development and is linked with shame and fear. Independence is welcomed with pleasure rather than questioned or challenged. An independent person is considered to be highly competent, impressive, able to take responsibility, autonomous and pleasing to overburdened supervisors. The dependent supervisee relies too much for too long on the supervisor for guidance, instructions, clarifying agency procedures, support, contact and reassurance of what indeed might be an issue (Nye, 2007).

However, there are positive sides to a dependent supervisee and negative sides to an independent one that can be profoundly beneficial in supervision. According to Nye (2007), some supervisors raise a concern about the supervisees' independence and autonomy as a learning issue. The reasons for it include the concerns with the independent supervisee being the 'know it all.' In addition, the supervisor has nothing to offer them and they cannot often reach them. These supervisees want to discuss solutions not problems and answers not questions. Supervisors feel useless in the learning process and that is why they consider the independent type of personality problematic. Therefore, knowing if the supervisees consider themselves independent or dependent can be beneficial. Even though their answer can follow what is culturally and socially expected, explaining the positive and negative of both types might function as a learning opportunity.

***What qualities should I have to promote and maximize your learning experience? E.g. patience, understanding, gentle way of giving positive and negative feedback, challenging and caring, approachability, willingness to share information, empathy, openness to student's point of view and orientation, clear explanation of expectations.***

There are many variables that make a supervisor either great or average. The tenth question provokes the idea that supervisor's qualities such as care, concern and years of experience are more important in establishing a safe environment than supervisor-supervisee gender equivalence (Jordan, 2008). Some professionals express an idea that gender influences outcomes of learning during supervision. Consequently, some female supervisees might feel more understood by a supervisor of the same gender. In addition, male supervisees might feel disparity when supervised by women. These gender biases are present in our culture in spite of the fact that many individuals try to avoid them. Nevertheless, as educated professionals, supervisees might prevent stereotyping and might be open to challenge their beliefs about gender effectiveness in supervision.

When a supervisor asks a supervisee what supervisor qualities would benefit him/her the most in supervision, then that shows care, concern and confidence. Using questions such as, "How can I help you do your work?," which was mentioned earlier, demonstrates experience and accountability of the supervisor. Jordan's (2008) study suggested that the beginning supervisee, in order to take risks and develop, must feel that his/her supervisor possesses care, concern and supervisory and clinical experience. In addition, in the early developmental process, supervisees feel anxious and insecure about their own abilities and, at that time, supervisors have a responsibility to support through care and concern and provide guidance and direction based on experience (Jordan, 2008). This study reported that although many supervisees prefer to work with supervisors who are the same gender as they are, the gender match seemed less important in establishing a safe learning environment in which inexperienced supervisees grow and develop.

### ***Contract***

The eleventh item on the SLSPQ is the contract between the supervisor and the supervisee. It should be developed and signed by both parties at the first session. Its purpose is to clarify expectations, needs, and set up content and relational parameters. The contract establishes rules, norms, commitment and negotiates specific tasks (Schultz et al., 2002). It should include the following sections: start and

end date, supervision time and day, lunch, directives on how to handle crisis situations and the most preferred means of contact between the parties. Having a clear understanding of what is expected as well as knowing agency rules helps evaluate the supervisee in the areas of corrective and rewarding activities as well as enhances the working alliance. At the same time, the supervisee has a chance to evaluate the supervisor based on what was promised by him/her and take appropriate actions to enforce the contract or use the grievance provision. Moreover, the supervisor is responsible for informing supervisees about what will and will not be disclosed to other staff or faculty at the training site, to their graduate school, and to other supervisees – confidentiality should be thought of and modeled (Enyedy et al., 2003).

### **Conclusion**

Indeed, supervision has three functions: administration, education and support. However, finding out how these functions should be facilitated in order to have a meaningful supervisory relationship could highly benefit both parties. In many situations, supervisees are not familiar before they start their work with who will supervise them during their learning experience. Consequently, the first session sets a tone for the following meetings as well as it helps build a foundation for the future interactions in supervision.

Using the Supervisee's Learning Style and Preferences Questionnaire (SLSPQ) at the first session can be very helpful and discussion-provoking. The SLSPQ is not a perfect tool and it can be modified to fit any first session. However, not using a tool in the first session to develop a supportive, quality supervisor - supervisee dyadic relationship can result in an unsuccessful and unproductive learning experience for both parties. The supervisors who show that they care about the supervisee and are curious about his/her growth and development in fact validate the trainee. This validation might contribute to a positive result from the supportive supervisory alliance, as well as client satisfaction with the services which is the ultimate goal of social work practice. Therefore, receiving effective supervision is essential in the learning process for students and in the ongoing work environment for licensed clinicians.

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**Kathryn Krzykala** is graduating from the Master of Social Work program at Loyola University Chicago in December 2013. She was very fortunate to have an opportunity to intern at Sarah's Inn, a domestic violence agency that works to break the cycle of domestic violence, and at Rainbow Hospice Palliative Care agency. Throughout the program, Kathryn has found her passion to work with hospice patients and to specialize in grief, bereavement and loss therapy as well as supervision. Kathryn is the founder of KSR (Klub Solo Rodzica), a support group for single parents which has served the Polish community for nearly ten years. Kathryn would like to thank her professors whose devotion, care, skills and talents had a remarkable impact on her personal and professional growth.

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## MASCULINITY ADHD AND OUR MASS EDUCATION SYSTEM

## Self-Control and Vulnerability: Masculinity, Attention-Deficit/Hyperactivity Disorder, and our Mass Public Education System

Jeremy D. Lynch

### Abstract

*Attention-deficit/hyperactivity disorder (ADHD) is arguably the most commonly diagnosed childhood psychiatric disorder (Sing, 2008; Polanczyk, 2007). Three out of every four children diagnosed with ADHD are male (Schneider & Eisenberg, 2006, p. e604), and most children are first diagnosed when they begin attending school (Singh, 2008, p. 957). Using social constructionism, in this paper I examine the social and historical context that forged masculinity and forged our model of schooling, as we understand it today in order to account for the diagnostic gender disparity and contemporary practice of diagnosing and treating ADHD. Key components of masculinity, such as self-control, valuing rationality over emotionality, and not showing vulnerability, became known as masculine traits as a response to the Industrial Revolution as it grew through the 19<sup>th</sup> century. Our current model of public education was also designed in the likeness of industry and to meet its demands at this time (Robinson, 2011, p. 57). However, the notions of masculinity intended to prepare men for industrial life in the public sphere severely limits how boys are culturally sanctioned to deal with feelings of vulnerability. Because of this, it places them into what William Pollack (1998) describes as a “gender straitjacket” (p. xxiv) where the diagnosis of ADHD can constitute another strap and buckle. I argue that our current model of education can exacerbate feelings of self-disavowal and restriction in boys by valuing standardization, certainty, and disincentivizing risk-taking. In this way, school continues the self-disavowal that masculine gender norms create while such norms give boys a limited number of means with which to cope with feelings of vulnerability. These cultural constraints can cause boys to act out feelings of*

*sadness and depression in ways that may look like symptoms of ADHD (Brownhill et al., 2005; Pollack, 1998).*

**Keywords:** Masculinity, ADHD, Public Education

### Introduction

Attention-deficit/hyperactivity disorder (ADHD), as defined by the American Psychiatric Association (APA), is “one of the most common childhood psychiatric disorders in the world,” (Singh, 2008, p. 957) and, according to some studies, is actually *the* most common childhood psychiatric disorder in the world (Polanczyk et al., 2007, p. 942). It is also one of the most disparate in terms of diagnosis by gender. Of children diagnosed with ADHD, roughly three out of every four are male (Schneider & Eisenberg, 2006, p. e604). The majority (52.4%) of these children are first diagnosed when they are old enough to begin attending school and teachers recommend the diagnosis (Schneider & Eisenberg, 2006, p. 602). Such figures leave us with these questions: Why is this such a prevalent diagnosis? Why are boys diagnosed at a much higher rate than girls? Why are school-aged children primarily the ones diagnosed?

If one tries to seek answers to these questions using the theoretical frame with which the APA’s *Diagnostic and Statistic Manual of Mental Disorders* (DSM) is founded—the medical model—one ends up limiting the scope of analysis to the individual and, in so doing, precludes finding answers that may exist in examining the socio-historical context in which ADHD has been derived and is diagnosed. The medical model assumes that pathology is located within an individual and that the pathology is something that clinicians are merely discovering independent of the clinician’s and individuals

cultural context— similar to an archeologist uncovering a fossil already existing in nature or a doctor discovering the specific germ causing a disease.<sup>1</sup> Although the DSM does not discuss treatment, this model also assumes that the primary locus of treatment for patients' internal mental disorders is at the level of the patients themselves. Such assumptions often preclude clinicians from examining the cultural context in which both they and their patients exist that may also be framing what they come to define as pathological.

By using social constructionism to examine the social and historical conditions in which current notions of masculinity and public school systems have arose, we can come up with viable answers as to why so many school-aged boys are being diagnosed with ADHD. There are many institutions and pressures that have forged ADHD and lead to its diagnosis. For example, behavior associated with ADHD in one culture may be associated with conduct disorder in another or may be associated with heroism in the same country at a different time period (Singh, 2011). Additionally, cultural expectations of what it means to be a good parent can also lead to an ADHD diagnosis. The diagnosis can relive parenting guilt by allowing a parent to feel their child's behavior is related to a disease and not their parenting (Singh, 2002, 2005). The pharmaceutical industry also influences ADHD treatment. For example, some pharmaceutical companies have affected dosing for ADHD by developing 'one-pill-a-day' solutions that help ease parents' anxieties and fears of judgment by eliminating the need for others to medicate their children while they are in school (Singh, 2005).

Though there are many institutions and pressures that have forged ADHD and lead to its diagnosis as mentioned above, this paper focuses on the social and historical conditions that gave rise to key traits of masculinity as we understand it today, discusses how those traits are used in conceptualizing ADHD, and examines how our current model of schooling, which was also forged under the same conditions as these key masculine traits, exacerbates the sense of true-self-denial boys are suffering today. Boys who

experience a denial to their sense of true self, but are only socially sanctioned to express feelings of vulnerability in 'masculine' ways, may be more likely to express those feelings in ways that appear like ADHD behaviors.

### ***ADHD, Self-Control, and Masculinity***

According to the DSM fifth edition (DSM V), there are five criteria that need to be met for a diagnosis of attention deficit/hyperactivity disorder (ADHD). The first criterion and most essential feature in ADHD "is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development as characterized by (1) [inattention] and/or (2) [hyperactivity and impulsivity]" (APA, 2013, p. 59). In addition to exhibiting six or more symptoms of inattention or six or more symptoms of hyperactivity-impulsivity consistently for six or more months, several of these symptoms causing impairment had to have been present before age twelve (Criterion B). Several symptoms of inattention or hyperactive-impulsivity must be present in two or more settings (e.g. at home and at school or work) (Criterion C). There must be clear evidence that these symptoms interfere with or reduce the quality of "social, academic, or occupational functioning" (Criterion D) (APA, 2013, p. 60). The final criterion is that the symptoms are not better accounted for by another mental disorder, nor do they appear exclusively "during the course of schizophrenia, or other psychotic disorder" (Criterion E) (APA, 2013, p. 60). Depending on their symptoms, clients can be diagnosed as having one of three subtypes: predominately inattentive, predominately hyperactive-impulsive, or combined. Perhaps as interesting, if not more so, is how ADHD is conceptualized and described by researchers, clinicians, and families.

Many articles and books point to the fact that ADHD is often seen and described as a disorder of self-control and self-regulation. Perhaps most notably are the various articles and books by Russell A. Barkley. For example, Barkley (1997), describes the nature of ADHD and warns that children whose "impulse control and self-regulation lag far behind expectations for their developmental level" will not be able to meet demands for healthy adaptation to their environment such as "the need to become more personally organized and self-sufficient," (pp. 1-2). In literature about ADHD and the brain, self-

<sup>1</sup> The DSM V (APA, 2013) addresses culture in a section called Cultural Formulation but this is described as something to aid clinicians in evaluating the impact of patients' cultural contexts on their mental disorders and not as a tool to help clinicians to evaluate their own cultural context and its role in diagnosing and defining such mental disorders (p. 14 & p. 749).

regulation is often coded as executive functioning. Barkley (2000), for example, describes how “many authors have recognized the substantial overlap or interchangeability between EF [executive functioning] and self-regulation” (p. 1065). Researcher Iina Singh (2011) notes how ADHD is often used to diagnose children who have difficulty with behavioral self-control (p. 889).

Conceiving the symptoms associated with ADHD as a disorder of self-control is nothing new. Around the turn of the 20<sup>th</sup> century, English physician George Still “provided what is considered the first modern description of the constellation of symptoms associated with what is now referred to as ADHD” (Neufeld & Foy, 2006, p. 453). Still described child patients of his as having “deficits in what he described as ‘inhibitory volition’ or ‘a morbid defect of moral control’ over their own behaviour” (Neufeld & Foy, 2006, p. 453).

Using social constructionism, particularly gender studies and the history of masculinity, we can see how we may be diagnosing boys with an antiquated notion of masculinity. Social constructionism posits that there is no objective truth but, rather, what we come to know in the world as true is socially constructed and mediated by people via language, culture, and society in general (Allen, 1993). Within this paradigm, masculinity studies examine “the social and cultural constructions of gender and masculinity used to support or seek power” (Carroll, 2003, p. 2). Self-control and “moderating one’s passions” have actually been obsessions, particularly around boys and men since before the turn of the 19<sup>th</sup> century; however, regulating and channeling those passions became a more important trait associated with masculinity around the Industrial Revolution (Rotundo, 1993, pp.1-3; Carroll, 2003, pp. 1-4). Around the turn of the 19<sup>th</sup> century, American men began conceptualizing the emerging capitalist economic system as masculine and defining themselves as having the traits necessary to thrive in such a system:

In defining white men alone as possessed of the qualities of self-control, rationality, competitiveness, and ambition necessary to succeed, and thus naturally suited to the amoral roughness of the marketplace, Americans effectively defined the public world of economic exchange as a masculine sphere of activity, and

financial success was thus seen as a masculine achievement. (Carroll, 2003, p. 3)

This new environment reinforced “the premium on male self control” due to its prizing of “orderliness, time-consciousness, industriousness, and restraint, and the unprecedented situations that many men encountered in their new urban environments” (Carroll, 2003, p. 411).

This emerging culture of masculinity and self-control also developed to “discourag[e] males from expressing emotions associated with tenderness and vulnerability” (Carroll, 2003, p. 413). This developed as a result of middle-class men’s anxiety over becoming “over-civilized” and not as physically tough as they were in more agrarian days (Carroll, 2003, p. 3). Interestingly, as late as 1845, men were much more free to express tender feelings towards women and towards each other (Carroll 2003, p. 413). Men would often address letters to each other as “Dearly Beloved” or “Lovely Boy” and could be seen, on occasion, holding hands or “casually reclining against each other” (Carroll, 2003, p. 413). Since the takeoff of the American Industrial Revolution, these feelings of sensitivity were relegated as being feminine in large part as a rhetorical move to keep women out of the workforce and at home raising children (Carroll, 2003, p. 413).

The non-vulnerable, self-controlled man is still a masculine cultural ideal today and it is causing many emotional and psychological problems for boys in today’s society (Pollack, 1998). Pollack (1998, 2000) describes the features of contemporary masculinity that put boys in what he calls a “gender straitjacket” (Pollack, 1998, p. xxiv). Pollack (1998) explains by placing a boy in this gender straitjacket, “society is limiting his emotional range and his ability to think and behave as freely and openly as he could, to succeed in the ever-changing world in which we live,” (p. xxiv). Throughout his books, there are first-hand accounts from boys who feel harmed by the gender role imposed on them. A typical account is summed up by Scotty, a 13-year-old-boy from a small town in northern New England who is quoted as saying that “boys are supposed to shut up and take it, to keep it all in. It’s harder for them to release or vent without feeling girly. And that can drive them to shoot themselves” (Pollack,



2000, p. xix). Boys are not culturally sanctioned to feel vulnerable or out of control.

The masculine ideals of self-control and invulnerability isolate boys from others and from themselves. Brown (2010, 2012) describes how being able to negotiate vulnerability helps people lead more authentic and deeply meaningful lives (2010, 2012, p. 145). People's ability to be vulnerable allows them to make connections with others and to be able to explore and foster the most deeply meaningful things within themselves without shame and thus develop a more authentic sense of self. Being able to successfully negotiate vulnerability helps make them feel worthy and vice-versa. However, if people cut themselves off from being able to be vulnerable and engage in acts that may not have a guaranteed outcome, Brown (2010, 2012) explains that they end up in a vicious cycle of numbing themselves to their own feelings, trying to make the uncertain things in their lives certain, and pretending that they do not have an effect on others (2012, p. 137). All of these limitations, Brown (2010, 2012) explains, leave people deeply dissatisfied and disconnected and inevitably lead to feelings of vulnerability and shame, which begin the cycle all over again (2010, 2012, p. 58). This is akin to the personal trauma inflicted on boys by our cultural ideal of masculinity.

Not being culturally sanctioned to show feelings of sadness or vulnerability, boys are more likely to find expressions that are more culturally sanctioned along the lines of masculinity, which may lead to behavior that is more susceptible to the diagnosis of ADHD. Pollack (2000) discusses how "sad boys" can appear as "bad boys" (p. 147). Since boys are often ostracized as being "a baby," "wimp," or "gay" for showing feelings of sadness, they often externalize those feelings and express them by acting out often in the form of anger and aggression (Pollack, 2000, p. 142). As Xavier, a 17-year-old-boy from a suburb in the Northeastern United States, explains, "Depression and anger are such close cousins. Anger is just depression pointed outward. And depression is anger pointed inward" (Pollack, 2000, p. 142). However— and this is likely one of the reasons such male gender norms are described as a straitjacket —while being somewhat safer from being shamed and ridiculed by acting out instead of acting sad, acting out at all is still at odds with the masculine ideal of self-control. As a result, boys who may be trying

to cope with their inability to negotiate vulnerability, isolation, and disconnection with themselves by acting out may be more likely to be diagnosed with ADHD for breaking the masculine norm of self-control. This can be explained in part because children who externalize problem behaviors have been found to have greater impulsivity and less attention-control than control groups or children who just internalize problem behaviors (Eisenberg et al., 2005, p. 207).

In an industrial and masculine school system school-aged boys are particularly susceptible to ADHD diagnoses as a result of compounding issues they have with a mass educational system that was also designed during the same socio-historical era as some of the defining features of contemporary American masculinity—the 19<sup>th</sup> century rise of American industrialization and capitalism. The mass public education system as we know it today was designed on a model that reflected and sought to meet the needs of industrialization. It was itself designed along a factory model with separate facilities, separate subjects, students batched by age group, and bells that signaled to change classes (Robinson, 2006; Robinson, 2010; Robinson 2011, p. 57). It sought to meet the needs of industry by valuing science, math, and language over the humanities and the arts (Robinson, 2010; Robinson, 2011, p. 57). It valued linearity, conformity, and certainty and continues to have an emphasis on standardized learning (Robinson, 2006; Robinson, 2011, p. 57). This system skews learning towards a model that discourages divergent and multiple answers to questions versus a model that values only one correct answer. The grading system also creates disincentives to students taking risks, rewards students for getting answers correct the first time, and penalizes students if they do not get answers correct the first time (Bain, 2004). Those who try and venture a guess or a creative answer run the risk of getting a bad grade, which incentivizes students to stick to what they are good at and not necessarily what is meaningful for them, particularly if it is something not valued in this educational model.

Although other educational models exist, they are not in the majority. These alternative models exist and are able to exist in places where funding sources and regulations allow them relative autonomy from the mass standardization requirements of policies like "No Child Left Behind," which ties school funding to

student performance on standardized tests (Moses & Nanna, 2007). Public schools and, to a certain extent, public charter schools, rely on federal funding and thus must conform to the more standardized education model. In the 2007-2008 school year, of the 119,150 schools in the United States, 87,190 (73%) were traditional public schools, 3,560 (3%) were public charter schools, and 24% were private schools (United States Department of Education, 2009). This leaves less than a quarter of the schools in the country with enough means to stray from the standard mass public education model.

The problem becomes compounded when boys encounter a school system based on this educational model after they already struggle outside of school negotiating feelings of vulnerability and isolation from the things that may be deeply meaningful to them. In this way, boys may be pre-disposed to have difficulty coping with many of the vulnerabilities that come with entering public school as well as the further individual disavowal that can occur in this system. Robinson (2010, 2011) warns that the industrial model of education steeped in standardization and certainty does not allow room for students to be able to explore what is deeply meaningful to them (Robinson, 2011, p. 61). This model is based upon a narrow definition of ability and talent that can leave many feeling as if they do not have an ability or talent for anything (Robinson, 2006; Robinson, 2010). Boys who are already bringing a sense of rejection to school may experience a compounding issue when they are again taught that what is deeply meaningful to them may not be valued. This may continue to exacerbate their sense of rejection and shame and further lead them to express these emotions by acting out as children and, perhaps, dropping out of school as older adolescents. This may provide a partial explanation as to why fewer men are graduating high school in the United States and going to college. At the current rate, it is projected that by 2019 there will be 50% more women in college than men in the United States (Coy, 2012).

All this is to say that the current public education model, based upon and designed for the needs of industrialization and capitalism, is promoting some of the same values that are making it difficult for boys to develop the ability to negotiate vulnerability. A system valuing certainty, self-control, and rationality esteems precisely the characteristics valued by people attempting to avoid vulnerability, as Brown

(2010, 2012) has described, and, in so doing, may limit male students' abilities to negotiate vulnerability and develop a more authentic sense of self.

## Conclusion

Examining ADHD solely through a medical framework limits our understanding of ADHD treatment and diagnosis by precluding explanations that fall outside of an individual's body and thus precludes social or cultural explanations. With even a small amount of research, there are a couple of cultural explanations that open up some non-medical model treatments. Boys may be diagnosed more than girls in regards to ADHD because 1) they are viewed through a cultural lens that expects them to live up to the gender norm of "self-control"<sup>2</sup> and 2) living up to the gender norms of masculinity limits their ability to negotiate feelings of vulnerability which may cause them to externalize problematic feelings and behaviors. Difficulty in being able to negotiate these feelings of vulnerability and to develop a more authentic sense of self may be compounded in the current model of public education. This model, with many of the features of what we recognize as masculinity, was formed in reaction to the rise of American industrialization beginning at the turn of the 19<sup>th</sup> century.

In looking at ADHD diagnosis within the medical model theoretical framework, we may be likely to say that boys are diagnosed more because boys act out more. This view may lead to treatments at the individual level. However, such treatment could function as another strap and buckle on the "gender straitjacket" of masculinity into which boys are forced (Pollack, 2000, p. 15). Instead, using social constructionism and looking historically at the construction of masculinity and our current education system, we see that there are other ways to understand this diagnosis that allows for alternative treatment options instead of treating an individual directly via drugs, for example. For clinicians, this understanding of ADHD diagnosis may provide an intervention to rule out

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<sup>2</sup> This is not to say that self-control and self-regulation of behavior and emotions is something we should disregard. Having these skills can help people adapt effectively to different situations in life. I am merely saying that, because of the cultural norms regarding masculinity, boys' behaviors deviating from such norms may be viewed as a disorder.

whether a boy's behavior is a result of difficulty managing feelings of vulnerability in a culture and school system that may make it hard for boys to do so. If so, it may be more effective to help boys learn how to embrace and effectively cope with vulnerability in the current social system so they may develop a more authentic sense of self. We may also be able to do this culturally by educating people about masculinity to show that it is not something that is objective, but something that can change. Educating people about some of the negative effects that social norms of masculinity have on boys today may help to develop a culture in which boys have more socially acceptable means to help them negotiate feelings of vulnerability and to assist them in developing a more authentic sense of self.

As Robinson (2006) suggests, we could also look to change our educational models from an industrial manufacturing model valuing certainty, conformity, and batching people to a model based on agriculture which values human flourishing. This alternative model takes the stance that human flourishing is an organic process as opposed to a mechanical process. The mechanical process would be akin to the industrial model. In an agricultural model, focus is shifted to creating the conditions in which students can flourish, as farmers do with their crops (Robinson, 2006). It recognizes that, just as different plants need different types of conditions in which to grow, so do different students. It concerns itself more with "customizing to your circumstances and personalizing education to the people you're actually teaching" (Robinson, 2006). Other constructivist models of education along these lines, such as Newmann's (1996) "Authentic Pedagogy" model, have been shown to be effective.

Pollack (1998, 2000) advises creating safe spaces where boys can feel comfortable being themselves (Pollack, 2000, p. xxiii). He describes the importance of having a place where boys do not feel that they are forced to live up to masculine ideals. As Pollack (2000) states in his fifteen-step program to help create safe spaces for boys to be free of this gender straitjacket, "the biggest gift you can give to [a boy] is to make him feel good about being his real self" (p. 389). Other useful steps in line with this philosophy in Pollack's (2000) fifteen-step program include: creating many highly accessible, safe, "shame-free" zones; developing

sensitivity to boys' unique communication styles; talking candidly about the Boy Code and the gender straightjacket; teaching boys that there are many different ways to become a real man; and validating authenticity instead of traditional masculine "success" (pp. 383-390).

This paper identifies the need for further research. Future areas to explore may include: other possible cultural explanations regarding the gender disparity in the diagnosis of ADHD; how boys may feel about school in relation to feelings of authenticity and vulnerability; the relationship between some common features of masculinity and our mass public education model; and an examination of different school models and any differences in students' feelings of authenticity or their abilities to negotiate vulnerability when in these different school models.

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### Bereavement versus Depression

## Bereavement versus Major Depressive Disorder: The Value of Retaining the Bereavement Exclusion Clause in DSM-5

Jessie C. Macdonald

### Abstract

*The diagnostic criterion for Major Depressive Disorder (MDD) in the Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV-TR included an exclusion clause for symptoms caused by bereavement. The newly published DSM-5 eliminates that exclusion and subjects a person in mourning to the diagnosis of a mental disorder after only two weeks. Many of the symptoms of clinical depression can be found in individuals experiencing bereavement but the contexts in which those symptoms appear are very different. Bereavement carries within it the possibility of personal growth and emotional transformation. This paper looks at the historical understanding of grief and depression and how the symptoms differ but can also overlap. This paper reviews the development of the MDD criteria first published in the DSM-III and mentions some of the outcomes of that decision. Finally, the paper discusses the intrinsic value of the mourning experience. It encourages the mourner and the social work practitioner to view death and mourning as normative events that are stressful but also can be experienced in such a way as to deepen and enrich an individual's life.*

**Keywords:** Bereavement, Major Depression Disorder

### Introduction

#### ***Bereavement versus Major Depressive Disorder: The Value of Retaining the Bereavement Exclusion Clause in DSM-5***

Bereavement, the state of mourning the death of a loved one, is a universal human experience that transcends time and culture. Grieving for the dead crosses religious and ethnic lines and the rituals associated with mourning help the bereaved person acknowledge the finality of death and begin the process of establishing a new life without the beloved (Sadock and Sadock, 2007). The intensity of normal

responses to grief may include symptoms that are identical to those found in the fourth edition, text revision, of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) under the classification of symptoms for Major Depressive Episode (American Psychiatric Association [APA], 2000). Symptoms such as sadness, tearfulness, inability to feel pleasure, loss of appetite, diminished ability to concentrate, and difficulty with sleep are conditions common to both depression and bereavement. They were acknowledged as such by a bereavement exclusion clause in DSM-IV-TR that prevented most people in mourning from being diagnosed with Major Depressive Disorder (APA, 2000).

The DSM-5, released in May 2013, eliminates this exclusion clause on the recommendation of the mood disorder work group. According to the DSM-5 development website, the revision process was guided by an emphasis on research-based evidence. The results were then presented to medical specialists for further critique and review. In one such study, Kendler, Myers, and Zisook (2008) examined data from the Virginia Twin Study that supported the conclusion that the loss of a loved one is not substantially different from other stressors that cause similar depressive symptoms, such as the loss of a job or a romantic crisis. This is the APA position as articulated by Kendler (2010) who further states that all depression arising from other psychosocial stressors would need to be excluded from medical diagnosis to make the exclusion clause logical. Kendler (2010) argues that removing the exclusion clause brings the DSM position in line with the International Classification of Diseases and that its removal will not automatically necessitate treatment for depression. He claims the decision will still be made by physician and client together and would take into consideration the psychosocial environment of the client (Kendler, 2010).

There are, however, benefits in allowing the grieving person to work through the process of

mourning with the support of family and friends but without the stigma of a mental disorder. Flaskerud (2011) cites Frances, former chair of the DSM-IV task force. Frances warns that “turning bereavement into major depression would substitute a heartless medical treatment for the profound mourning rituals that have survived and sustained human groups for millennia” (p. 339). The DSM-5 criteria would increase the likelihood that normal bereavement would be over-diagnosed, over-treated, and subject to a marketing campaign by pharmaceutical companies to treat the condition with drugs (Flaskerud, 2011).

The ideal situation is to keep the exclusion clause intact, recognizing that bereavement is different from other stressors in its universal, normative nature and that in most circumstances, it does not result in a depressive disorder. Acknowledging the importance of the bereavement exclusion clause necessitates some understanding of the symptoms of grief and how they differ from, but under some circumstances can lead to, clinical depression. It is also helpful to trace the development of the DSM diagnosis of Major Depressive Disorder to understand what is at stake in eliminating the exclusion clause. Finally, it is important to look at the spiritual and psychosocial dimensions of bereavement and their compatibility with a social work perspective. The bereavement exclusion clause keeps with the tenets of social work because it encourages an emphasis on the person-in-environment approach. It encourages both practitioner and client to view death and mourning as normative events that are painful but can be experienced in such a way as to deepen and enrich an individual’s life.

## Symptoms of Grief

The pain of losing a loved one to death often brings intense suffering and distress to the bereaved. Suffering may be manifested both physically and psychologically and reflects the specific cultural context of the individual. This paper discusses bereavement from a majority cultural perspective, but it is important to note that rituals and practices vary both between and within cultures. Generalizing about any aspect of death and grieving minimizes the diversity of a particular ethnic group and the individual human experience within that group (Rosenblatt, 2007). Although grief is always highly personal, its manifestations are fundamentally influenced by the surrounding culture.

Family and religious faith play an important role in African American communities, where a

strong belief in life after death sustains mourners (Bougere, 2008). In Hispanic cultures, the concept of “respect” and the primacy of family and social relationships are paramount (Bougere, 2008). The entire family is often involved in mourning rituals, although there is a strict hierarchy in decision-making, from older to younger, male to female. In Mexican American culture, the link between the living and dead is embraced, often with joyous public celebrations observed in early November during the “Days of the Dead.” Native American cultures vary according to tribe but there is often an emphasis on the natural world and the union of the human spirit after death with some aspect of nature (National Association of School Psychologists, 2003).

In their *Handbook of Bereavement Research*, Stroebe, Hansson, Stroebe, and Schut (2001) describe some common grief reactions. The grieving person may experience affective changes, such as despair, dejection, anxiety, anger, and loneliness. Behavioral changes may include agitation, fatigue, crying, and social withdrawal. Cognitively, a person in mourning may experience memory and concentration problems or have a sense of helplessness. Physical symptoms may be manifested through a decrease in appetite, sleep disturbances, loss of energy, and increased susceptibility to illness. In one of the classic bereavement narratives, *A Grief Observed*, C. S. Lewis (1961) described the pain of losing his wife to cancer as analogous to the sensation of fear. “No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing” (p. 3).

Grief reactions vary widely among people and there is no specific timetable for knowing when mourning is completed. The DSM-IV-TR states that two months may be considered sufficient to differentiate bereavement from a major depressive episode (Sadock & Sadock, 2007) but most grief theorists find the timing to be more variable and fluid. Since grief is not a disease, most people will not need psychotherapeutic or pharmacological interventions and the intensity of their reactions will lessen on their own within the first year after death (Raphael, Minkov, & Dobson, 2001). The empathy and comfort provided by family and community members are usually sufficient to support the bereaved and alleviate their suffering, but some people will continue to experience depression and anxiety and may require therapeutic intervention. Certain kinds of loss are more difficult to manage without outside help, particularly when the attachment to the loved one has been ambivalent or if

the loss was sudden and traumatic. Bereavement can also be a cause of depression in the elderly where it can cause social isolation, loneliness, and lack of care (Parkes, 2001).

In his book *Grief Counseling and Grief Therapy*, Worden (2009) discusses factors termed “mediators of mourning” that determine how easily a person navigates the process of mourning (p. 57). These include: (a) the relationship with the deceased – was the deceased a spouse? child? sibling? parent?; (b) the nature of the attachment – was it secure? ambivalent? conflicted?; (c) how the person died – an accident? a homicide? from natural causes? by suicide?; (d) the mental health history of the mourner; (e) personality variables such as age, gender, coping style, cognitive style, ego-strength, and worldview; (f) social variables such as religious resources, community and family supports; and (g) concurrent stresses, such as economic hardship or loss of a home (Worden, 2009). Worden (2009) cautions against simplistic assumptions about how a particular loss will be experienced by any individual. The interplay of these mediators can determine whether a person will need only general support throughout the mourning process or may in fact develop deeper, more complicated, or chronic grief necessitating therapeutic interventions (Worden, 2009).

### Grief versus Clinical Depression

The distinction between normal grief and sadness versus clinical depression has been recognized for centuries. As early as the fifth century, Hippocrates differentiated between the two by noting that “if fear or sadness last for a long time it is melancholia” (Horwitz & Wakefield, 2007, p. 57). Passages in Aristotle’s *Problemata* explicate the relationship between the amount of sadness a person feels at any given time by comparing it to the quality of the circumstances that cause that sadness (Horwitz & Wakefield, 2007). Several psalms in the Old Testament beautifully express both depression and bereavement. In Psalm 38, King David speaks of being prostrate with the knowledge of his sins, but in another passage where he sadly mourns the death of a friend he displays none of the self-loathing expressed in the psalm (Pies, 2008). Christian writers as early as the 14<sup>th</sup> century noted the appropriateness of sorrow in certain situations and acknowledged that a grieving person has the capacity to still feel connected to others without the sense of being an outcast (Pies, 2008).

In his essay, *The Anatomy of Sorrow: A Spiritual, Phenomenological, and Neurological Perspective*, Pies (2008) comments that two kinds of sorrow are also noted in Buddhist thinking: the concept of *dukha* expresses normal sadness, including bereavement, while *tanha* is similar to depression that arises seemingly from nowhere. The 12<sup>th</sup> century Jewish philosopher, Maimonides, wrote movingly of his deep depression after the tragic death of his brother at sea. Examples of acute grief that resemble clinical depression can be found in the *Iliad* with the description of Achilles’ reaction to the death of his beloved Patroclus. Contrasted to these expressions that resemble clinical depression are writings such as Martin Luther’s words to his dying child that encapsulated a sense of hope in life after death while also acknowledging his deep sadness: “I am happy in the spirit, but in the flesh I am very sorrowful.” (Pies, 2008, p. 3).

There is an intentional aspect to grieving that is missing from depression. “We are *overtaken* by depression, but *give ourselves over* to sorrow” and thus open up the possibility that there is something positive to be gained through the experience (Pies, 2008, p. 3). Although the two conditions can mutually reinforce each other, normal grief does not usually contain feelings of guilt and self-reproach that are commonly seen in clinical depression. Freud posited that feelings of self-hatred often seen in depression (or “melancholia” as Freud referred to it) were caused by unacknowledged, ambivalent feelings towards another. These unexpressed emotions are turned inward resulting in a feeling of great emptiness.

Freud’s theories on melancholia influenced later psychodynamic explanations of depression. Ego psychologists thought that an individual’s capacity to accept sadness and grief as a normal part of the human condition could be an indication of a healthy mental state and of ego-strength and not something to be avoided. The psychologist, Edward Bibring (2008) thought that depression was caused by a lack of self-esteem resulting from the recognition that there is an incongruity between one’s aspirations and the perception of one’s capabilities (Berzoff, Flanagan, & Hertz, 2008). Object relations theorists emphasize the importance of one’s developmental level at the time of a loss. The ability to grieve without becoming clinically depressed was influenced by how well a person integrates both the positive and negative aspects of their loved one into a realistic image of that person (Berzoff, Flanagan, & Hertz, 2008). The work of Bowlby and other theorists examines the causal relationship of insecure



and ambivalent attachments in early childhood to the development of pathological responses later in life.

Differentiating between normal sorrow and clinical depression is helped by recognizing that the causes of depression can be endogenous in origin with no obvious external event as their source (Berzoff, Flanagan, & Hertz, 2008). The reasons could be genetic, biochemical, or hormonal. They could be a result of life cycle issues, such as aging and the loss of physical abilities. It is generally recognized that depression must entail two of three altered mood states: apathy or loss of interest in events; asthenia or loss of energy; and anhedonia or loss of the ability to take pleasure in anything (Berzoff, Flanagan, & Hertz, 2008).

Pies (2008) refers to the work of Dr. Naomi Simon at Massachusetts General Hospital in which she describes symptoms of complicated grief and observed that they were similar to symptoms of clinical depression and might be thought to be a “kind of conceptual bridge between *ordinary bereavement* and full-blown *major depression*” (p. 5). These symptoms have to last at least six months after the death of a loved one and have to include a feeling of disbelief about the death, an overwhelming longing for the person who died, recurrent images of that person, and avoidance of reminders of the death (Pies, 2008). Although research studies have attempted to find solid neurological, genetic, or biochemical evidence of the difference between bereavement and depression, these studies have been inconclusive (Horwitz & Wakefield, 2007). In spite of the lack of evidence-based results, there has clearly been a recognition that bereavement is handled differently by all people, but in certain circumstances, can lead to a depressive disorder.

### The “Rise” of Major Depressive Disorder

The bereavement exclusion clause first appeared in the DSM-III in 1980 under the direction of research psychiatrist Robert Spitzer. Prior to that publication, depression was generally viewed as a psychotic disorder most often found in hospitalized patients rather than in outpatient clinics or among the general population seeking assistance from primary care doctors (Horwitz, 2011). The most widespread diagnosis for mood disorders at that time was anxiety. Horwitz (2011) cites Herzberg in chronicling the prevalence rates of anxiety versus depression in the early 1960s; approximately twelve million people were diagnosed with anxiety disorder and only four million with depression. These numbers changed rapidly following DSM-III. Major

Depressive Disorder (MDD) now accounts for forty percent of all mood disorder diagnoses and it is viewed by the World Health Organization as one of the top two disabling health conditions in the world, with the other being heart disease (Horwitz, 2011). It is valuable to trace how Major Depressive Disorder became the predominant mood disorder it is today in order to appreciate the significance of the bereavement exclusion clause in preventing bereavement from being over-diagnosed as clinical depression.

During the mid-1970s, researchers studying depression disagreed about whether the disorder should be classified by symptoms, etiology, or response to treatments. There was also intense debate regarding whether depression fell on a continuum of severity or whether the types of depression that were observed were discrete and warranted individual diagnoses (Horwitz, 2011). In 1976, Feighner, a psychiatric resident at Washington University Department of Psychiatry, developed a set of criteria to describe symptoms of depression that was based upon an earlier study of 100 severely disturbed hospitalized patients. Feighner (1976) listed symptoms of depression that have become commonplace: a sad, hopeless, and depressed mood that was often combined with loss of appetite, sleep disturbances, lack of energy, cognitive impairment, or suicidal thoughts. In addition, the Feighner criteria designated that the symptoms must last for at least one month (Horwitz, 2011). Unfortunately, the criteria lacked empirical evidence as they were almost exclusively developed from the same state hospital patients used in the original study. Nevertheless, these symptoms became widely cited and eventually were included almost verbatim in Spitzer’s description of MDD in the DSM-III. There were two important caveats: bereavement was exempted from MDD and the duration of symptoms was changed to two weeks instead of one month.

Spitzer wanted to bring the diagnosis of MDD in line with other mental disorders that were characterized by a classification of symptoms instead of psychodynamic theories. He worked closely with Washington University psychiatrists and researchers who were heavily influenced by the Feighner criteria. There was little participation by outside groups such as the pharmaceutical and insurance industries and lay advocacy groups, but Spitzer succeeded in his goal: the establishment of a single standard of measurement for depression (Horwitz, 2011). Horwitz (2011) states that “the MDD category encompassed all of the heterogeneous categories of endogenous, exogenous, and neurotic forms of depression that existed before 1980” (p. 48). The

MDD diagnosis remained intact through subsequent revisions of the DSM.

An outcome of the new diagnosis was a blurring of the line between mental illness and normal sadness. Symptoms were seen outside of their context and symptoms as severe as suicidal ideation could equate with fatigue or insomnia in requiring medical treatment. While the bereavement exclusion clause recognized that the same symptoms could be considered a “normal” response to the sadness caused by the death of a loved one, MDD did not exclude any other losses that could account for such unhappiness, such as the end of a romantic attachment, the loss of a job or home, or the loss of health. As a result, “between 1987 and 1997, the proportion of the U.S. population receiving outpatient therapy for conditions called ‘depression’ increased by more than 300 percent” (Horwitz, 2011, p. 49). Depression thus became one of the most heavily prescribed disorders and a major source of revenue for pharmaceutical companies that marketed drugs such as Prozac and other selective serotonin reuptake inhibitors (SSRIs), which are drugs that have been found to be effective in treating a myriad of conditions from eating disorders to drug and alcohol problems. Horwitz (2011) warns that “when antidepressants are used to treat such an array of symptoms, these symptoms all come to be seen as signs of ‘depression’” (p.50).

The rise of managed care as a prominent form of medical supervision coincided with the new DSM diagnosis and reinforced the use of medication to treat symptoms of depression (Horwitz & Wakefield, 2007). Patients were more apt to ask a primary care doctor for a prescription to lessen their symptoms because health insurance policies in the managed care system usually had generous coverage for medications and lower out-of-pocket co-payments.

Another important factor in this increasing rate of drug treatment has been the legalization of direct-to-consumer advertising by pharmaceutical companies (Horwitz & Wakefield, 2007). Since 1997, it has been possible for companies to appeal directly to consumers to sell their products and to bypass the former marketing aimed at physicians. Citing the legitimate, symptom-based diagnosis of MDD in the DSM, all forms of media ads further capitalized on blurring the distinction between depression and other forms of sadness. The number of people using antidepressant drugs to treat all kinds of symptoms “almost doubled, from 7.9 million in 1996 to 15.4 million in 2001” (Horwitz & Wakefield, 2007, p. 187). Thus, the consequences of the DSM-III diagnostic criteria for MDD greatly diminished

the importance of the context in which a person experienced sadness and whether those emotions could be better understood as common, albeit painful, reactions to normal life events. Sensibly, the bereavement exclusion clause has protected the person in mourning from being labeled pathological. The proposed DSM-5 removal of the exclusion clause threatens that protection.

### **The Human Context of Bereavement: The Value of Mourning**

*“Sorrow removes your attention from the active life and focuses it on the things that matter most. When you are going through a period of extreme loss or pain, you reflect on the people who mean the most to you instead of on personal success; and the deep design of your life, instead of distracting gadgets and entertainments. You may be more open to the beauty of your world as a relief from distress.”* (Pies, 2008, p. 3)

This lovely passage from Catholic philosopher and theologian Thomas Moore encapsulates some of the positive effects from the process of mourning, giving it value as part of the human experience. Mourning the death of a loved one has been part of human life since its beginnings. Mourners question the meaning of life and how their emotional response to death relates to their understanding of existence. Religion, philosophy, and other forms of spirituality have always provided deeply meaningful avenues to explore those questions. Death causes the survivors to face life’s disappointments and sorrows directly. Horwitz and Wakefield (2007) quote the philosopher Carl Elliott who said, “At least part of the nagging worry about Prozac and its ilk, is that for all the good they do, the ills that they treat are part and parcel of the lonely, forgetful, unbearably sad place where we live” (p. 190). Equating bereavement with MDD encourages the mourner to see him or herself as deficient in some way, incapable of managing strong emotions. For example, a bereaved widow seeking counseling support at Rainbow Hospice and Palliative Care Center in Mount Prospect, Illinois expressed her anguish that she could not recover from her sadness within two weeks of the death of her husband of 42 years (personal communication, November 29, 2011). This was the amount of time her husband and sons had told her was sufficient to grieve and she sought assurance that she was not “crazy.”

Although each bereaved individual has a unique experience, most mourners are faced with a

re-evaluation of their role and relationship within their family. This process can be painful but can also lead the way to a personal transformation marked by greater wisdom, compassion, and understanding of others (Schaefer & Moos, 2001). Many people become less judgmental and more tolerant of others as a result of the personal growth that can come from this period of introspection. In an effort to derive meaning from the life and death of their loved one, mourners often re-evaluate their priorities and find a greater purpose in their own lives. In their research, Schaefer and Moos (2001) have found that many widowed people eventually develop greater resiliency from having to live independently, particularly if they view new tasks and roles as a manageable challenge. Studies have also shown that adults who have lost a parent generally review their own lives, revise their goals, and often develop a stronger relationship with their siblings. The death of a child is a very challenging adjustment for parents, but even here, studies show that there can be positive outcomes for the bereaved parents (Schaefer & Moos, 2001).

How successfully a person copes with the death of a loved one is often a function of the interaction between the environment, the circumstances of the death, and the resources that person has to cope with the death. Worden (2009) explains that there are four tasks a mourner faces in order to adjust to the death of a loved one. The person must accept fully the death of their beloved; they must experience and work through the pain of losing that person; they must adjust to living in a world without the person and adapt to new roles; and they must keep the memories of the person within himself/herself while moving forward to a new life.

Factors such as the mourner's financial situation, support from family and friends, and whether the death was sudden or expected all play a part in the personal growth that can result from the death. Equally important are the resiliency, ego-strength, and coping skills the mourner brings to the situation (Schaefer & Moos, 2001). A study by Oltjenbruns, Schaefer, and Moos (2001) found that 95 percent of late adolescents reported some kind of

positive outcome from experiencing the death of a family member. These eventual outcomes included better communication abilities and problem-solving skills, as well as greater empathy for others and more emotional resiliency. However, it is important to remember that there is usually no quick resolution of the sadness and grief experienced by the bereaved. It may take many months for a mourner to find meaning in their loss and grow from that experience. C. S. Lewis (1961) wrote of the peace and acceptance he eventually felt after mourning his wife: "There was no sudden, striking, and emotional transition. Like the warming of a room or the coming of daylight. When you first notice them they have already been going on for some time." (p. 62).

## Conclusion

### *Taking a Spiritual, Biopsychosocial View of Bereavement*

Understanding bereavement through a spiritual, biopsychosocial lens is in keeping with the view of the human being that is emphasized in the social work profession. Social workers look at the human experience through all aspects of a person's physical, psychological, social, and cultural environments. The context in which a person experiences great sadness becomes of paramount importance in the decision to treat someone medically or to give only emotional support and validation. The bereavement exclusion clause encourages this kind of analysis by clinicians. Bereavement could thus be seen as a normal event, a potential source of growth for the individual and not a pathological condition that must be treated medically. With the removal of the exclusion clause in DSM-5, anyone grieving deeply and presenting the symptoms delineated under MDD will be at risk of that diagnosis after only two weeks. By not ignoring the relationship of symptoms to the context in which they are found, social work honors the complexity and resiliency of the human spirit.

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*Life in the managed community care program helping low income older adults.*

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**CHILDREN DIVORCE GROUPS**

## Children Divorce Groups: Variables That Impact Effectiveness

**Brittany R. Manzella**

### Abstract

*This paper explores nine published articles ranging from 1990 to 2011 that report on the need and effectiveness of children divorce groups. They discuss factors that are important to consider when facilitating this type of group. Currently there is some controversy regarding whether a leader should have a developmentally homogenous or heterogeneous group. It has been found that intervening early with children experiencing divorce helps prevent long term consequences cited by Wallerstein (2005). This paper discusses gaps found in the literature, such as divorce due to family trauma and same-sex family divorces. Finally, this paper makes the recommendation that intervening with children experiencing divorce using a group modality is preferable to individual interventions.*

**Keywords:** Children and divorce, divorce groups

### Introduction

Over the past several decades the divorce rate in the United States has continually risen. The United States has one of the highest rates of divorce in the world compared to other developed countries and English-speaking countries (Schaefer & Ginsburg-Block, 2007). Divorce is often referred to as an epidemic due to its increasing prevalence and its negative effects on family lives (Waldman et al., 2007). Divorce often causes a crisis for children and if the child's feelings and needs are not addressed, it can negatively impact their lives. Their school work may suffer and they can experience feelings of anxiety, depression, and low self-esteem (Waldman, Molloy, Hart, Ginsberg, & Mulvey, 2007). Morrison and Cherlin (1995) found that when comparing children in disrupted and intact families, boys in disrupted families had a higher presence of behavioral problems and girls in disrupted families scored lower on a reading recognition test. These reasons make

children divorce groups a pertinent topic for study. The purpose of this paper is to review the relevant literature and to provide updated information on using a group modality when working with children who have been affected by divorce. The use of group interventions in this population is relatively new. This paper will review different types of children divorce groups, group issues that arise, important leader variables, and ways to evaluate progress in these groups.

### Type of Groups

Groups are the preferred method for working with children who have experienced separation and divorce in their families because of the natural tendency for children to need peer support. A group gives children peer support in a structured way with an adult to guide the group and help them process feelings. Common features of these groups are no more than 10 children, a male and female leader, and session duration of approximately 45 minutes (DeLucia-Waack & Gellman, 2007; Farmer & Galaris, 1993; Schreier & Kalter, 1990). One female and one male leader are strongly recommended because it gives children of different genders someone to relate to, it lets the leaders play mother and father in role plays, and it gives the children an opportunity to see a female and male working together cooperatively (Schreier & Kalter, 1990).

Schaefer and Ginsburg-Block (2007) discussed known effective group interventions for children and adolescents dealing with divorce; they reported that both child-focused programs and parent-focused programs are effective. Child-focused programs emphasize support, problem-solving, and skill building in sessions while parent-focused programs emphasize educating parents on ways divorce affects children and building skills on how to talk and respond to the children's concerns (Schaefer & Ginsburg-Block, 2007). Most of the literature on children divorce groups involved both a psycho-educational and supportive

component and parental involvement is almost always included, either at the beginning and end of the group or they have a separate concurrent group. Parental involvement assures that parents learn about how divorce can impact their child and also teaches ways to respond appropriately and supportively to the child's needs and concerns (Farmer & Galaris, 1993).

Based on material in the following literature review, all groups have variations of the following goals: (1) provide a normalizing experience for children dealing with divorce by allowing them to share personal experience with peers, (2) clarify and talk about concerns related to divorce, (3) talk about and work through feelings and aspects of the divorce that are difficult, (4) teach coping strategies, and (5) communicate with parents about children and the divorce process (Farmer & Galaris, 1993; Schreier & Kalter, 1990). Both the psycho-educational and supportive components are addressed within these goals. With these goals, children divorce groups are structured in similar ways to what occurs during the beginning, middle, and end phase of the group therapy process.

### ***Beginning Phase***

Children divorce groups place importance on activities that encourage and increase cohesion among the group members. This is important to create a safe, supportive space for children to share their feelings comfortably. Some of the activities include jumping on pillows after saying a statement about yourself and art activities. One of the most effective activities was described by Schreier and Kalter (1990). They started their session (group) by using a group story to introduce the idea of divorce. Each child could add to the story and determine how the story ends. This offers an easy transition to talk about challenges and changes that go along with divorce. This technique matches a beginning phase of treatment as it allows the children to engage and share information without having to personally own their experiences or feelings. By allowing the children to share thorough the story they share their experiences in a safe way and the end product- the finished story- helps establish group identity.

### ***Middle Phase***

The main goals worked on in the middle phase are expressing and processing feelings surrounding divorce, enhancing problem solving abilities, and learning coping strategies within the group setting. Children's common concerns are that the parent they live with will leave them, the noncustodial parent will not want to see them if the children express their anger, feeling caught in the middle of their parents, parents dating or remarrying, feelings of self-blame, and feeling sadness and loss over the family they once had (Farmer & Galaris, 1993; Schreier & Kalter, 1990). Other common concerns are related to role or routine changes in the child's life, such as children assuming a parental role by tending to their parents or siblings needs.

Most groups have similar ways of dealing with the concerns stated above. Waldman et al. (2007) ran a support group for children ages 5-8 that utilized talk, art, and play method with the goal of helping children express their feelings regarding the divorce. They additionally ran a psychoeducational group for the parents of the children. The leaders used role plays depicting different divorce topics during each session. These topics included a pre-divorce argument, a child listening to an argument upstairs, parents telling their children about the divorce, visitation skits, and parental dating and remarriage (Waldman et al., 2007). These role plays were always followed by a discussion of feelings or coping strategies. For example, after the role play regarding the parents telling the children about the divorce, the group would talk about the family changes that occur because of a divorce and how to talk to parents about their concerns. Role play is a common intervention technique in children divorce groups because it has aspects of social learning, vicarious learning, and engages the child's cognitive, social, and verbal capabilities. Children act out what is going on in their lives through play (Landreth, 2002). In addition, numerous groups incorporate a snack time into group where the children can freely talk about their week together (Farmer & Galaris, 1993; Waldman et al., 2007). This continues to build cohesion established in the beginning phase as well as give the leaders information about what aspects of divorce the children are managing well or struggling with.

Because younger children tend to primarily express their world best through symbolic play, talk therapy can rarely be used as the main pathway of communication; therefore, expressive means of communication, such as art,

is commonly used as an intervention technique. Drawing pictures of their family can be a rich source of insight into how they feel about divorce and what their daily experiences and desires are. One child depicted his family like a war zone and another child drew her family all together in the house with happy faces (Waldman, 2007). Incorporating supportive, therapeutic features into art is helpful. For instance, telling the group members to draw a picture for an art gallery and then afterward explain their piece to the other group members is a good activity. This adds a fun and accepting aspect to sharing difficult emotions. Symbolic play is another effective means of communication for children. Farmer and Galaris (1993) used what they called “creative construction, destruction, and reconstruction activities” (p.45). An example would be making something with clay, destroying it and making something else. The point of this activity is to show children that even though something is destroyed something new and hopefully positive can come out of it.

### ***End Phase***

Most children divorce groups process issues related to termination in the second to last session, keeping the last session for fun activities to celebrate the accomplishments of the group. During the termination processing the groups summarize the main things they learned and ways they could continue to use those skills. In an example given by Waldman (2007) one group did a ‘newspaper wrap up’ where they summarized all the main points of the sessions, typed them out and each child was given a copy. In an example of another group elaborated upon by Farmer and Galaris (1993), the group made a ‘separation, divorce, and remarriage stew’. The children added advice or information they would share with other children dealing with divorce at the end of each session. The leaders typed up all the cumulated information and made a copy for each child at the end. The important aspect of the end phase is for the child to have something to remember the group process by and all the progress they made. This is helpful when the child needs a reminder or support.

### **Group Issues**

Common group issues identified in the literature are the age of the child and where to

hold the session. There is dispute between whether it is best to only include children of the same grade or if it is okay to mix grades in the group (Farmer & Galaris, 1993). From a developmental perspective, children in different grades are at different developmental levels and therefore may have different fears and behaviors surrounding divorce. Wallerstein (1983) described the following concerns accompanying different developmental ages:

“Preschoolers frequently regress, may fear abandonment, and often blame themselves. Latency aged children may experience moderate depression, may decline in academic performance, may perseverate on one parent’s departure from the home, may have strong reunification fantasies, and may often feel rejected by the parent who is no longer the primary caretaker and may fear being replaced. Older children may express rage, have a tendency to blame one parent, and may develop somatic symptoms” (as cited in Waldman et al., 2007, p. 164).

If children of different ages have different worries about divorces due to their developmental stage or cognitive development, then mixing ages/grades together would not serve the group process. Thus, the general practice in children divorce groups is to group children based on grade range. On the other hand, there is an argument for mixing grades together. Older children may not have resolved feelings from a divorce that happened years ago so they may have the same reasoning and concerns as younger children (Farmer & Galaris, 1993). Mixing age groups allows the older children to give encouragement and advice to younger children. It also allows younger children to bring up issues that older children may be thinking but feel they cannot bring it up because it is a worry only younger children should have. Farmer and Galaris (1993) found that mixing the ages has worked well in their groups. So far the evidence is inconclusive and warrants further research.

Another group issue is the location of the children divorce groups. A lot of these groups are held in schools because it is where children are all day, they have established peer support, it makes the group a part of their normal



routine, and it is convenient for parents because they do not have to drive them to an extra appointment after school (Schreier & Kalter, 1990). Problems related to school-based groups may include dynamics between children who know each other. For example, prior strained peer relationships brought into the first group session could negatively impact the group process. In addition to this, there is often a time constraint that is less than the ideal group session. It is disruptive to always have to excuse children from class and limit too much of their lunch or recess time.

An important issue not addressed in the literature, is to consider children whose parents are divorcing due to trauma. Domestic violence or cheating can have additional negative impacts on the child, especially if the child witnessed the event. These children will most likely need additional processing and support because of trauma and possible conflicting feelings toward their parents and the divorce. Further, as legislation allowing same-sex marriage increases, the rules and tools of managing children divorce groups may have to incorporate different rules and tools for same-sex children divorce groups.

### **Leader Variables**

In order to be an effective group leader when working with children, confidentiality needs to be emphasized and explained (Landreth, 2002). Children need to feel confident that what they say will be respected and kept secret. It is important for anyone who works in a school to not divulge specific information about any child in the group to the teachers because it can get back to the child and undermine the therapeutic relationship. This holds true for parents groups as well. If the leader is facilitating a parent group they should not breach confidentiality unless the child is in danger.

The leader needs to have a substantial knowledge of child development. They need to know that children express themselves through play so they should have activities geared toward that. Additionally, the leader needs to understand metaphors in art and play to effectively work with children. Because children have shorter attention spans, balance between activities and time to process helps in children groups. If children sit for too long they tend to get agitated and lose focus. It is best to incorporate activities

that require movement. Depending on the age of the child, the leader may want to use ways to display the situation. Puppets would be more suitable for younger children who might not understand that the role play argument is not real or who have a hard time separating the leader's role play character from the leader. Another developmental aspect to consider is the way children express emotions. A younger child may not be able to tell the leader that they are angry or sad as their parents are divorcing because they do not have the vocabulary or cognitive capacity to do that. Instead they may act out, become disorganized, or agitated. Knowing these are possible ways a child could react, will give the worker more insight into what the children in the group are feeling.

Patience and ability to interpret non-verbal cues are important skills for a leader running a group with children. Not all children will feel comfortable talking right away or may not want to participate in an activity. The leader should respect whatever the child wants because that is where the child is at the moment. While the leader takes on an authoritarian role in the group, it needs to be qualitatively different from that of other significant adults in the child's life. Validating feelings and experiences and letting the child progress at their own pace is just as important when working with children as it is with adults.

### **Evaluation of Progress**

Measuring change in a children divorce group is optimal if it can be done both qualitatively and quantitatively. Farmer and Galaris (1993) used art work to measure change in the children. Having children draw a picture of their family at the first session, the middle session, and the last session could be helpful to see if their subjective feeling of their family was less hostile, disconnected, etc. If the children are older maybe stories of their families could be used alternatively. They could write a story at the first, middle, and last session and the stories could be compared to see if there is any improvement. A main reaction of children to parental divorce is anxiety, hence, using the Revised Children's Manifest Anxiety Scale (RCMAS) to measure change in anxiety from the first session to the last session could be helpful. This measure developed by DeLucia-Waack & Gellman (2007) was tested on five thousand

children with ages ranging from 6-19 and both Caucasian and African American children of both genders were included. It consists of 37 questions that measure the following areas of anxiety: physiological, worry/oversensitivity, and concentration. It is well advised to talk to the parents about any changes they are observing in their child and their relationship with the child since the child has joined the group.

## Conclusion

Considering the potential short-term and long-term consequences of divorce on children's wellbeing, providing help is a cost-effective preventative approach for potential future problems. Wallerstein's (2005) study followed 131 children ages 3-18 going through a parental divorce for 25 years and found that the biggest impact was when the children of divorced families reached adulthood, their experience their parents' with divorce impacted their intimate relationships. These children believed that the relationship would not last even though it was going well or avoided relationships altogether. Some participants would not break off a relationship because they remembered their parents' history. Other negative long term consequences for adult children of divorce include higher anxiety, seeking psychotherapy more often, and having more feelings of isolation, frustration, anger and self-blame than adults who never experienced divorce in their childhood. They may be more likely to consider divorce instead of marriage counseling during difficulties compared to adult children who never went through divorce (Mental Health America Augustana, 2011). Psycho-educational groups have a positive effect on ameliorating symptoms and are currently the preferred, cost effective method for treating this particular population (DeLucia-Waack & Gellman, 2007). Lastly, being in groups is a natural thing for humans because we are social in nature. This is especially true for children who figure out their world by interacting and playing with other children. Therefore, treating children who are affected by a divorce in a group setting is preferred to individual sessions.

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