

PRAXIS

Where Reflection & Practice Meet

VOLUME 16

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Editor-in-Chief

Sam Foist Swart (MSW/MA in WSGS Candidate, 2016)

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Mission Statement

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. Articles should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc or .docx). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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EDITORIAL

Social Workers as Change- Makers and Super(s)heroes

As another academic year draws to a close, individuals in the MSW program are often asked, “What is social work?” Confusion is understandable and comes with the territory of receiving a degree in a field that is immensely interdisciplinary. The social work profession implements and utilizes insights from the fields of psychology, counseling, marriage and family therapy, philosophy, health, business, policy, etc. Much to the chagrin of parents, friends, and family members, a social worker’s response of, “We do everything!” seems to be a broad, oftentimes inadequate response, albeit a truthful one. The question then becomes, what differentiates social work from other helping professions? What are key tenants and goals of an individual who holds a Master of Social Work?

Put simply, social workers are change-makers and super(s)heroes. Through the avenues of case management, therapy, group work, management, and policy, we are the advocates trained to walk with individuals in times of grief, pain, joy, and growth. We are the ones lucky enough to come face to face with human potential and hope. Wearing metaphorical capes, social workers are equipped to address individual and global social change while remaining critical of economic, racial, gender, age, class, and able-bodied justice. We assist others to become the best versions of themselves because we believe that individuals who are better versions of themselves, whatever that is defined as, makes for a more equitable, engaged, socially-conscious, and just society.

In Volume 16, Alyssa Cohen’s, “If I Could See How You See Me: Depression in an Adolescent Female” and Sabrina S. Massey’s, “Critical Review of Social Anxiety Disorder” both address the socioemotional needs of two high school students, struggling with functioning in and adapting to their surrounding environment. Sexuality and oppressed identities are discussed in Eliza Evans’ “Safe, Sane, and Consensual: The BDSM Community as a Sexual Minority” and Patrick Rodgers’ “Exploring Uganda’s Antigay Policies: Social Work Advocacy for Internationally Oppressed Same-Sex Oriented Individuals”. Rodgers pays particular attention to a global critique of how individuals from the LGB community are

criminalized and persecuted. Kristin M. Rubbelke and Mara Maeglin explore ways the United States’ criminal justice system has operated as an entity rife with racial inequality and harsh treatment for individuals impacted by mental illness. Their works, “Neoliberalism or Neoslavery? The Case of Ferguson, MO” and “An Examination of the Treatment of Mentally Ill Offenders in the Criminal Justice System” each offer an in-depth analysis of a broader structure for which we all play a role in the creation and perpetuation of. In her work, “The Debate over Early Medical Interventions for Transgender Youth Seeking a Gender-Confirmed Body”, Kristin N. Sabatino presents research on the highly contested issue of youth taking measures to confirm their transgender identity and it also engages in the idea of how clinicians can empower youth and families to have positive discussions about adolescent identity. Lastly, Emily Shayman’s work, “Perspectives of *Empowerment* throughout History- Using a Case Study to Form Understanding” interweaves ideas of empowering clients and advocates with creating long-lasting social changes.

This edition of *Praxis* features the work of fellow change-makers seeking to keep the field of social work current and is wonderfully indicative of a myriad of different approaches to creating communities that thrive. My hope for the profession is that it flexes to take in that which makes the field of social work stronger and indicative of its nature to problem-solve in an increasingly globalized society. May we as social workers and the individuals we serve never fail to follow the advice of the late Maya Angelou, “My mission in life is not merely to survive, but to thrive; and to do so with some passion, some compassion, some humor, and some style¹”. Doing so encapsulates not only the hope we have for ourselves to become better professionals, colleagues, and family members, but it also serves as the ideal call for individuals we journey with to do the same.

Sam Foist Swart, Editor-in-Chief
MSW/MA in WSGS Candidate, 2016

¹ Angelou, M. (2011). Retrieved from <https://www.facebook.com/MayaAngelou/posts/10150251846629796>

If I Could See How You See Me: Depression in an Adolescent Female

Alyssa Cohen, Type 73 Schools Certification
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Abstract

This paper explores the case of a freshman student, Sarah Edwards, who is diagnosed with depression, anxiety and exhibits disordered eating. Throughout this paper, the author, the student's school-based clinician, discusses the work she does with this student. The clinician provides an overview of the client's family, history of the problem, current coping strategies, strengths and clinical presentation. The clinician uses theory to examine and understand the client's symptom complex as related to depression, anxiety and disordered eating. Furthermore, the clinician discusses her use of evidence-based treatment in addressing the client's symptom complex. Drawing on attachment theory, theory of mind and Mentalized Based Treatment for Adolescents (MBT-A), the author reveals her understanding of and work with Sarah Edwards to exemplify a therapeutic experience treating adolescents with depression, anxiety and dysfunctional relationships with eating.

Keywords: depression, anxiety, eating disorder, symptom complex, attachment theory, theory of mind, Mentalized Based Treatment for Adolescents (MBT-A)

Introduction

According to the National Institute of Mental Health (2014), "in 2014, an estimated 2.8 million adolescents aged 12 to 17 in the United States had at least one major depressive episode in the past year. This number represented 11.4 percent of the U.S. population aged 12 to 17" (para. 1). According to these statistics, it is evident that depression is a phenomenon affecting a significant amount of the nation's youth. This case evaluation will focus on Sarah Edwards, a freshman girl at a north suburban high school in Chicago who is diagnosed with depression, anxiety and experiences a disordered relationship with food, although, is not formally diagnosed as having an eating disorder. For the purposes of preserving this client's confidentiality, the names

in this paper have been changed. This paper presents the client in the middle of treatment with the clinician. The clinician examines Sarah's symptom complex, clinical presentation, coping mechanisms and history of the problem, while drawing on attachment theory and theory of mind to understand the client's clinical manifestation. Furthermore, the clinician will consider clinical treatment that best supports this client.

Symptom Complex of Depression: A Case Study

Sarah is a white, middle class, freshman at New Trier. She is a caring, sweet, smart and enjoyable girl. According to her articulation with the middle school social worker, she was initially suggested to social work for the following: mood issues (depressive symptoms), flat affect, relationship problems, and choosing to be more of a loner. Sarah presents as insecure, self-conscious and as having low self-esteem. This is particularly apparent in her expression of how she perceives her parents treat and view her, and in her academic and creative achievements she discusses in comparison to her twin brother, Andy. She describes Andy as depressed, anxious and having difficulties socially and emotionally regulating. Sarah's parents have been divorced since elementary school. She spends most weeks with her mother and every other weekend with her father and his second wife. Sarah also has an older brother who is currently away at college. Sarah claims to have a more positive relationship with mom and Andy than she does with dad, step mom and her older brother. Although the articulation notes that Sarah is resistant to therapy, she has been consistently meeting with the clinician every Monday morning since the beginning of the school year.

Sarah sees an outside psychiatrist every other week. The psychiatrist has prescribed Sarah medication to manage her depression. She has recently altered Sarah's prescription, which seems to be a positive change according to both Sarah and the doctor. Furthermore, last weekend the

psychiatrist added a mood stabilizer to Sarah's medication regimen to address her anxiety.

After meeting and building a relationship with Sarah throughout the year, Sarah's struggles have become more apparent. Sarah reports she is depressed and experiences anxiety regularly and that she has been struggling with these issues since December of 2015. During sessions, she discusses her issues relative to relationships in her life. As mentioned, she feels much closer to her mom and Andy than she does to her dad and older brother; however, Sarah expresses frustrations with her mom and Andy. For example, her twin has significant mood issues and has attempted suicide before. Sarah has made comments that mom does not acknowledge the depressive and anxiety symptoms that Sarah experiences as much as she does for Andy, stating that Sarah is "acting out for attention". Sarah has had an episode with overdosing on medication during junior high, which increased mom's concern for Sarah's mental and emotional issues; however, Sarah still feels she is seen as lesser than her twin brother. Sarah reports both mom and mostly dad make comments about her being overweight. Sarah reports feeling self-conscious and insecure about her body around mom and dad as a result of them scrutinizing her weight. Sarah reports feeling self-conscious around her older brother due to his frequent "picking on her". For example, the last visit she made to him, he made hurtful comments about her and this made her feel sad, anxious and self-conscious.

Consistent with Bowen Family Systems theoretical concept of "nuclear family emotional process," Sarah's family struggles with the impairment of one or more child (Nuclear Family Emotional Process, 2015). Nuclear family emotional process purports that children can become impaired when parents focus their anxieties on one or more child resulting in an idealized or negative view of the child (Nuclear Family Emotional Process, 2015). With the increased focus on the child, the child in turn is more reactive than siblings to the attitudes, needs and expectations of parents, which compromises the child's differentiation from the family and causes him or her to act out or internalize family issues (Nuclear Family Emotional Process, 2015). In this case, mom focuses anxieties onto Sarah and her twin brother. As a result, mom fixates on the idea that Sarah is overweight and that her impairment is "acting out for attention". With the increased negative attention focused on Sarah, Sarah is reactive to the attitudes and expectations of her parents, which causes her to internalize

family issues. Consequently, Sarah feels depressed and anxious through this internalization process and experiences difficulty externally expressing frustrations and coping in a healthy way.

Sarah also reports experiencing social anxiety in many contexts. She is particularly anxious in large groups, around strangers and her older brother, and when she is unexpectedly called on during class. In school, she prefers to be alone because she feels more comfortable; however, stated she would like to feel more comfortable around people. Sarah also reported feeling anxious when she notices things out of place. For example, she mentioned a book being out of place on her teacher's desk and she spent a class period internally frustrated and distracted by the book's misplacement. Additionally, the clinician observed Sarah rearrange a Kleenex box in her office after it had been accidentally moved out of place.

Research indicates that depression and anxiety symptoms often co-occur and that there is an elevated association between social phobia and depression among adolescents (O'Neil, Podell, Benjamin, & Kendall, 2010). Furthermore, dually diagnosed adolescents with anxiety and depression report heightened social anxiety (O'Neil et al., 2010). Anxious and depressed youth more often report feeling sad, negatively evaluate their abilities and express anhedonia (an inability to experience pleasure) (O'Neil et al., 2010). This research supports Sarah's depression and anxiety experiences manifesting in large groups and in particular social situations. As a result of Sarah's self-consciousness, poor self-concept and insecurities, it is reasonable to associate these negative feelings about herself to the anxiety she experiences in social situations. Furthermore, with her inability to experience pleasure and feel comfortable in social situations, it is also reasonable to associate these experiences with her feeling depressed. Currently, Sarah engages in both healthy and unhealthy coping mechanisms to manage her depression and anxiety symptoms. Some of the healthy coping mechanisms include: removing herself from the anxiety-producing situation, listening to music, writing in a journal and connecting with her friends from summer camp. Sarah reports that isolating herself at home or at school and listening to music offers her an escape when she is feeling anxious and/or her mood is particularly low. Removing herself from a situation helps her to temporarily avoid the anxious and/or depressed feelings that a situation may cause her to feel.

While isolating herself does offer relief, this strategy also serves as a means of reinforcing her fear about anxiety-producing situations. Sarah additionally reports that she will occasionally journal about her feelings as a way to express her emotions, to which the clinician encourages her to continue. Sarah focuses on the positive relationships she has with friends from her six-week summer camp. She states she feels comfortable and that she can be herself around these girls. Last summer, she built a special relationship with one girl in particular who lives across the country, who she now calls her girlfriend.

Some of the unhealthy coping mechanisms Sarah engages in include: cutting, binge eating and purging, and social isolation. Since the clinician has been seeing Sarah, she has reported three to four cutting episodes. The clinician has examined her scars and they appear superficial. She has not cut herself the past three weeks. Sarah states that thinking about how nauseous she feels following cutting helps her to abstain from acting out on that urge. The clinician believes that through Sarah's developing an increased awareness of the negative consequences she experiences following cutting (feeling nauseous afterward) she is deterred from engaging in self harm. Sarah reports that her binge-eating and purging episodes vary. She has had one week during which she binged and purged twice and other weeks she has not engaged in any bingeing or purging. Similarly, when she contemplates bingeing and purging before acting out, she recognizes the nausea she will experience following the episode and this is sometimes enough to stop her from actually going through with it. While Sarah's consciously removing herself from anxiety-producing situations when possible can be viewed as healthy, it also perpetuates her social isolation and therefore contributes to her unhappiness.

The concepts theory of mind (ToM) and mentalization can be used to understand the symptom complex and clinical presentation associated with adolescent depression. Mentalization describes one's ability to participate in imaginative mental activity, which allows him/her to perceive and translate human behavior via mental states (i.e. needs, desires, feelings, beliefs, goals, purposes and reason) (Fonagy & Allison, 2012). It is important to note that mentalization abilities are influenced by both genetic factors and childhood experiences (Fonagy & Allison, 2012). Furthermore, the evolutionary function of attachment relationships

that individuals form with caregivers is characterized as "the opportunity that they offer infants to develop social intelligence" and "acquire the capacity for affect regulation and attentional control" (Fonagy & Allison, 2012, p. 11). As such, the early attachment relationships that individuals form with parents/caregivers are influential in the development of their ability to mentalize and operate social informational processing skills.

Internalizing problems such as depression and anxiety are often co-occurring clinical disorders. Through a social information processing framework, it is possible to understand the social deficits adolescents experience contributing to their presentation of depression and/or anxiety. More specifically, depression is linked to several social processing domains including: "negative self-schemas, selectively focused attention and recall for negative stimuli, negative and maladaptive attributional style, rumination, and impulsive and suboptimal decision-making" (Sharp & Venta, 2012, p. 45). Similarly, clinical processes of anxiety are characterized by hypervigilance concerning possible threat and negative evaluations of social events and past encounters as a result of mentalization deficits (Sharp & Venta, 2012). ToM deficits in this case manifest as deficits in social skills and hypervigilance resulting in the absence of knowledge about the minds of others (Sharp & Venta, 2012).

Furthermore, insecure, disorganized attachment "is a risk factor for suboptimal emotional and social development" (Fonagy & Allison, 2012, p. 14). Attachment theory argues that caregivers replay their own childhood attachment experiences with caregivers in interactions with their own children; such interactions teach infants about understanding how loveable he or she is (Dallos & Shaw, 2005). Additionally, adolescents who have experienced strained attachment relationships may find it particularly stressful to manage transition in relationships with parents during adolescence due to their difficulty understanding and regulating complex emotions, thoughts and rules about relationships; as a result of an uncertain or threatening relationships, they may have more historical barriers to overcome, fewer guiding rules, and less opportunities to rehearse healthy strategies (Dallos & Shaw, 2005).

In Sarah's case, the insecure attachment relationship the clinician observes she has with mom can be used to understand her compromised ability to regulate affect, operate social

informational processing skills, in addition to her lacking the control to maintain attention. Individuals are not born with the capacity to regulate their emotional reactions, but learn this through the caregiver's understanding and response to the infant's signals of momentary changes in his/her mental emotional state. The caregiver serves the role of reestablishing equilibrium when the infant feels emotionally over-stimulated (Fonagy & Allison, 2012). In absence of the caregiver's understanding and responsiveness to the infant, the infant is at risk for developing an insecure attachment, presenting significant disadvantages for his/her future development. Sarah's mom did not form a secure attachment with Sarah, which is observed through their current strained relationship. While the clinician does not have much historical information about Sarah's relationship with mom during infancy and throughout her childhood, Sarah has expressed that mom has "always favored Andy" as a result of concern for his mental and emotional well-being "ever since she can remember". Furthermore, Sarah shares a brief history of the "fights" mom and dad used to get into and still occasionally engage in and mentions their lack of recognition for how their inability to remain civil deeply affects her. While the clinician cannot say for certain, she hypothesizes that through the investment in their own issues, mom and dad were unable to see and meet Sarah's mental and emotional needs both as an adolescent and throughout her childhood. Sarah is unable to regulate the overwhelming emotional arousal she experiences in family conflict and social situations, causing her to internalize these feelings that manifest as depression and anxiety.

From a psychosocial developmental perspective, it is plausible to claim that Sarah was unable to successfully resolve developmental psychosocial crises, resulting in her inability to attain the associated developmental virtues. For example, during infancy, Sarah looked to mom for stability and consistent care in an unfamiliar world. The stability and consistency in care reflects the degree of trust or mistrust the infant will develop and carry out through other relationships. Working backwards through development, it is conceivable to postulate that Sarah experienced unstable and inconsistent care either during infancy or through development over time from mom as evidenced by her current mistrust, heightened anxieties and insecurities resulting in a lack of hope (McLeod, 2013). As mentioned previously, although the clinician has limited knowledge about Sarah's early childhood,

she has made mention of both mom and dad's inability to see how deeply affected she was by her parent's fighting both before, during and after their divorce. Furthermore, Sarah perceives that her parents always treated her needs as less important than those of her twin sibling. The inability for her parents to properly attend to Sarah's needs may have contributed to her insecure attachment and the clinician suspects this could have been a historical pattern for this family system. Conversely, if Sarah were to have successfully resolved this stage, she would have developed a sense of trust and hope that should a crisis arise, there is a real possibility that others can provide her support (McLeod, 2013). Sarah's failure to accomplish the psychosocial task of trust versus mistrust has led to fear.

With more in depth understanding of the symptom complex the adolescent client is experiencing, the clinician is able to consider appropriate and effective treatments. In the following section, the clinician outlines the techniques she will utilize in effectively addressing the clinical problems manifesting in this case.

Treatment for Depression Symptom Complex: A Case Study

In order to best work with Sarah, the clinician will employ a variety of treatment techniques to address the symptom complex that Sarah is experiencing. It is important to consider the context for which the clinician works with Sarah; the clinician is a school social worker who meets with Sarah weekly for 40 minute sessions. As such, the clinician is cognizant that she is limited in her scope to employ more intensive techniques (i.e. formal family therapy, partial hospitalization). However, the clinician intends to incorporate various techniques in Sarah's treatment including: the therapeutic alliance, mindfulness techniques, Mentalization-Based Treatment for Adolescents (MBT-A) and cognitive behavioral strategies to comprehensively treat the various facets of Sarah's clinically presenting problem. Furthermore, the therapist will continue to collaborate with Sarah's mom and psychiatrist to ensure continuity of care.

It is necessary that the clinician form a therapeutic alliance with the adolescent. Clinicians consistently report that the most significant indicator of success in treatment is the therapeutic alliance formed with their adolescent

clients (Labouliere, Reyes, Shirk, & Karver, 2015). The therapeutic alliance refers to the collaboration that occurs between the clinician and the conscious, observing ego of the client so that together they work on the adolescent's problems (Bernet & Meeks, 2005). The clinician will ally with Sarah's healthier, more reality-oriented aspect of her ego so that collaboratively they may observe the maladaptive, neurotically defended and conflicted facets of her personality (Bernet & Meeks, 2005). The clinician allies with Sarah's reality-oriented ego to bring awareness to her maladaptive thinking contributing to anxiety and depression in addition to her maladaptive coping behaviors of self-harm and bingeing and purging. Research has shown that the therapeutic alliance plays a significant role in the reduction of depression symptomology in adolescents (Labouliere et al., 2015). The clinician hopes that through establishing a positive and trusting therapeutic relationship with Sarah, she will allow the student to be open with the clinician and suggestible to healthier coping mechanisms ultimately reducing depressive, anxiety and dysfunctional eating related symptomology. Through the formed therapeutic relationship, the clinician will be able to connect with Sarah in effort to create a foundation for long lasting change.

As discussed, mentalization and theory of mind can be used to understand depression in adolescents, particularly looking at deficits in social informational processing. A clinical application of mentalization for depression treatment may be to include mindfulness in the work with the adolescent (Sharp & Venta, 2012). Mentalization is the ability to engage in imaginative mental activities enabling individuals to perceive and interpret human behavior via mental states (i.e. needs, desires, feelings, beliefs, goals, purposes and reasons; Midgley & Vrouva, 2012). Incorporating mindfulness treatment aims to address mentalization by helping to bring awareness of human behavior and mental states so that individuals may bridge the gap of ToM deficits resulting in internalizing behaviors (Sharp & Venta, 2012). In Sarah's case, the clinician will engage Sarah in mindfulness activities that intend to refocus her attention in the "here and now". For example, using a "mindfulness of thoughts" prompt, the clinician will facilitate bringing awareness to Sarah's automatic, subconscious thoughts that frame her perspective of herself and the world around her. In doing so, the clinician hopes to bring deep seeded thoughts to the surface allowing for Sarah and the clinician to identify

thought patterns and eventually work towards altering automatic thoughts and associated beliefs.

The clinician will additionally incorporate cognitive behavioral strategies with Sarah to explore the relationships between her thoughts, feelings and behaviors. Sarah and the clinician will collaborate to uncover her maladaptive thought patterns, and how these patterns cause beliefs and self-destructive behaviors (i.e. self-harm and bingeing and purging). Research indicates a depressive organization of self-concept impacts the way in which an individual interprets information and events about oneself and consequently presents social challenges (Dallos & Shaw, 2005). For example, some find it challenging to establish social networks or identify individuals they trust, which ultimately works as a disservice to the individual due to the positive buffering effects social support offers individuals during stressful events (Dallos & Shaw, 2005). In this sense, these individuals are not only inhibited by their negative self-concepts, but are also reluctant to seek social support due to their adverse view of self and lacking trust in others; this sequence of experiences presents implications for how individuals express depressive symptoms (Dallos & Shaw, 2005).

The core principles of cognitive behavioral therapy (CBT) are to identify negative and/or false beliefs and to reframe them (National Alliance on Mental Illness, 2015). In Sarah's case, the clinician will use CBT to reframe maladaptive thoughts into adaptive ones. For example, Sarah believes that she is "not good enough". The clinician works with Sarah to uncover the root of this belief by identifying the thoughts that accompany her self-image as "not good enough". Sarah explains to the clinician that she perceives mom giving Andy more positive attention for the same art project that Sarah has completed. Sarah's perception of this feedback is the thought that her twin is more valued in the family than Sarah is, resulting in Sarah's belief she is "not good enough". After working with Sarah to identify the connection between this event, her thought and belief, the clinician and Sarah work to reframe the thought and create a new framework for perceiving this interaction. In this case, the clinician will work with Sarah to break down the belief "I am not good enough" into: "My twin brother and I have both created an art project," "I am proud of my art project," "I do not need the approval or feedback from others to sustain the pride I have in my art project," and therefore "I

am good enough, because I take pride in the product I created". Establishing a new cognitive framework for perceiving herself and the world around her will support altering negative and maladaptive thoughts into more positive and adaptive ones.

It is relevant to note Sarah's history with treatment and the therapeutic strategies that have already been employed to support her. The clinician speaks with Sarah's psychiatrist regularly to establish continuity of care and to ensure she is aware of self-harm and eating concerns. The clinician also speaks with Sarah's mom typically once per month to check in. It is important that the clinician speak with other relevant figures in Sarah's life to achieve greater perspective and context for the issues that she presents with during sessions. Furthermore, speaking with mom allows the clinician to gain insight into how mom views Sarah and her issues. With this information, the clinician is able to assess for consistency of information presented both by the client and mom. Speaking with the psychiatrist, who has been working with Sarah for a longer period of time, allows the clinician to acquire more historical information about Sarah, her struggles and her relationships with family members. An additional unbiased perspective supports seeking consistency among information and Sarah's clinical presentation.

Through conversations with her doctor, mom, and Sarah, the clinician has learned that Sarah previously saw a nutritionist and an outside therapist during junior high; however, she no longer sees them. Sarah reports that her work with the nutritionist was focused on working on body image issues versus managing her eating patterns and creating a healthy diet. The clinician has made suggestive referrals to a reputable dialectical behavior therapy (DBT) group in the area and outside programs such as Insight Behavioral Center, however, Sarah is disinterested. The clinician is aware that depression symptoms manifest in a variety of ways, and changes in and/or unhealthy eating habits can be associated with the depression symptom complex. Literature on depression refers to a symptom complex including "anhedonia, emotional flatness or emptiness with diurnal variation, low mood, changes in sleep and/or appetite, and cognitive futility and hopelessness" (Dallos & Shaw, 2005). In Sarah's case, the clinician suspects that changes in her appetite and eating habits are a result of her experiencing depression. The clinician mentioned a "Mothers and Daughters Workshop" hosted by

the high school in December and Sarah expressed some interest in this program. When asked if she would like the clinician to discuss this with mom, she said she would do it herself and declined taking the flyer the clinician printed for her.

The clinician worries that because she does not verbally assert herself when it comes to advocating her feelings and needs. The clinician is concerned that Sarah will not discuss the workshop with mom despite her interest. The clinician struggles with trying to guide Sarah and "push" her to take advantage of more comprehensive services that would help her achieve goals she wants to achieve, but is concerned about losing her interest and trust due to her resistance to therapy. From a conversation with Sarah's psychiatrist, it appears that she has not maintained a consistent mental health provider and that it is surprising she is still seeing the school social worker weekly. That being said, the clinician worries she enables Sarah by not being more confrontational in connecting her to more appropriate care (particularly in regards to eating issues).

Sarah and the clinician discussed alternatives to cutting (i.e. using a rubber band in place of cutting when she experiences the urge to cut). The clinician is aware that self-harm is often a manifestation of depressive symptoms. Research refers to several motivations adolescents have to engage in self-harm: "to die, escape thoughts and feelings, feel better, get help, or to replace emotional pain with physical pain" (Ougrin, Tranah, Leigh, Taylor, & Tranah, 2012). While the clinician's suggestion to use a rubber band as an alternative to cutting is not a long term solution, it does offer the student an in-the-moment coping tool to express intense emotions during a time of crisis and/or possible vulnerability to engage in unhealthy behaviors. Since this has been suggested, she has not acted out on cutting and reports not having used a rubber band yet, but is open to this alternative. Sarah and the clinician have worked on communication strategies and how to assert herself so that she is able to express her thoughts and feelings. There seems to be a significant barrier to Sarah feeling comfortable expressing herself to mom, Andy, dad and her older brother; however, she feels much more comfortable speaking with friends from camp. Sarah and the clinician replay family interactions and brainstorm communication strategies that feel comfortable and realistic for her. Although Sarah reports having the therapeutic space to vent is

beneficial for her, the clinician wonders if she is helping her to maintain long-lasting change.

Evaluation and Concluding Thoughts

The clinician will evaluate treatment outcomes with Sarah by conducting clinical assessments periodically during their weekly sessions. As part of her treatment, Sarah will journal in a “mood diary” so that she logs her mood throughout the day and connects any events, interactions or situations that are associated with the identified mood. During therapy sessions, Sarah and the clinician will review the mood diary and discuss the event and associated mood and brainstorm the cognitions supporting the mood associated with the event. Over time, the clinician expects that Sarah will

require less prompts from the clinician to make thought, belief and behavior connections and furthermore that Sarah will be able to self-regulate her emotions due to the development of a more adaptive cognitive framework. The clinician additionally expects that Sarah will have ceased utilizing self-harm via cutting and bingeing and purging to employ more adaptive coping tools (i.e. rubberband use, music, mindfulness). Furthermore, the clinician will continue to collaborate with Sarah’s psychiatrist and mother to review their perspectives of her progress. The clinician is hopeful that by the end of the school year, Sarah will be better able to mentalize and self-regulate her emotions through employing mindfulness, cognitive reframing and use of adaptive coping mechanisms.

Alyssa Cohen is a MSW Candidate at Loyola University Chicago, with a concentration in Schools and Mental Health. Alyssa grew up in the north suburbs of Chicago and attended the University of Michigan in Ann Arbor for her undergraduate degree in Psychology. Cohen wrote this paper as a reflection of her therapeutic work with a student as a school social work intern at a north suburban high school in Chicago. She is currently a school social work intern at a north suburban high school and plans to continue her therapeutic training in a behavioral health center for children, adolescents and young adults following graduation in May 2016.

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Safe, Sane and Consensual: The BDSM Community as a Sexual Minority

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Abstract

This paper looks at the sexual practices that make up BDSM through the lens of affirming social work. First, it looks at social demographics of BDSM participants, with special attention paid to the topic of their mental health. The author next discusses disclosure of BDSM activities and social stigma. Abuse in BDSM is examined, including the recommendation of harm reduction techniques and safe words, which are words or phrases used during BDSM practice that are meant to immediately slow or stop activities. Affirming and non-affirming clinical approaches are examined, followed by recommendations for practice when working with clients who practice BDSM.

Keywords: BDSM, consent, social work

Introduction

BDSM is a set of related sexual practices that can involve bondage and discipline, domination and submission, and sadism and masochism. Moser (1998) asserted, “there is no universally accepted definition of BDSM, although these activities usually involve an exchange of power and/or the application of pain or otherwise intense sensations within a sexual context” (as cited in Turley, King, & Butt, 2011, p. 123). This paper will discuss some history and demographics of the BDSM community, mental health in the BDSM community, coming out and disclosure, abuse, and affirming and non-affirming clinician actions for members of this community.

The original intention of this paper was to examine BDSM in LGBTQ communities. However, the research and literature focusing on this aspect of the LGBTQ community was sparse. There is also a significant gap in research about BDSM from the social work perspective. Thus, much of the literature used in this paper comes from the field of psychology. In addition, there was literature from the field of forensics that focused on sadism as a criminal behavior,

which this paper does not explore, instead investigating the sexual behavior of consenting adults.

Demographics

Kolmes, Stock and Moser (2006) asserted, “up to 14% of American males and 11% of American females have engaged in some form of sadomasochistic (BDSM or SM) sexual behavior,” also noting that many others have sexual fantasies about BDSM topics, even if they do not act on them (p. 302). It stands to reason, then, that a great deal of clinicians could have clients who practice or fantasize about BDSM activities, making it important to learn about healthy expressions of the practice in order to provide the best, most affirming care.

Breslow, Evans, and Langley (1985) stated that awareness of BDSM fantasies have typically emerged by the time a person is under age 25, while knowledge of BDSM desires can “appear at an early age,” though a specific age range is not discussed (as cited in Bezreh, Weinberg, & Edgar, 2012, p. 39). According to Connolly, in her 2006 quantitative study of the psychopathology prevalent in a sample of respondents who practice BDSM, around 11% of respondents sampled shared that BDSM is their only form of sexual expression, while 32% noted that they spent the majority of the time with sexual partners not practicing BDSM (p. 91).

Connolly (2006) found that individuals in the BDSM community are more educated than the general population in the United States: almost 97% with a high school diploma, almost 58% with a bachelor’s degree, and around 17% with master’s or doctoral degrees (p. 88). Connolly (2006) also reported around 34% of respondents were “exclusively heterosexual”, 14% “exclusively gay or lesbian”, while the remaining 52% engaged in sexual practices with partners of their own and other sexes (p. 89). Connolly (2006) noted that the number of survey respondents who practiced mostly dominant BDSM or mostly submissive BDSM were about equal, around 46-48%, while 6.5% of respondents were *switches*, meaning that they preferred to take both dominant and submissive roles (p. 89).

Interestingly, Connolly (2006) found that most males in her sample reported practicing domination while most females practiced submission (p. 89). Unfortunately, there was no discussion about any cultural factors as to why the desires of individuals in the BDSM community are so gendered in this study.

According to Turley, King, and Butt (2011), straight and gay men practice BDSM differently. They asserted:

Heterosexual proclivities were focused on verbal humiliation, sensory deprivation, cross-dressing, and role-playing. Gay men were sadistically orientated with a preference for masculinisation of their sexual behavior, whereas heterosexual men adopt more submissive roles with an emphasis on humiliation and pain. (p. 126)

Notably, the authors do not address lesbians in this analysis.

The phrase, “safe, sane, and consensual” coined in 1983 by BDSM community member David Stein (2002), is often used to describe safely practiced BDSM activities (p. 1). Safe BDSM can seem like a paradox to those outside the community. Safety simply means that no individual who practices BDSM is permanently physically harmed while doing so. Stein (2002) noted that when creating the phrase he meant, “doing your homework and taking reasonable precautions” (p. 6). In BDSM communities, “the term *sane* seems to assume some standard of psychological health” (Williams, Thomas, Prior & Christensen, 2014, para. 5). Consensual refers to the mutual negotiation that occurs during the practice of BDSM. Individuals decide before engaging in BDSM where their limits are, what they are willing to do and not do. Those conversations can happen beforehand so that during *play* the individuals practicing BDSM do not have to make a split-second decision to defend their boundaries. Additionally, ongoing consent is encouraged. Barker (2013), in her paper comparing consent in the *Fifty Shades of Grey* novels to the BDSM blog community, noted that in the online community’s discussion of abuse in BDSM, “[t]here is also a sense that consent needs to be an ongoing negotiation rather than, as a one-off moment after which it can be assumed” (p. 904).

Mental Health among the BDSM Community

Connolly (2006) noted, “[p]sychanalytical writers have long interpreted BDSM eroticism as a symptom of underlying psychopathology” (p. 80). Kolmes et al. (2006) noted that clinicians with this perspective can assume that clients who participate in BDSM activities have a mental disorder simply because of their participation in BDSM (pp. 303-304). In Connolly’s (2006) study, the author found that study respondents were no more than one standard deviation from the mean on scales for depression, anxiety, Post-Traumatic Stress Disorder (PTSD) and other trauma-related phenomena, borderline pathology, and avoidant personality features; respondents also had lower levels of paranoia (Connolly, 2006, p. 100). This research indicates little difference in the mental health of people who practice BDSM and those who do not.

Study subjects who identified as dominant received higher scores on narcissistic and histrionic scales when considering the gender identity of the subject (Connolly, 2006, p. 104). The study’s sample was drawn from a community where individuals in the community often practice BDSM in public settings; the author surmised that perhaps those who have histrionic traits might be more drawn to practicing BDSM in a setting with other observers (Connolly, 2006, p. 109). Research of individuals in the BDSM community who do not practice BDSM in a public setting would be useful to see if narcissism and histrionic tendencies are still more prevalent. Overall, this study elucidates that many of the mental disorders that are assumed to be present in individuals who practice BDSM are no more prevalent than in the rest of the population.

Disclosure Issues

Bezreh, et al. (2012) observed that, although research shows that BDSM is negatively viewed, there are few studies investigating the effects of that attitude on people who practice it (p. 39). Even if a person who practices BDSM does not feel the need to be out about the sexual activities they partake in, stigma from the wider culture can still be damaging. The authors asserted that such stigma can lead to people who are not educated about safe BDSM practices or those who are hurt by the knowledge that their desires are seen as negative play is one consequence of not being taught about BDSM in a comprehensive and accepting way, but another is the risk of learning about BDSM in a negative

frame” (Bezreh et al., 2012, p. 47). Lack of acceptance of BDSM means that new participants might learn about how to practice it via pornography or literature, such as the *Fifty Shades of Grey* books and movies, which can lead to practices that are dangerous both physically, such as tying of the wrists too tightly, and mentally, such as not having an understanding of the need for negotiation and consent while playing. For individuals who discover their alignment toward BDSM at a young age, learning that their fantasies can be seen as negative or perverse can cause significant distress.

Abuse within the BDSM Community

It is also important to remember that, while BDSM is not abuse, abuse can masquerade as BDSM. Clinicians who are educated in BDSM and have attended trainings on the topic will have more skills to be able to tell the difference. According to Kolmes, et al. (2006), therapists in their study highlighted, “[t]he need for therapists who can recognize the complexity and presence of both abuse and BDSM in some BDSM relationships” (pp. 316-317). BDSM blogger Kitty Stryker (2011) enumerates a list of abusive practices that she experienced during BDSM scenes: ignoring safe words or saying no, the use of toys and or sexual acts that she refused or had previously said no to, and play partners persisting after she said she was finished (as cited in Barker, 2013, p. 902).

However, if a person who is being abused feels that their sexual orientation falls under the BDSM umbrella, it could be damaging to the therapeutic alliance for a clinician to tell the client to quit practicing BDSM. It is possible a client would quit working with a clinician rather than choosing to quit BDSM. Instead, with clients who are being abused, a harm reduction framework might be useful. The concept of harm reduction is to understand that a person might continue to participate in a risky behavior, which leads instead to a clinician focus on reducing negative outcomes by lessening a behavior (Stratton, Shetty, Wallace, & Bondurant, eds., 2001, p. 38). Encouraging a client to practice safe and consensual BDSM, and being able to define the difference is more helpful than urging a client to quit altogether. For example, encouraging the use of condoms and other barriers such as latex gloves during play that involves blood and other bodily fluids, or playing with others who are known to the client instead of strangers, are two harm reduction techniques for safer BDSM.

The use of safe words is very common within the BDSM culture and community. Connolly (2006) defined safe words as, “pre-arranged signals used between players to indicate their levels of comfort during an ongoing scene or negotiated BDSM experience” (p. 90). Additionally, in Connolly’s (2006) sample, more than 90% of those who practice BDSM used safe words, with almost 50% using them “without exception” (p. 90). Since in BDSM “no” does not always mean “no” (e.g. if ignoring a no is part of the role play) the use of safe words are vital as a signal to stop the behavior.

Affirming and Non-Affirming Clinical Approaches

The first concern for social work practice is the lack of social work research on the topic of BDSM. Learning about the BDSM community through the lens of psychology leaves much out. Social work focuses on a person-in-environment framework that looks at each client as a part of many other systems such as families and communities, whereas psychology’s lens focuses on the person with less consideration of their environment. Considering that many people who practice BDSM do so in community settings, not looking at a client’s environment can lead to vital information being missed.

Though sadism and masochism are listed in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) as paraphilic disorders, it is important to remember that one of the diagnostic criteria for both is that “the sexual urges or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (pp. 694-695). Additionally, the criteria for sexual sadism disorder includes the person who, “has acted on these sexual urges with a non-consenting person” (American Psychiatric Association, 2013, p. 695). If a therapy client discusses BDSM practice that is not distressing, and sadists are not acting on others without permission, then a person does not report symptoms consistent with either of those disorders. It is not good social work practice to then diagnose a client with a paraphilia when their sexual practice is not a presenting problem for him, her, or them.

Study subjects in Kolmes, et al.’s (2006) survey related that some therapists, “[p]rovided care demonstrating special sensitivity to a BDSM client” (p. 315). Themes included, “(1)

therapist(s) being open to reading/learning more about BDSM, (2) therapist(s) showing comfort in talking about BDSM issues, (3) therapists who understand and promote “safe, sane, consensual” BDSM” (Kolmes, et al., 2006, p. 315).

In Kolmes, et al.’s (2006) research, more than 70% of therapy clients surveyed indicated that the reason they were in therapy was not because of their BDSM practice (p. 312). Just as when an LGBTQ client comes to therapy, it is important for clinicians not to assume that a person being a member of a sexual minority needs help with challenges found within that identity. The authors itemized several other therapist missteps:

- (1) not understanding that BDSM involves consensual interactions,
- (2) “kink aware” professionals who lack appropriate boundaries...
- (3) assuming that “bottoms” are self-destructive,
- (4) therapists abandoning clients who engage in BDSM behavior,
- (5) trying to “fix” the BDSM client solely on the basis of the BDSM interests,
- (6) making reports/breaking confidentiality because the therapist assumes others are at risk solely due to the BDSM activities,
- (7) assuming past trauma is the cause of the BDSM interests,
- (8) expecting the client to teach the therapist about BDSM, and
- (9) having a prurient interest in the client’s BDSM sexual lifestyle. (p. 316)

Recommendations for Practice

Since according to Kolmes, et al. (2006) up to eleven percent of women and fourteen percent of men have practiced BDSM, it is likely that clinical social workers will have clients who practice BDSM, whether the therapist is aware of such practices or not (p. 302). Best practice would be to act as an affirming clinician in the same way one would for any client identifying as a sexual minority. Individuals who practice BDSM are no more likely to have a mental disorder than any other person. If countertransference with BDSM clients cannot be managed, the ideal option is to potentially refer the client to another clinician who is trained in working with individuals in the BDSM community. Encouraging a client to cease any type of sexual activity is likely to lead to a rupture in the therapeutic alliance and poorer outcomes in the future. Additionally, clinicians should consider furthering their own educations about BDSM communities and practices, by attending workshops and seminars and by seeking out research. Ongoing study of consent and BDSM communities is necessary to better understand the needs of the BDSM community from the perspective of social work to provide affirming practice and support members of this widely diverse community.

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An Examination of the Treatment of Mentally Ill Offenders in the Criminal Justice System

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Abstract

In the United States, law enforcement officers and correctional facilities encounter an increasing number of individuals with mental illness. Rooted in the movement to deinstitutionalize mental illness—a failed undertaking to transfer the domain of mental health treatment from state hospitals to outpatient settings—the criminalization of mental illness gave rise to a number of issues related to the treatment of criminal recidivism and mental disorders. The paper seeks to explore comorbidity of criminality and mental illness among offender populations, with a review of the literature on the difficulties of managing mental illness in a correctional context; the challenges that law enforcement officers encounter in responding to mentally ill individuals; and the current state of mental health treatment in correctional settings. This paper concludes with several suggestions for policy reform and future research directions.

Keywords: mental health; offender treatment; serious mental illness; criminality; criminal justice

Introduction

Individuals with mental illness are largely overrepresented in the criminal justice system. In the United States, the number of individuals with mental illness in prison has surpassed that of mental health facilities; individuals with mental illness are three times more likely to be incarcerated than imprisoned (Abramsky & Fellner, 2003; as cited in Morgan et al., 2012). Research on the prevalence of mental illness among offender populations estimates that 14.5 percent of male jail inmates and 31 percent of female jail inmates have a serious mental illness. (Steadman, Osher, Clark-Robbins, Case, & Samuels, 2009). Moreover, when accounting for mental illness among both jail and prison populations, research suggests that more than half of all inmates have a mental health problem (James & Glaze, 2006).

Similarly, the literature indicates that individuals displaying signs of mental illness are more likely to be arrested. In a study conducted on police-citizen encounters, findings suggest that individuals displaying signs of mental illness were 67 percent more likely to be arrested compared to individuals who did not display signs of mental illness (Teplin, 1984; as cited in Teplin, 2000). It appears that mentally ill individuals are disproportionately likely to come in contact with law enforcement officers and to be arrested; the issues of substance use and trauma only further complicate this disparity. Among mentally ill justice-involved individuals, co-occurring substance use and trauma-related disorders, especially posttraumatic stress disorder (PTSD) is high (Abram & Teplin, 1991; Sadeh & McNiel, 2015; Sindicich et al., 2014). This overrepresentation of justice-involved individuals with mental illness is a manifestation of the disintegration between legal and health sectors, making the criminal justice system the principal provider of mental health services.

The placement of mentally ill individuals in the legal system, as opposed to the mental health system, is arguably a consequence of issues related to policy changes and inadequate funding, rooted in the movement to deinstitutionalize the mentally ill (Teplin, 2000). The deinstitutionalization movement—a failed undertaking to transfer the domain of mental health treatment from state hospitals to outpatient settings—yielded a persistent deficit in community-based mental health services and supports that are essential for mentally ill individuals to function in their communities (Cloud & Davis, 2015). Problematically, this system-level change has criminalized mental illness to the extent that mentally ill individuals are processed through the criminal justice system, with police officers frequently serving as “frontline mental health workers” (Cloud & Davis, 2015, p. 5). Correctional facilities then become burdened with the responsibility of providing mental health treatment for mentally ill offenders.

Difficulties of Mental Illness in Institutional Context

Correctional institutions are ill equipped to meet the needs of offenders with mental illness and the inadequacies in accessing mental health services within such facilities are complimented by the challenges inherent to effective mental health assessment. Estimates indicate that nearly a quarter of individuals incarcerated in state prisons have a history of mental health problems, including prior mental disorder diagnoses, psychiatric hospitalizations, and mental health treatments (i.e., prescription medications or therapy; James & Glaze, 2006). This point highlights the importance of utilizing accurate and effective screening and assessment tools, particularly during intake procedures, in order to ensure that offenders with mental illness are appropriately identified and offered the best available treatment (Bonta, Blais, & Wilson, 2014). Hills, Siegfried, and Ickowitz (2004) elaborate on the difficulties in managing mentally ill offenders and divide the challenges into five categories: 1) determining whom and how to treat; 2) managing inmate behavior and symptoms; 3) recognizing the negative effects of the prison environment on mental health; 4) understanding inmates' difficulties in adjusting to institutional life; and 5) determining the need for special services.

In addressing the challenges of managing inmate behavior and symptoms, Hills et al. (2004) note that the symptoms of mental illnesses might affect an offender's capacity for self-care, rule compliance, and directional adherence. Additionally, mental illness might induce fear, adversity, and hostility from other inmates and correctional staff; these responses present a challenge for mentally ill offenders in adjusting to the correctional environment (Hills et al., 2004). Specific conditions of the prison environment (e.g., overcrowding, noise level, victimization) might exacerbate symptoms of mental illness; the likelihood of placement in segregation or isolation is high for individuals with mental illness due to their increased vulnerability for abuse and their tendency to receive more infractions as a consequence of disruptive or non-compliant behaviors (Hills et al., 2004). Moreover, isolation might have significant consequences for mentally ill offenders, such as symptom exacerbation.

It is beyond the scope of this paper to provide a comprehensive review of the challenges

in caring for and managing mentally ill individuals in correctional facilities; however, such difficulties parallel and expand on some of the challenges police officers encounter in interactions with mentally ill individuals in the community.

Police Response to Mentally Ill Individuals

Police officers are frequently required to serve as "de-facto street corner psychiatrists" (Teplin, 2000, p. 9). The goal of the criminal justice system is to ensure public safety and according to Teplin (2000), police involvement with mentally ill individuals stems from the power and authority granted to police officers by two common law principles: 1) to protect the safety and welfare of the public and 2) to protect citizens with disabilities, including those with a mental illness. Police officers have a professional obligation to protect both citizens with and without mental illness alike. However, with limited resources and inadequate training, police officers are often unequipped to manage individuals with serious mental illness despite their frequent contact with this population.

The research suggests that 10 percent of all police calls involve individuals with mental illness (Watson & Angell, 2013), with up to 6 percent of criminal suspects estimated to have a mental illness (Morabito et al., 2012). It should be noted that estimates of police contacts involving individuals with mental illness vary; according to Short, MacDonald, Luebbers, Ogloff, and Thomas (2014), between 7 and 20 percent of police contacts involve individuals with mental illness. Therefore, police officers are placed in a unique position, "serving as gatekeepers to both criminal justice and mental health systems" (Gur, 2010, p. 223).

The discretionary power traditionally granted to police officers in making judgments and arrest decisions is restricted in cases involving mentally ill individuals. Police interactions with mentally ill individuals expand beyond contacts that are crime-related (Short et al., 2014). Police officers are often called to provide assistance to individuals displaying erratic or bizarre behaviors (Short et al., 2014). Teplin (2000) elaborates on this point: "Officers who encounter an irrational person creating a disturbance have three choices: transport that person to a mental hospital, arrest the person, or resolve the matter informally" (p. 9).

Problematically, the bureaucratic nature of the criminal justice system produces a legal system that is rooted in efficient (e.g., timely, feasible, low cost) rather than fair and just practices and procedures. Thus, when hospitalization or treatment is deemed an appropriate response over arrest, system efficiency creates a context in which police response to mentally ill individuals is largely informed by organizational and legal factors.

In addressing individuals with mental illness, police officers indicate that accessing mental health care is often time-consuming (Morabito et al., 2012), especially given the difficulties in obtaining commitment and making mental health referrals (Teplin, 2000). Rigid hospital admission criteria reject those who are overly dangerous, have a substance abuse disorder, or have numerous previous hospitalizations (Teplin, 2000). Therefore, the decision to arrest might be one of necessity, such that it is the only option that will ensure public safety. The mission to protect and serve that underscores policing behaviors may be compromised by individual officer bias. Operating under the assumption that jail is the only means to provide certain individuals with food, shelter, and health services, police officers might engage in “mercy bookings” (Cloud & Davis, 2015, p. 7), which involve the arrest of individuals for petty offenses who present with symptoms of mental illness. Police officers frequently arrest individuals with mental illness as a means to ensure public safety and individual well-being (Teplin, 2000). However, research suggests that in cases of domestic violence, police officers are less likely to make an arrest if no future danger exists or if conviction is unlikely (Stalans & Finn, 1995). It appears that police officers’ decision to arrest may also be influenced by factors that extend beyond public safety and individual well-being.

Prior research on mental illness and police use of force highlights how arrest might be a consequence of inadequate police training. The behavior of mentally ill individuals might be judged as abnormal or unusual, and police officers may interpret such behaviors as signs of hostility, aggression, and noncompliance (Morabito et al., 2012). When responding to mental health crises in which a mentally ill individual is experiencing acute symptoms or is in a state of psychiatric distress, the situation might quickly escalate into violence without adequate resources (e.g., specialized training, diversion options; Cloud & Davis, 2015). Such behavioral misinterpretations

are further complicated by the comorbidity of mental illness and substance abuse. That is, individuals with a mental illness might also be under the influence of drugs or alcohol, which makes it difficult for police officers to manage the incident or to recognize the presence of mental illness (Morabito et al., 2012). In all police responses, the goal of the responding officer is to gain control of the situation, and when the behaviors of mentally ill individuals are construed as unpredictable or resistant, police may resort to arrest (Morabito et al., 2012).

Mental Illness and False Confessions

Mentally ill individuals are at a greater risk for false confessions (FCs). Research suggests that individuals with serious mental disorders frequently have substantial impairments that influence their understanding of *Miranda* warnings, which offer protection against conditions that might produce self-incrimination (i.e., involuntary and unreliable confessions; Kassin et al., 2010). Some research suggests that poor comprehension of *Miranda* warnings might be predictive of the likelihood to provide a FC (Kassin et al., 2010). That is, by waiving their right to silence and counsel, individuals with mental illness might be more vulnerable to falsely confess under psychologically manipulative police interrogation tactics (Kassin et al., 2010; Redlich, Summers, & Hoover, 2010). According to research conducted by Redlich and colleagues (2010), the majority of self-reported FCs among individuals with mental illness was attributed to the desire to end police questioning, to get out of jail, or to go home.

The high prevalence of mental illness in the criminal justice system might be attributed, in part, to limited mental health resources, bureaucratic and legal constraints, and inadequate police training that leads to increased arrests and false confessions among mentally ill individuals. Therefore, it is also important to consider mental health treatment options within correctional and community contexts.

Treatment for Mentally Ill Offenders

The difficulty in providing treatment for offenders with mental illness is rooted in the complex relationship between mental illness and

criminal behavior, and the controversial nature of determining the most appropriate target of treatment. A review of the literature on treatment programs for offenders with mental illness found little evidence of existing treatment programs that are effectively tailored to address dual issues of criminal behavior and mental illness (Morgan et al., 2012).

Morgan et al. (2012) performed a meta-analytic review of studies evaluating therapy interventions provided in a correctional setting, which was the first systematic investigation of effective treatment interventions for offenders with mental illness. Morgan and colleagues (2012) determined several treatment components that were beneficial for offenders with mental illness. More specifically, the researchers found that the most effective intervention programs for offenders with mental illness include those that maintain an open admission policy (i.e., participants may enter the program at any time throughout its course), as well as active homework and behavioral practice (i.e., activities performed that require practicing newly learned skills or mandate social interaction). Although no statistically significant conclusions could be drawn regarding treatment effects on criminal or psychiatric improvements, the findings determined that open admission and active homework in treatment effectively reduced offenders' distress and improved their coping skills, general functioning, and their capacity to adapt to the institutional environment. Thus, some research on current service provisions for mentally ill offenders exists, yet this field of inquiry needs further examination to address the dual treatment of criminal behavior and mental health.

Skeem, Manchak, and Peterson (2011) suggest that mental illness is infrequently a direct cause of criminal behavior; instead, most criminal offenses committed by individuals with mental illness are likely the indirect result of their mental illness. Accordingly, Skeem and colleagues (2011) argue that the major risk factors (i.e., predictors of violence and crime) are the same for offenders both with and without mental illness but that offenders with mental illness are likely to have a *greater number* of general risk factors. This emphasizes the importance of identifying the risk factors that link mental illness and criminal behaviors.

The need for effective interventions in the context of treatment for dual issues of mental illness and criminality highlights the importance of identifying criminogenic risks and level of

clinical impairment, which can better inform sentencing and supervision practices. According to the literature, offenders at greater risk for recidivism will likely be more responsive to evidence-based correctional principles (e.g., reduce recidivism risk), whereas offenders with more pronounced psychopathology and functional impairments will likely be more responsive to evidence-based mental health practices (e.g., reduced hospitalizations, symptoms, or employment- or housing-related issues; Skeem et al., 2011). Given that offenders differ in their degree of recidivism risk and levels of clinical impairment, both need to be addressed when assessing and treating offenders with mental illness.

Presently, the best evidence-based intervention for offenders involves programs based on the principles of the Risk-Need-Responsivity (R-N-R) model. Research suggests that R-N-R is the most commonly used model for offender assessment and treatment (Morgan et al., 2012). The R-N-R model contends:

Offenders are less likely to recidivate when programs match the intensity of supervision and treatment to their level of risk for recidivism (*Risk* principle), target their criminogenic needs, or changeable risk factors for recidivism (*Need* principle), and match modes of service to their abilities and styles (*Responsivity* principle). (Skeem et al., 2011, p. 121)

Therefore, the intensity of treatment should match the risk of reoffending with interventions that target risk factors linked to criminal behavior and cognitive-behavioral treatments that uniquely match the specific needs of the offender (Morgan et al., 2012). The responsivity principle is particularly relevant, such that services should match the cognitive abilities, learning styles, motivation, and personality functioning of offenders (Morgan et al., 2012).

For most offenders with mental illness, psychiatric symptomology is not a criminogenic need (i.e., the mental illness does not have a direct effect on criminal behavior; Skeem et al., 2011). In a study conducted by Morgan, Fisher, Duan, Mandracchia, and Murray (2010) on the prevalence of criminal thinking in mentally disordered offenders, the researchers found that the criminal thinking scores of the participants diagnosed with a serious mental illness were similar to the criminal thinking scores of non-mentally ill offenders. In fact, research on the relationship between mental illness symptoms

and criminal offending demonstrates that psychiatric symptoms are rarely direct motivators for criminal behaviors (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014). Among the 429 crimes assessed, Peterson et al. (2014) found that symptoms of psychosis, depression, and bipolar disorder had a direct influence on criminal activity in only 4 percent, 3 percent, and 10 percent of the cases, respectively. Therefore, it is important for interventions to focus on risk factors beyond mental illness (e.g., antisocial personality pattern, pro-criminal attitudes, substance use, employment and housing needs).

Although the R-N-R model is an empirically supported intervention for reducing criminal recidivism among offenders in general (Morgan et al., 2012), correctional interventions should be used in conjunction with effective psychiatric treatment. Psychiatric rehabilitation aims to provide mentally ill individuals with educational services, social services, and supportive community interventions to promote behavioral functioning and independency (Morgan et al., 2012). The components of effective, evidence-based psychiatric treatment include collaborative psychopharmacology, assertive community-based treatment (ACT), family psychoeducation, supported employment, illness management, and integrated dual-disorder treatment (Morgan et al., 2012). The impact of mental health treatment on criminal recidivism is not well researched; however, mental health services may be important in the advancement of public health outcomes for mentally ill offenders (e.g., psychiatric recidivism), including symptom reduction, decreased substance use, and fewer psychiatric hospitalizations (Skeem et al., 2011).

Thus, the most intensive supervision and treatment resources are allocated for the individuals with the greatest criminogenic risk and clinical need, and offenders who are considered low-risk and low-need might require some combination of supervision and community-based mental health treatment (Skeem et al., 2011). This proposed correctional and psychiatric treatment framework can be applied more broadly to mental health and forensic populations; however, this framework for assessment, diagnosis, and treatment will take significant policy reform and funding to promote collaboration between mental health and criminal justice systems.

Skeem et al. (2011) indicate that recidivism might be mediated by system bias, including officers' stigma, close monitoring, paternalism, and fear of mentally ill offenders.

For example, mentally ill individuals are frequently perceived as being more violent, threatening, or dangerous (Skeem et al., 2011). Research suggests that police officers use their prior knowledge to inform decisions to arrest (Stalans & Finn, 1995); such stereotyped images that are informed by prior knowledge might promote stigma and bias in police response to the mentally ill, thereby increasing the likelihood for rearrest.

Individuals both with and without mental illness are likely to be rearrested for new crimes, yet it appears that, among offenders on community supervision, those with a mental illness are more likely to commit technical violations of their supervision and to have their term suspended or revoked (Skeem et al., 2011). Mentally ill offenders are subject to increased monitoring and control and in the context of greater surveillance exists a greater chance for minor infractions to be detected (Skeem et al., 2011). Additionally, individuals with mental illness might have functional impairments that hinder their ability to follow the standard conditions of community release (e.g., maintaining employment, paying fines and fees) (Skeem et al., 2011). Offenders with mental illness might be more likely to experience revocation or incarceration as a consequence of mental illness, such that they are required to abide by more conditions of release because of their mental illness (e.g., mandated treatment) (Skeem et al., 2011). Therefore, in order to limit involvement in the criminal justice system, the supervision failures of the system need to be addressed.

When addressing the issue of recidivism as a violation of supervision requirements, it is important to consider the high prevalence of co-occurring mental illness and substance abuse disorders, particularly in the context of trauma. According to a study conducted by Sadeh and McNeil (2015), posttraumatic stress disorder (PTSD) was associated with an increased risk of recidivism among justice-involved individuals with mental disorders, and the risk for rearrest among individuals with PTSD was similar to those who had a substance use disorder.

Interestingly, Sadeh and McNeil (2015) describe these findings in providing support for PTSD as a conferring risk for other maladaptive behaviors (e.g., substance use, aggression), but substance use disorders cannot fully explain the relationship between PTSD and criminal recidivism. These findings offer support for trauma-informed interventions in correctional

settings. However, the literature on trauma and violence also emphasizes similar findings among non-offender populations. That is, individuals with PTSD within the general population might also be more likely to engage in violent and aggressive behaviors (e.g., intimate partner violence; Hahn, Aldarondo, Silverman, & McCormick, 2015). Hahn et al. (2015) elaborate on this point and note that untreated trauma symptoms feed into the “continuing cycle of violence and poor health outcomes,” such as recurrent injury, substance abuse, school dropout, unemployment, and violent behavior (p. 748). It appears that trauma experiences are associated with justice system involvement among mentally ill individuals and further exacerbate substance use and aggression (Sindicich et al., 2014).

More specifically, a study of male offenders in Australia conducted by Sindicich et al. (2014) found that among participants, 90 percent had a history of substance dependence and more than half met the diagnostic criteria for PTSD. Of significant importance is the finding that 43 percent of the participants reported experiencing a prison-based trauma. These findings speak to other research findings that suggest inmates with mental illness have an increased risk for victimization within correctional settings (Wolff, Blitz, & Shi, 2007).

Trauma among offender populations is widespread (Sindicich et al., 2014); it appears that the research on PTSD and criminal recidivism (e.g., Sadeh & McNeil, 2015) juxtaposes the research on mental illness and criminal recidivism (e.g., Skeem et al., 2011). As previously described, Skeem et al. (2011) argue that mental illness plays a limited role in recidivism, and the researchers concede that mental illness might contribute directly to the criminal behavior of a small group of mentally ill individuals. However, the research on PTSD suggests that mental illness derived from trauma is directly related to criminal recidivism (Sadeh & McNeil, 2015). Although a further discussion of this difference is beyond the scope of this paper, it is necessary to critically examine the findings offered by Skeem and colleagues (2011) utilizing a trauma-informed perspective. Arguably, the complexity of trauma and substance abuse further intensifies the role of mental illness in the commission of crime, and the number of offenders for whom mental illness is proposed to be directly related to recidivism might be higher than the research suggests. Thus, there is a need for trauma-informed interventions in both correctional and community contexts.

Future Directions for Research and Treatment

In light of the aforementioned information, several implications should be considered in order to limit justice involvement among offenders with mental illness. The overrepresentation of individuals with mental illness in correctional facilities underscores the demand for effective treatment interventions that address mental health and criminality. Current treatment programs effective among offender populations adhere to the general principles of the R-N-R model and use a cognitive-behavioral framework with intensive, structured interventions (Morgan, Kroner, Mills, Bauer, & Serna, 2014). However, future investigative efforts should be devoted to the development of effective treatment protocols that specifically address criminality and mental health symptoms.

It is important that screening and assessment measures are used to address individual risks and needs, as well as to inform supervision decisions (i.e., community or correctional treatment) and treatment interventions (e.g., criminal thinking, mental health treatment, trauma-informed practices, and substance abuse treatment). The methods for screening and assessment should be universal, thereby allowing for effective communication between correctional facilities, probation and parole agencies, and mental health treatment providers. Morgan et al. (2014) highlight the importance of implementing a screening protocol that identifies mentally ill offenders who have co-occurring criminal thinking patterns in order to better inform treatment and intervention strategies.

Moreover, given the high rate of trauma and comorbid substance use disorders among offenders with mental illness, interventions that address trauma and substance use need to be implemented. Trauma symptoms and substance use often contribute to recidivism via parole or probation revocations or arrests for new offenses. For example, a study conducted by Barrett, Teesson, and Mills (2014) found that PTSD hyperarousal symptoms were consistently associated with the perpetration of violent crime in individuals with substance use disorders. The researchers emphasized the importance of utilizing interventions that address hyperarousal symptoms to reduce the likelihood of violence among individuals with this comorbidity, noting

that such interventions might be a useful “crime reduction tool” (Barrett et al., 2014, p. 1079).

Additionally, police departments need to employ specialized training and law enforcement response programs in order to equip officers to better respond to mental health crises and to educate officers on mental illness. The goal of this training is to reduce the likelihood of police use of force, to increase the likelihood that individuals with mental illness will receive adequate treatment, and to decrease the contact that mentally ill individuals have with law enforcement officers.

For example, Crisis Intervention Team (CIT) programs have gained national recognition as a best practice model for the diversion of individuals with mental illness (Franz & Borum, 2011). CIT police officers are educated on mental health disorders and trained in crisis intervention for individuals with mental illness (Franz & Borum, 2011). The goal of CIT programs is to improve police officer responses to individuals with mental illness (Morabito et al., 2012). Additionally, CIT programs promote collaboration and partnerships among law enforcement officials and mental health professionals (Broussard, McGriff, Demir Neubert, D’Orio, Compton, 2010). For example,

Broussard et al. (2010) note several evaluation studies focused on officer-level data with positive findings for police officers, such as increased knowledge of mental illness, improved attitude towards mentally ill individuals, enhanced feelings of self-efficacy, and greater number of referrals for mental health services.

Concluding Thoughts

The criminal justice and mental health systems are often responsible for providing services to the same population. Thus, the coordination and collaboration between the two systems is both critical and necessary. The goal is to integrate the efforts between the systems to provide supervision and treatment that is responsive to the needs of offenders with mental illness, both in correctional facilities and in the community. The deinstitutionalization of mental illness has created a context in which mental illness has become re-institutionalized in correctional settings. Treating mental illness alone cannot minimize criminal recidivism; however, correctional treatment and law enforcement reforms cannot entirely ignore issues related to mental health.

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Critical Review of Social Anxiety Disorder

Sabrina S. Massey

Abstract

The following review is a presentation of a case regarding a high school adolescent presenting with social anxiety disorder within a secondary educational setting. After gathering previous data on the student from a parent, the student's previous school, and the student herself, the school social worker conducted a review of existing literature and previous studies on successful social anxiety disorder interventions that were conducted within school settings. Gathering this information allows school mental health professionals to prepare the best possible course of treatment for a student, yielding an increase in social-emotional learning and the enhancement of the student's academic performance and achievement. Aspects of each of the interventions were integrated into the student's treatment plan with the aid of an FBA/BIP to help create appropriate, measurable goals and to connect the target and replacement behaviors to the intervention plan, making her overall school treatment effective and valuable.

Keywords: social anxiety disorder, school social work, adolescent, evidence based practice, evidence informed practice, social-emotional learning, FBA/BIP, goals, target behavior, replacement behavior.

Introduction

This clinical review is of a 14-year old high school female that for the purposes of anonymity will be referred to as Sam. Sam is a freshman at a public secondary school located in the northwest suburbs of Chicago, Illinois. Sam suffers from a social anxiety disorder and has held this diagnosis for a year and a half. In nearly all school or social settings, Sam has a significant fear that adults or her peers will negatively scrutinize and criticize her. When exposed to these settings, Sam typically becomes visibly anxious by sweating, crying, blushing, and shrieking. In these moments, she loses her ability to speak except to meekly voice her concern that she will be judged as boring, crazy, and

unpleasant. Sam spends an inordinate amount of her time hoping that people will like her.

Sam is a middle class, Mexican American female living in a community that is highly populated with other Mexican Americans. She lives in a community with people her age, many of whom she has been friends with her whole life, but feels she can no longer socialize with them unless in a one-on-one setting, preferably in her own home. Sam states that she wants to be able to socialize with her peers in group settings, but is often overwhelmed by the idea that she might say or do something to offend or upset others.

Sam lives with her mother, father, and two sisters, and is the eldest child. Both parents are very authoritarian in their parenting styles, and Sam describes them as strict and unfair. She feels that as the oldest child substantial pressure is placed on her from her parents to succeed academically and socially, specifically by her mother. According to Sam, social and cultural norms dictate that Sam should be spending more time with large groups of friends, becoming interested in boys and fashion, and working at a job to help the family financially, but these are all activities Sam describes as "impossible" due to the anxiety they cause her.

Despite the limitations of Sam's social anxiety disorder, she has several strengths that she utilizes to help her manage and cope. Sam is aware of her diagnosis and condition, and is mindful enough to know when to avoid situations in which her social anxiety will overcome her. She has created a list of coping mechanisms that have proven to work for her when she begins to feel anxious, and she keeps this list on her cell phone for easy access. While Sam is aware that she has very few friends from school and the community, she has been intentionally working to foster positive friendships with her closest friend from school and both of her sisters. Sam is diligent in seeing her school social worker for weekly sessions and brave enough to share her diagnosis with her friends in order to gain support from them. Sam is kind and generous with her peers, and respectful to her parents and teachers. She is hard working and maintains a B average in her classes.

This year, Sam and her school social worker have been focusing primarily on getting her to be able to answer questions aloud in class, eat lunch in the cafeteria, and take the school bus home. These situations have been consistently causing Sam the most difficulty in school and need to be addressed.

Data Collected

Unfortunately, there has been very little data collected on Sam by her previous school. The file that was sent to the high school from her middle school is missing significant documentation, leaving gaps in the information provided. There is documentation of her diagnosis and a brief write up of her eligibility for her current 504 plan, but no further detail, support, or data. Without a full report of Sam's case, her social worker is left with minimal understanding of the client and is unaware of the best possible course of action the 504 team needs to take in order to proceed appropriately. When the social worker, as well as Sam, is at a disadvantage, this in turn leaves Sam at a disadvantage. The team cannot appropriately advance without properly knowing what Sam has already done and tried in the past.

Despite the lack of information provided in the file, there was still adequate substance included to begin to piece this case together. Sam was initially added to the Early Intervention Team's At-Risk List because of the lack of data provided and the potential severity of her condition. Being added to this list to be monitored kept her on the team's radar, so they could ensure that she was receiving supports before her situation got out of hand and would ensure that she was not be overlooked. In the annual review, Sam and her mother were both contacted to help the social worker better understand Sam's needs. Both were aware of her current 504 plan from middle school, and they collectively decided that it was working for them both. Sam wanted to continue receiving the 504 accommodations through her high school career to assist her in her education; these included modifications to homework assignments that required presenting in front of the class and using counseling with the school social worker as needed.

Due to the absence of reports submitted from the middle school, a Behavior Assessment System for Children, Second Edition (BASC-2) was completed for Sam. The BASC-2 is "a multi-method, multi-dimensional approach to evaluating behavior and self-perception of

children ages 2 years 6 months to 18 years" (Reynolds & Kamphaus, 2002). It was designed to aid in the educational categorizing of social, emotional, and behavioral difficulties and support in the design of treatment plans.

Sam, her mother, and two teachers completed their portion of the BASC-2 assessment, and their compiled results showed that Sam's disorder was impeding her functioning, but was not clinically significant enough to warrant an Individualized Education Program (IEP). However, because Sam's functioning was suffering greatly in school, it was determined that a formal Functional Behavior Assessment/Behavioral Intervention Plan (FBA/BIP) would be conducted in order to create a plan to manage Sam's behavior. Before a plan could be created to dictate Sam's next steps, it was essential to look into and consider the research that has already been conducted regarding school-based interventions for adolescents with a social anxiety disorder. Authors Massat, Kelly, and Constable (2016) state the following:

As recent reviews have shown, a number of effective school-based interventions exist for students with anxiety disorders (Kelly, 2008; Kelly, Raines, et al., 2010; Neil & Christensen, 2009). These include cognitive-behavioral one-on-one work or in small groups, classroom-based interventions (mindfulness training and relaxation/meditation), and family-based coaching and psychoeducation. These approaches can improve the anxiety symptoms of many youths in schools (Kelly, Raines, et al., 2010). (p. 604)

Professionals understanding and implementing this kind of evidence-based and relevant information is vital to the creation of a well-informed intervention and treatment plan, and is fundamental to the behavioral health of the student.

In this next section, three different studies are examined to better understand their successful outcomes using evidence-informed interventions to help students overcome social anxiety within a school setting.

Previous Studies

Study One

Cognitive Bias Modification versus CBT in Reducing Adolescent Social Anxiety: A Randomized Controlled Trial (Sportel, de Hullu, de Jong, & Nauta, 2013) describes effective

interventions to treat social anxiety in adolescents. Researchers investigated the efficacy of two early interventions that may be possible for adolescents with social anxiety and test anxiety. The study compared an internet-based cognitive bias modification (CBM; n=86) with a school-based cognitive behavioral group (CBT; n=84) and a control group (n=70) to see if symptoms could be reduced for students aged 13-15 who had high social or test anxiety. The 240 participants were randomized over the three conditions using a multi-arm parallel group approach that utilized a balanced, stratified design. Assessments were conducted before and after the intervention, as well as at follow-up points at six and twelve months-. The test results concluded that the interventions resulted in fewer social anxiety symptoms, with test anxiety being influenced long-term by the CBT intervention and the CBM intervention leading to increased positive automatic threat-related associations.

The CBM intervention was comprised of twenty 40-minute sessions, delivered twice a week to the participants at home over the Internet. The participants were presented with ambiguous social scenarios, ones meant to heighten anxiety slightly, and then their initial attention was directed toward a positive or neutral stimulus instead of at threatening stimuli. Additionally, there were tasks included meant to strengthen the association between social-evaluative situations (i.e. tests) and positive outcomes, and an evaluative conditioning task meant to augment inherent self-esteem by associating self-relevant data with positive outcomes. All of these tasks were included to decrease anxiety by associating the situations with either a neutral or positive thought.

The CBT intervention was comprised of ten weekly 1.5 hour sessions delivered in small groups by a licensed psychologist at school after school hours. The group included psycho-education, a critical thinking assessment to improve focus and attention control, cognitive restructuring, exposure to provocative states, tips on avoiding relapse, and homework. After the pretest, a set of participants were randomly assigned to the control group. The participants were notified that they were placed in this group and would not receive any interventions.

After reviewing the results from the Revised Child Anxiety and Depression Scale (RCADS), the Spielberger's Test Anxiety Inventory, and the Anxiety Disorders Interview Schedule for Children (ADIS-C), this study revealed that there was a decrease in social

anxiety scores for both applied interventions. At the six-month follow up, the reduction of social anxiety was stronger in the CBT condition than the CBM or control group. The continued increase in positive automatic associations was found to be stronger for CBM than for both the CBT or control group. While there was no difference in social anxiety between the CBM, CBT, and control groups at the twelve-month follow up, there was a noticeably strong improvement in the CBM and CBT groups at the six-months follow up. This suggests that the interventions show results, but potentially need monitoring, practice, and further direction to help reinforce a student's strengths, build confidence, and reinforce newly created cognitions.

This study demonstrates the impact CBT and CBM can have on a student within a school setting for those who are suffering from social anxiety during the school day. While the article mentions that there were not enough students present in the study with a diagnosis to report the effectiveness in preventing the development of the disorder, the results of the study have found that the use of the interventions are effective in treating the symptoms associated with social anxiety.

For the client, this potentially can have beneficial implications. The use of CBM and CBT on Sam will potentially work to address her fear of large crowds, hyper-concern about how others perceive or judge her, somatic anxiety related symptoms, as well as her mild depression. The only necessary modification to the CBM process that should be used in Sam's case would be altering the location; the study was conducted in homes, but for the purposes of the client and the social worker in the school setting, this intervention would be modified to occur during school hours.

Study Two

School-Based Intervention for Adolescents with Social Anxiety Disorder: Results of a Controlled Study (Masia-Warner et al., 2005) discusses effective interventions to treat social anxiety in adolescents. This study argues that it would be more effective to transport services for social anxiety disorder into the school setting to circumvent barriers to treatment, especially as the disorder's peak onset is adolescence and few youths receive services. The efficacy of a school-based intervention was examined in a wait-list control trial of 35 adolescents. The participants demonstrated a significantly greater reduction in

social anxiety and avoidance, as well as significantly improved overall functioning. The findings of this study support the efficacy of school-based intervention for facilitating treatment for socially anxious adolescents.

The method used in this study involved recruiting via the use of self-rating scales measuring social anxiety and teacher nominations. Eligible students completed the Social Phobia and Anxiety Inventory for Children (SPAI-C), the Social Anxiety Scale for Adolescents (SAS-A) and the social subscale of the Multidimensional Anxiety Scale for Children (MASC). Their parents were interviewed, and informed consent was obtained. Parents and adolescents were then both separately interviewed using the Anxiety Disorder Interview Schedule for DSM-IV (ADIS-PC). Based on the results of this screener, students were then deemed appropriate for this study.

Students were randomly assigned to either a Skills for Academic and Social Success (SASS) intervention or the control group. The SASS group met during a non-academic class period instead of a full hour for 12 weekly group sessions with two brief individual sessions, two group booster sessions, and four weekend social events to provide real world exposure. Parents and teachers received two sessions of psychoeducation separately. The program spanned three months and was by a clinical psychologist.

The participants were evaluated before and after the intervention, as well as at a nine-month follow up assessment. Assessments included self-report inventories, parent and teacher ratings, and independent evaluator ratings. The clinical significance of treatment effects was estimated by the participants no longer meeting DSM-IV criteria for social anxiety disorder. Among the SASS group, twelve of the eighteen adolescents no longer met the criteria. Overall results of the nine-month follow up indicate that the intervention group maintained clinical achievements nine months after the completion of the treatment.

For those who are suffering from social anxiety in a school setting, research by Masia-Warner et al. (2005, p. 716) suggests that “an empirically-based school intervention including exposure, social skills training, and realistic thinking results in significant improvement in the functioning of adolescents with a social anxiety disorder”. Particularly, a SASS intervention is key to increasing social functioning and reducing social anxiety and avoidance. The results of this

study are not only clinically significant, but also statistically significant. The positive effects of the school-based SASS intervention were maintained not only by the participants that completed the study, but also by those who dropped out part way through.

The SASS intervention has results that can be greatly beneficial to Sam. As previously mentioned, Sam often avoids large groups of students, such as those found at assemblies or in the cafeteria. This method of intervention includes exposure therapy that is meant to be done during school hours, which is particularly helpful for Sam since her parents refuse to take her to a therapist outside of school. The intervention also allows Sam the psychoeducation needed to help her social skills and shift her distorted thinking. This gives Sam the opportunity to reduce her symptoms, to receive the treatment she needs for her condition, and also to give her the training in social settings that might allow her to practice her new social skills with an advocate by her side, offering her the support and encouragement she needs to succeed.

Study Three

Exploring the Relevance of Expressed Emotion to the Treatment of Social Anxiety Disorder in Adolescence (Garcia-Lopez, Muela, Espinosa-Fernandez, Diaz-Castela, 2009) discusses effective interventions to treat social anxiety in adolescents. This article seeks to find out if the involvement of parents plays a role in the treatment outcome of their children with social anxiety disorders. While the article mentions there are other studies showing that parents with high expressed emotion (EE) (i.e. criticism, over-involvement, hostility) influence the outcome and relapse with anxiety disorders, this study seeks to understand if there is an association between EE and lower treatment outcomes for social anxiety. The results disclosed that parents with a low EE showed a noteworthy reduction of the scores at their student’s social anxiety posttest.

The sample of sixteen adolescents ranged in age from fifteen to eighteen and all participants had a primary diagnosis of social anxiety disorder. The sample population received the Intervencion en Adolescentes con Fobia Social [Treatment for Adolescents with Social Phobia] (IAFS), a school-based, cognitive-behavioral intervention directed at overcoming social anxiety, for twelve weekly sessions, each 90 minutes in length. Techniques included social

skills exposure and cognitive restructuring. Additionally, the ADIS-C and childhood social anxiety scales were administered at pretest, posttest and 6-month follow-up.

The results of this study revealed that adolescents whose parents had low EE showed a statistically significant decrease in their social anxiety posttest scores, as opposed to parents with high EE. The parents with low EE also scored significantly lower than high EE parents at the six month follow-up. These findings suggest that not only does low parental EE greatly influence the treatment outcomes of adolescents with social anxiety, but also it can be inferred that parental psychopathology (parents with high EE) may work to prevent poor treatment outcomes, such as increased anxiety, family conflict, and withdrawal.

The article also stresses the influence perceived criticism from parents can have on adolescents. Socially anxious adolescents are averse to ask for help due to their social reservations, making the implementation of proactive strategies vital in the school setting (Garcia-Lopez et al., 2009). The results of this study support the value of social anxiety interventions implemented in the school setting, and suggest that mental health treatments for social anxiety in adolescents result in progress that is sustained and established over a 6-month follow-up interval for adolescents with low EE parents.

This method of intervention has results that can be greatly beneficial to the client from the case example, but it also has limitations. From a legal standpoint, Sam's mother cannot be tested for low EE as she is not the client. However, based on conversations had with her and reports from Sam, it is evident that Sam's mother has a tendency to be critical and overtly hostile toward her, especially in regard to the shortcomings of her disorder. This data allows the social worker the insight to know that Sam's mom might be hindering the progress of the interventions conducted at school. Furthermore, this also serves to inform the school social worker that it would greatly benefit the client to utilize family therapy techniques with her mother to allow her to find ways to be more positive and encouraging at home for the sake and benefit of her daughter. These results are not only advantageous for Sam, but for any student that may be afflicted with the same disorder.

Integration and Analysis

The evidence-informed data from the studies presented has developed a clear outline of what methods and interventions will not only be effective for the client, but will also have short and long term results. Based on the information in the studies, an FBA/BIP was the next course of action for Sam. For the sake of saving time, this assessment is usually pre-written by the student's case manager, and then the entire 504 team completes the official assessment together to make sure that each component of the form is comprehensively completed.

In the FBA, Sam's target behavior is defined as a visibly emotional or anxious response to a group social experience that lasts for several minutes. This behavior can occur at school or at home, but most often occurs in the cafeteria, in the classroom, or on the school bus. There are no relevant events that occur before the target behavior escalates; it is specifically the congregation of people that elicits great fear and anxiety in Sam. Consequences of the target behavior include further exclusion and bullying from peers, lowered grades and academic performance, aversion to experiences she had previously enjoyed, and mild depression. The only environmental variable affecting her behavior is social factors, primarily her social environment. Sam has previously sought counseling through her middle school social worker and has been medicated for her anxiety, though she is not currently on medication. The goal to address this target behavior is to replace the behavior with a response that results in 70% less fear and anxiety when faced with a large social situation - specifically being in the cafeteria, in the classroom, and on the school bus - by the end of the school year.

The BIP puts the evidence informed data to practice for the client. Based on the information put forth by the Sportel, de Hullu, de Jong, and Nauta study (2013), Sam would be receiving the positive supports she needs, such as weekly CBT homework, social skills training, and realistic thinking practice to begin to cognitively shift her perception of large social gatherings. Additionally, according to Masia-Warner et al. (2005), it is also best to keep Sam's classroom environment and instructional strategies as is in order to allow Sam the opportunity to engage in exposure therapy that can offer her the chance to offset her symptoms while putting her positive supports and interventions to practice.

This combined use of CBM and CBT with Sam will potentially work to address her fear of large crowds, hyper-concern about how others

perceive her, somatic symptoms, and mild depression. Sam will be rewarded with praise and positive reinforcement from her teachers. In a crisis, Sam will see her social worker immediately, with the potential for a formal evaluation and hospitalization if her anxiety severely escalates for a long period of time without ameliorating. Data will be collected weekly in the form of self-reported questionnaires from Sam, a bi-weekly questionnaire from her mother, and monthly questionnaires from three teachers. The intervention will be implemented for the remainder of the school year (six months) and will then be evaluated by the social worker. The social worker will communicate and coordinate with Sam's mother on a bi-weekly basis to share information regarding progress or lack thereof. The social worker will also offer resources and training to Sam's mother, as the findings of the Garcia-Lopez et al. (2009) article suggest that the critical and hostile approach Sam's mom uses may be hindering Sam's progress. Informing Sam's mother of different ways to manage and cope with Sam's symptoms might yield better results for both Sam and her mom. These communications will occur via the telephone, unless Sam's mother requests an in-person meeting.

In the upcoming school semester, this data will be shared with Sam's 504 team, and then presented to Sam and her mother during her impending 504 annual evaluation meeting. The findings retrieved from these articles will be implemented in Sam's weekly social work sessions, focusing on cognitive restructuring.

Conclusion

This data-driven process demonstrates the value of having an evidence informed practice

and mindset. Before this process, there was much time spent attempting interventions with Sam that were not clearly connected to her diagnoses, symptoms, or needs. The social worker, being new to the field, was attempting to interject her personal wishes into her treatment plan simply to try out new skills she had recently learned. It was not until the research and data-informed process was put into place that it was realized that Sam's treatment plan was more about the school social worker, and less about Sam's course of progress. What is even more troubling to consider is that there are many other social workers in the field today that also have this selfish mode of thinking and practice when it comes to assembling a treatment plan for a client. Ultimately, the course of a client's treatment should never be about the clinician's personal desires or biases, yet this is something that remains a common problem. It is the ethical duty and responsibility of all mental health professionals to constantly self-evaluate and consistently remember that the work done is meant for the benefit of only the client and not for any personal gain.

Additionally, it is essential to have a written plan in place for any student in a caseload. Previously for Sam, the goals created were vague and untimely, but the social worker was unaware how this was problematic for a treatment plan. The FBA/BIP not only helped create appropriate and measurable goals for Sam, but also allowed her social worker the holistic perspective of the client, which connected the target and replacement behaviors to the intervention plan making her overall school treatment more effective and valuable.

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Exploring Uganda's Antigay Policies: Social Work Advocacy for Internationally Oppressed Same-Sex Oriented Individuals

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Abstract

The following paper is an in-depth explanation of Uganda's extreme antigay laws and policies, specifically the Anti-Homosexuality Bills of 2009 and 2014. The top political and cultural leaders have criminalized homosexuality, which in essence, has had a deleterious effect for Uganda's lesbian, gay, and bisexual or LGB citizens. A brief overview of Uganda's colonial history, the role of the Christian church, and fixed cultural values lend clear examples of why homophobia has reached epic proportions across the society. Uganda is used to exemplify the reasons why social workers need to advocate for internationally oppressed LGB individuals. There are numerous governments globally that criminalize homosexuality in some form. Same-sex oriented individuals are terrorized throughout the world because of their sexual orientation. Social workers, bound by their ethical responsibilities, must help to affect change and protect LGB individuals globally.

Keywords: internationally oppressed LGB individuals, sexual stigma, heterosexism, immigration equality, advocacy

Introduction

Uganda's antigay position is one of the most extreme examples of the 80 countries worldwide that criminalize homosexuality and same-sex activities (Immigration Equality, About Us section, 2015). This sub-Saharan country has attempted to pass insidious policies against its gay and bisexual citizens in an attempt to obliterate homosexuality. This attempt at a legislated genocide is an affront to basic human rights. Uganda's antigay policies epitomize the extent to which antigay governments will go in order to confront their perceived problem with homosexuality. Consequently, international lesbian, gay, and bisexual (LGB) individuals living in antigay societies, are forced to make difficult decisions regarding their livelihood and sexuality. This paper explores the cultural underpinnings in Uganda that led to the creation

of the draconian Anti-Homosexuality Bills of 2009, and 2014; it also demonstrates why social workers must advocate for oppressed LGB individuals worldwide.

Sexual Stigma in Uganda

Homosexuality is a natural expression of human diversity; it can be found across all cultures worldwide (Morrow & Tyson, 2006). It is not a Western framework. However, there are no international laws prohibiting autonomous countries from passing legislation that criminalizes homosexuality (Englander, 2011). Consequently, same-sex oriented citizens are vulnerable to national laws which persecute them because of their sexual orientation. Many antigay governments create policies that instill fear and criminalize their sexual non-conforming citizens. The extent of the punishments can often result in life imprisonment or death; for example, the 2009 Anti-Homosexuality Bill in Uganda sought to punish individuals charged with multiple homosexual offences with the death penalty (Englander, 2011).

There is a homophobic sentiment that pervades the cultural milieu of Uganda. Herek (2007) describes this phenomenon as cultural heterosexism, the widespread belief that heterosexual orientation is the only acceptable sexual expression (as cited in Morrow & Tyson, 2006, p. 55). Uganda's widespread cultural heterosexism reflected in the countries' laws, religious institution, media, and populace. Ugandan LGB individuals endure a sexual stigma, which Herek (2007) elaborates as a function of heterosexism and which reduces an individual's societal status due to their sexual orientation.

The origins for sexual stigma for homosexuality in Uganda began during their colonial era from the late nineteenth until the mid-twentieth century. Englander (2011) explains that British laws prohibited homosexual acts encoded in "decency laws". However, because there was evidence of same-sex relationships that preceded British colonization, new local laws were exposed to the stigmatization of homosexuality after

established colonial rule. When Uganda gained independence, the newly formed government passed The Penal Codes of 1950, which maintained that homosexuality was outside the agreed upon socially accepted values of sexual appropriateness, and prohibited same-sex activity (Thoreson, 2014). The discriminatory “decency laws” that were manipulated to include homosexuality, has stayed fixed in Uganda until the present day. According to Englander (2011), the drafting of the Anti-Homosexuality Bills of 2009 and 2014 intended on increasing the punishments for homosexuality. This was achieved by expanding the definition of homosexuality to include HIV-positive individuals, those who used sex toys, and parents of those who were charged with homosexual acts. This strategy increased the amount of people being charged. The hope was to both stamp out active homosexuality and to deter future homosexual impulses (Englander, 2011).

Religion plays a key role for shaping Uganda's cultural heterosexism. Christianity is the dominate religion in Uganda, using the Bible as its sacred text. There are eight biblical passages that seem to admonish homosexual acts; however, Morrow and Tyson (2006) assert that same-sex acts were not singled out as violations, rather any sex acts that broke the strict Hebrew purity were considered to breach sexual norms, and were condemned. The original understanding and context was lost over time due to translations across different cultures. Uganda's biblical literalists do not think of lost meanings in translations; rather the eight passages are all the evidence they need to determine that homosexuality is wrong and immoral.

Influence from Evangelical Christians in the United States, particularly the financially powerful group, The Family, have magnified the sexual stigma for homosexuality in Uganda (Englander, 2011). This conservative group insists that homosexual acts are an affront to Christian teaching. According to Englander (2011), members of The Family have donated large sums of money to the Ugandan government, specifically to President Museveni, in order to promote the creation of antigay legislation. United States' Christians who condone only traditional heteronormative family structures have influenced religious leaders in Uganda to spew antigay rhetoric in their own churches.

The media is another major culturally heterosexual institution that promotes hateful sexual prejudice and discrimination against confirmed and suspected gay and bisexual

Ugandans. Newspapers and Magazines have joined the national anti-LGB fervor. Major tabloid magazines in Uganda printed the names of over 100 men and women who were “suspected homosexuals,” along with their phone numbers. The article, entitled, “Hang Them!” listed names of same-sex oriented individuals in order for them to be harassed. This resulted in the murder of a vocal LGB activist who was found beaten to death in his own home (Englander, 2011). The media breach caused numerous LGB citizens to be harassed and/or go mysteriously missing.

Since colonial times, Uganda's institutions have fomented a strong sexual prejudice among the general populace resulting in rampant homophobia. In fact, the cultural heterosexist attitude is so pervasive that most people view gay and bisexual men and women as less than human. The antigay sentiment is so strong among Ugandan citizens that popular bumper stickers read, “Say no 2 sodomy, Say yes 2 family,” and “We should drive out homosexuality” (Boyd, 2013, p. 697). Being gay in Uganda and throughout Sub-Saharan Africa is considered to be “Un-African.” This explains why thirty-six African countries have antigay laws; however, it is notable that none are as severe as Uganda (Englander, 2011, p. 1264).

Politicians, religious elite, and the media led Uganda's parliament to draft the draconian bills targeting gays and lesbians. The Anti-homosexuality Bills of 2009 and 2014 attempted to criminalize those engaged in same-sex activities by instituting a mandated life sentence for their crimes. If caught a second time, judges would charge LGB individuals with, “aggravated homosexuality,” with the sentence of the death penalty (Englander, 2011; Balter, 2014). Same-sex oriented individuals, their parents, and those who were HIV-positive, with no regard to one's sexual orientation could be charged with “aggravated homosexuality” (Englander, 2011). By expanding this to family members, the bill was a powerful tool to instill fear. The bill sought to eradicate homosexuality from Uganda; the government supported genocide against its LGB citizens.

The Anti-Homosexuality Bills of 2009 and 2014 were meant to uphold the heterosexist status-quo in Uganda. Englander (2011) argued that the bill's purpose was to, “Strengthen the nations capacity to deal with emerging internal and external threats to the traditional heterosexual family” (p. 1274). The bills included extensive definitions of homosexuality and banned all organizations and international governments that

were allies of same-sex oriented individuals. Moreover, the Ugandan government urged its citizenry to report all homosexual acts. In essence, the bills created a system of reporting likened to a witch-hunt (Englander, 2011).

These provocative and controversial bills sparked vehement arguments nationally and internationally (Englander, 2011). Government officials within Uganda were ready to defend the bill at any cost. Uganda's President Museveni and his cabinet member for the Ministry of Ethics and Integrity, were ready to withdraw membership and support for the United Nations (UN), Declaration on Human Rights. This would have meant a significant loss of financial support for Uganda from other UN nations (Englander, 2011).

President Museveni is an avid supporter of the 2009 and 2014 Anti-Homosexuality Bills because he believes these bills will ultimately protect vulnerable youth. He stated that, adult homosexual "mercenaries" recruit young people to engage in gay activities (Balter, 2014, p. 956; Boyd, 2013). Museveni's critics would not consider him a protector of his citizenry. He has been in power since 1986, extending his presidency beyond the constitutional term limits, which allow him and his party, the National Resistance Movement (NRM) to have considerable power over the population resulting in mounting human rights violations (Balter, 2014; Thoreson, 2014). Museveni's authoritarian regime is cloaked as a democratic constitutional government. Uganda's constitution proclaims equality for all, but the government has worked tirelessly to usurp LGB citizens' freedom. Although, the UN has been unsuccessful at passing international laws that ban the criminalization of homosexuality, human rights organizations have campaigned to bring attention to the horrific tenants of the Anti-homosexuality bills of 2009 and 2014. International pressures have prevented the bills from becoming law (Balter, 2014).

Ugandan LGB individuals have been affected by the shadows of the 2009 and 2014 Anti-homosexuality bills. The anxiety producing legislation has forced many to keep their sexuality concealed. This is for their own safety and for their families' protection. However, others have stood up against the oppression. LGB groups have organized and challenged the discriminatory laws risking potential imprisonment and/or death. Many same-sex oriented Ugandans have formed human rights agencies such as, The Ugandan Civil Coalition on Human Rights and

Constitutional Law, which not only criticizes government oppression, but supports the expansion of HIV services, and promotes refugee causes (Minor Peters, 2012). This community agency has been met with backlash; for example, in 2011, a well-known Ugandan gay rights proponent, David Kato, was brutally murdered in 2011 for speaking out about the atrocities committed against the gay community (Boyd, 2013). This sparked waves of fear; consequently, many LGB individuals fearing for their lives decided to flee Uganda to search for international protection.

Uganda's antigay stance is important to examine when thinking about the plight of internationally oppressed LGB individuals. Globally, the criminalization of homosexuality and related activities is rampant (Thoreson, 2014). The threat of the death penalty for homosexuality extends beyond Uganda. According to Englander (2011), Islamic Sharia Law that governs Iran, Saudi Arabia, Yemen, Sudan, and Mauritania mandates the death penalty for homosexuality (p. 1278). Thoreson (2014), explains that an overwhelming majority of governments in sub-Saharan Africa have national laws that criminalize homosexuality; each country has violent examples of enforcing these laws, which include lengthy prison sentences, torture, and murder of LGB individuals throughout the cone of Africa.

The Role of Social Workers

Same-sex oriented individuals affected by antigay policies often try to flee their homeland, but it is a decision rife with barriers. Many seek international support by becoming an asylum seeker or a refugee, and some enter as irregular immigrants. There are two immigrant categories which provide international protection: asylees and refugees. According to Koser (2007), an asylee is an individual seeking international political protection. Asylum is difficult to obtain. For example, an immigrant seeking asylum who does not report themselves to an immigration official within one year of entry will be denied and can no longer apply; moreover, geo-political events such as 9/11 motivated US Congress members to ask for stricter restrictions for asylum seekers (Kenney & Schrag, 2008) On the other hand, refugees are a special immigrant status determined from the 1951 United Nations conference, protecting discriminated group categories. However, this status does not

explicitly protect those discriminated by sex or sexuality, leaving LGB people around the world vulnerable (Koser, 2007).

Social workers can be important agents of change for immigrant populations, and to help minimize immigrant stress. Whether through policy or through therapeutic intervention, social workers have a responsibility to advocate for international LGB individuals seeking relief, this is reflected in the core values of the NASW *Code of Ethics*. For example, standard 1.05 regarding the ethical responsibility Cultural Competency and Social Diversity, as well as the six ethical principles: service, social justice, dignity and worth of a person, service, and integrity, call social workers to help internationally oppressed LGB individuals (National Association of Social Workers, 2015).

It is important for social workers to look beyond their own communities to widen their scope: innocent people are being sentenced to death because of their sexual orientation. Social workers can work on the macro level with policy makers. They can help organize, educate, and volunteer with gay rights advocacy groups that wield influence at the local, state, national and international levels. One way to achieve international relief for oppressed LGB individuals living abroad is to advocate for changes in international law prohibiting charges of the death penalty based on religious teachings. Englander (2011) argues that religion should not influence international law

Social work advocacy is necessary nationally to help change the complicated asylum and refugee application process. According to Turney (2011), Congress made the asylum seeking process more difficult due to the 2005 REAL ID ACT, which gives asylum-seekers the burden of proving that their safety is threatened in their home countries. This is difficult for same-sex oriented individuals for two reasons: first, gay and bisexual men and women have to prove that they are, in fact LGB. This can be scary for individuals who have been traumatized for their sexual orientation in their countries of origin. Moreover, it gives the government the power to decide group membership. Second, applicants may not convincingly prove their membership due to the inability to answer Western concepts of the gay experience. For example, Turney (2011), describes the inability for some applicants to tell their "coming out" experience because that concept might not be relevant in their homeland (p.1358). The inability to prove group membership may increase detention time and the

possibility of deportation. This puts internationally oppressed LGB lives in danger, especially because they left in the first place.

Refugee status is often difficult for same-sex individuals who have defected from their countries of origin. This is due to different interpretations of the 1951 UN Convention regarding sex and sexuality as membership of a social group. Some countries do not consider sex and sexual orientation as categories for group membership; therefore, LGB people do not always qualify for refugee status (Koser, 2007). International social workers should lobby to amend the 1951 UN Conventions in order for sex and sexuality to be included as categories to apply for refugee status. Luckily, in the United States, the 1951 UN Convention is interpreted so that a person can claim "reasonable fear" to apply for refugee status. According to the Immigration Equality website (2015), many lower courts in the US have generally included homosexuality as a category to fit under the umbrella of 'belonging to a social group' as means to obtain refugee status based, which was established in the 1994 *Tobaso-Alfonso* case where former Attorney General Janet Reno argued that one's sexual orientation can indeed produce fear of persecution (Asylum Law Basics: A Quick History section).

Another way social workers can help oppressed LGB immigrants is by changing United States Immigration policies that give harsh treatments to irregular immigrants. Koser (2007) describes illegal or irregular immigrants as those who enter a country's borders without being inspected; and entering with incorrect, or forged visas. This migrant category also applies to immigrants who have overstayed their visas. The Illegal Immigration Reform and Immigrant Responsibility Act of 1996, or IIRIRA, a United States immigration policy, mandates detention for immigrants entering the United States without legal permission, this is especially complicated for LGB individuals because detention puts them at higher risk for attacks from other inmates or security forces because of their sexual orientation (Turney, 2011).

After irregular immigrants have been detained, most are deported back to their countries of origin. According to Orner and Andes (2008), when an immigrant enters the United States unlawfully, and is caught, and then deported, they are banned from the country for 10 years. For an internationally oppressed LGB individual, this can mean life or death. There have been many cases of immigrants who fled their countries for fear of persecution. They were caught in the

United States, deported, and sent back to a death sentence (Ortiz, 2014). Social workers can advocate to stop the deportation of LGB individuals, as well as for the repeal of a 10-year waiting period for deported LGB individuals.

Volunteering is a practical step social workers can take to work with groups such as, Immigration Equality and other human rights advocacy groups. Immigration Equality, a non-profit based out of Washington, D.C, fights for LGB and HIV-positive asylum seekers, detainees, and binational couples who are seeking safety, fair treatment, and freedom (Immigration Equality, About Us section 2015). Since 1994, the organization has been representing people from around the world fleeing violence, abuse, and persecution because of their sexual orientation, gender identity, and HIV status (Immigration Equality, 2015). The organization's advocacy team, that organizes and lobbies for fair treatment on a national level, would be a great fit for social workers interested in utilizing their voices at the political level.

There are some strategies social workers can utilize to create policy changes. First, they can help vulnerable LGB individuals with the asylum process, which gives them a greater chance of staying in the US and seeking relief. One goal of organizations such as Immigration Equality is through advocacy, with the objective of changing the "arbitrary one-year filing deadline for asylum" because this prohibits "LGB people from applying for life-saving relief and to change the dysfunctional immigration detention system endangers LGB lives" (Immigration Equality, 2015). Other ways social workers can help affect change is by: holding policy makers accountable for positive change; writing immigration guidelines; advocating for policy reform; and demanding fair treatment for all LGB immigrants. Next, social workers can lobby the government to create changes within the current immigration policies that help oppressed LGB individuals.

Closing Thoughts

As I get ready to enter the field, I am passionately dedicated to assist those who live outside the borders of the United States;

especially those who are persecuted for their sexual orientation. I will take a social work policy approach and align myself with an agency that aims to change asylum-seeking procedures. As I consider my practice, this is a stretch for me because I feel I am more comfortable practicing in a clinical setting. Nevertheless, I wish to expand my skill set to work on national and international levels. I will seek to join committees, lobby, and even go outside the United States border to advocate for change.

As I think of advocacy, on a policy level, I look to feminist philosopher, Martha Nussbaum to guide my practice. Nussbaum's work seeks to balance gender, sex equality, and all oppressed groups seeking social justice. Nussbaum came up with a list of ten capabilities known as a "quality-of-life measure," (2003, p. 40). I think Nussbaum's capabilities approach applies directly to the LGB community. Her first goal for all people is to have a good life-a good life lived to its completion and without harm (Nussbaum, 2003). I will work with my clients, recognizing their agency and self-determination. I will advocate for internationally oppressed LGB individuals, and undocumented immigrants living in the U.S., who are detained, or living in harm's way.

Nussbaum (2003) also listed the importance for all people to be able to travel and move freely throughout the world. Focusing again on the many LGB Ugandan's who suffer living with harsh, antigay policies demonstrates the need for porous borders. I support the idea that people should be able to move around the world freely, especially if they face persecution due to their sexual identities. Therefore, in my practice I will advocate to help asylum seekers enter and stay in the United States.

The manner in which many internationally oppressed LGB individuals are demoralized, traumatized, and run the risk of bodily harm ignites anger and indignation in me. I will channel this energy in my practice, and turn it into passion to advocate for change. I have to be reminded of the possibilities to affect good change, by aligning myself with the philosophical ideals of Nussbaum. Somewhere in that complicated emotional range, I hope to be driven, and clear to help lift up my LGB family.

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Neoliberalism or Neoslavery? The Case of Ferguson, MO

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Abstract

Neoliberalism affects our country in more ways than just an ideological opinion. This paper will provide a sense of understanding of this issue by defining neoliberalism, highlighting leaders who promoted this ideology, and defining the role of racism. This information provides a contextual understanding of how these two concepts affect our current economic situation, which will therefore create a more accurate picture of the case study of events in Ferguson, MO, involving the death of Michael Brown. This case study proves to be only one example of the recurrent issues that arise from a neoliberal state that blindly perpetuates racism.

Keywords: neoliberalism, inequality, racism, Ronald Reagan, Bill Clinton, Ferguson, Michael Brown, Department of Justice

Introduction

In the United States, where ideals such as free trade, rugged individualism, and equal opportunity are given weight and priority, one can accurately conclude that these ideologies become more like idolatries in the mind of the common person. There are numerous instances, such as Clinton's welfare reform, where the dedication to certain ideas (like self-sufficiency) takes precedence over the well-being of individuals. Securing lifeless concepts or materials over the livelihood of people seems almost unimaginable until an exploration of these concepts reveal deeper meanings not immediately apparent. The intention of this paper is to further digest the meanings and interconnected implications of principles such as neoliberalism and racism. Ferguson, Missouri, will be the concluding case study.

Neoliberalism

Neoliberalism can be defined as an ideology of capitalism that emphasizes free trade, rejects government intervention, and seeks fiscal

austerity (Jessop, 2002). Neoliberalism prefers privatization, often seeking ways to facilitate the private ownership and operation of government-run organizations so as to expand their trading capacities and liberalization; which focuses on reducing government interference in market and trade relations (Stiglitz, 2002). The idea behind this ideology is that the economy is self-correcting and, if left to itself, will effectively provide for the needs of the people (Porfilio, 2007). Neoliberalism values fiscal austerity, enterprise, and efficiency (Stiglitz, 2002). It aims to increase productivity while decreasing costs and taxes.

Neoliberalism seeks to decrease taxes on the wealthy, emphasizing a theory called "trickle-down economics" (Porfilio, 2007, p. 1022). This theory believes that if tax breaks are given to the wealthy, or the "economic entrepreneurs" of society, they will, in turn, use the money to stimulate job creation and opportunity for the working class. This practice may be argued to be effective in sustaining economic growth but it remains ineffective in creating economic security for the working class, the working poor, and those who live below the poverty line (Stiglitz, 2002).

Policies and Principles that Support Neoliberalism

From a neoliberalist lens, productivity creates value (Hickel, 2012). The conversation about who is and who is not productive in society also determines who is and who is not valued in society. Although some may outwardly voice these opinions the typical rhetoric used in this type of situation usually manifests itself in indirect, metaphorical ways (Goldberg, 2009, p. 339). Politicians usually lead these conversations and develop their opinions from political agendas and public opinion.

Conservative and liberal politicians have varying opinions on the political agenda (Conservative vs. Liberal Beliefs, 2010). Take, for instance, their opinions on poverty. Conservatives tend to see poverty as an individual issue that should not be reinforced by public assistance. Liberals, on the other hand, tend to see

poverty as a reflection of broad, societal problems that need to be addressed. These varying views have been manipulated throughout the years.

In his book, *The Future of the Capitalistic State*, Bob Jessop (2002) describes the shifting views of the United States government—from welfare to workfare, or as Jessop describes it more formally, the Keynesian welfare national state (KWNS) to a Schumpeterian workfare post-national regime (SWPR). The difference between these two ideas is the role they ascribe to the government. Jessop (2002) uses these definitions to help define the current transformation of the US government.

The KWNS focuses primarily on John Maynard Keynes' idea of the necessity of government intervention in market economics. Unlike neoliberals Keynes believed that the market would not correct itself and government intervention was necessary, especially in times of need (Solomon, 2010). KWNS can be summarized as a state that takes responsibility for the basic needs of the community and provides a safety net in times of hardship, even if that means job creation for the unemployed. It tends to favor economic policies that aim to restore employment (Jessop, 2002).

SWPR, on the other hand, reinforces the shift to neoliberalism by supporting innovation and flexibility in an open market. It alters the conversation from the national to the global and supports monetary policy, like trickle-down economics, over welfare. Instead of the Fordist perspective—where a person would obtain a “job for life” and be paid well enough in this job to make them consumers of the products they create—SWPR supports a post-Fordist perspective in which new ways of education are favored in order to adapt to the changing society (Jessop, 2002, p. 156). “Thus, whilst the KWNS tried to extend the social rights of its citizens, the SWPR is more concerned [with providing] welfare services that benefit business and thereby demotes individual needs to second place” (Jessop, 2002, p. 251).

These shifts from a welfare state to a post-welfare state have been noted to be most prominent during the Reagan-Thatcher revolution, concentrating on the market while distancing itself from social welfare. Reagan saw social welfare as a creator of dependency and inner-city poverty (O'Connor, 2002). President Bill Clinton's first presidential campaign, as well as his welfare reform act, was highly influenced by the Reagan era, as well as its altered perception of the role of government.

Ronald Reagan and Welfare

Through the influence of leaders like Ronald Reagan, the shift from the welfare state to the workfare state can be most clearly seen. During Reagan's time in office, both as governor of California and as the United States President, Reagan projected an ideology that has shifted the strategies of the government. His reforms, often cited as neoliberal, heavily emphasized the privatization of government programs and fiscal austerity in government spending (Albo, 2001). These attributes, in addition to his famous tax cuts, led to the institutionalization of neoliberalism (Prasad, 2012).

Ronald Reagan had various opinions on welfare until welfare reform became a necessity at both state and federal levels (Crafton, 2014). When he was governor of California, Reagan prioritized welfare transformation in his state. He appointed task forces to study the issues within the welfare system and ultimately decided on the need to increase eligibility requirements and establish “welfare-to-work programs” (Crafton, 2014, p. 28).

During this time, Nixon and Carter attempted to restructure the welfare system. Nixon declared that welfare had failed to extreme effects and was in need of reform. The welfare programs throughout the state appeared to be increasingly underfunded and vastly diverse. In order to overcome this failure, Nixon formulated a plan that would provide a foundational structure to increase dignity for those in need. This new strategy for welfare would provide a guaranteed income, equal benefits throughout the states, incentives to work, and a work requirement (Crafton, 2014).

Gov. Reagan was adamantly opposed to the federal changes due to its guaranteed income (Crafton, 2014). This income not only was in opposition to the Republican ideology but would also put a heavy financial burden on his state. Reagan sent letters and spoke to the president multiple times to try to dissuade him from enacting the reform. He also engaged in intimate conversations with Senate members. Gov. Reagan and his rhetoric swayed Senate members, which eventually led to the bill's death.

Once Reagan became President of the United States, a promise of his was to reduce the budget deficit, but neoliberal ideologies curbed this course for him (Prasad, 2012). He did end up cutting social services, deregulating private corporations, and stepping back from

employment initiatives (Albo, 2001). However, his prime failure in his quest to lower the deficit was when he increased military spending and gave tax cuts instead of increasing taxes to match the increased spending (Prasad, 2012). This tax cut, enacted in the Economic Recovery Tax Act of 1981 (ERTA), not only redistributed income to the wealthy but set a standard in the US for further requests for tax cuts by Republicans (Albo, 2001; Prasad, 2012). Prasad (2012) refers to this tax cut as the most severe upset in American history and the “rise of the era of the market in which we currently live in,” meaning the neoliberal world (p. 352).

During Reagan’s time as both governor and president, he vastly changed the conversation about the necessity of welfare. He emphasized the importance of distinguishing those who are in dire need of help from those who are entitled (Crafton, 2014). Reagan was also documented saying that the government needs to “place heavy emphasis on the tax-payer as opposed to the tax-taker” (p. 34), later calling them the “truly needy as opposed to the lazy unemployable” (Reagan, n.d., as cited in Crafton, 2014, pg. 34).

Reagan’s preferred model for the “tax-taker” was the “Welfare Queen” (Goldberg, 2009, p. 336). Goldberg (2009) describes the media’s interpretation of the Welfare Queen as a:

Stereotypic black mother of multiple children, usually portrayed as having different fathers, minimally educated, irresponsible, refusing work, and collecting welfare while partying all night long. Sex, drugs, and rock ‘n’ roll, at the expense of the state;” implying that welfare supports the “idle, undeserving, and overly fertile black women. (p. 336)

This reference misrepresented welfare recipients, as a whole, to the public—reducing their state of vulnerability to a shameful, deceptive state of being. This goes back to the neoliberalist emphasis on productivity. Personhood becomes “less than” others when that person can no longer contribute to society.

Clinton often used this type of language to gain votes during his presidential campaign. He rejected the original Democratic stance on welfare, claiming to be a Third Way (O’Connor, 2002). This Third Way movement strived to be a middle ground between Democrats and Conservatives, so as to rejuvenate and revive the old democracy, paving the way for a new kind of Democrat. According to Walker (1996):

A new Democrat was tough on crime, tough on welfare, resolute about the

death penalty, and insisted on personal responsibility rather than state handouts...[They also stated] that there was a difference between the deserving and the undeserving poor. The state should prefer the poor who were prepared to work to those who were not, [reinforcing neoliberal ideologies]. (as cited in O’Connor, 2002, p. 401)

Clinton’s campaign appeared to be very different from that of a “bleeding heart liberal,” but his plan for welfare reform showed more compassion. In 1992, Clinton’s original plan was to create a system that aided in the process of attaining a job by providing training and jobs to assist people out of poverty (O’Connor, 2002). He wanted to set a time limit on welfare but provide further support in education, training, and childcare. Clinton’s plan stood firm on the idea that anyone who works a full time job should not suffer from poverty. He went on to further state that the legislators uphold the value of hard work but have done nothing to help the Americans that work hard to survive (O’Connor, 2002).

In 1996, during his re-election campaign, Clinton signed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). This act, despite his original plan and course of action as a Democrat, set a time limit for welfare (O’Connor, 2002)—reinforcing the idea that welfare was a personal responsibility (Albo, 2001)—but did not include any of the other supportive services Clinton intended it to. As stated in O’Connor (2002), David Elwood—one of Clinton’s advisors at this time—was disturbed by Clinton’s decision to sign the act and emphasized “the original plan never assumed ‘no government support’ at the end of the time limit. Work was *meant* to be guaranteed” (p. 406-407). Clinton’s other two advisors, Peter Edelman and Wendell Primus, both resigned after Clinton’s decision to sign (O’Connor, 2002).

O’Connor (2002) argues that Clinton’s welfare reform, although well-intentioned, failed the people of the United States. The bill did not create a more just environment for the most vulnerable populations, but gave them a way to remain impoverished even if they were working. This bill is only one example of many government policies that have created further despair in vulnerable populations; it pushed Reagan’s neoliberal ideology forward and attempted to sway the low-income earners with “neoliberal market incentives” (Albo, 2001, p. 86).

Meeterpol (1998) stated, “The Clinton Administration surrender[ed] to an unelected group of people who represent the financial sector of the economy” (as cited in Albo, 2001, p. 86).

Misrepresentation of Data

One needs to remember that studies conducted by the parties serve to legitimate their own perspectives. Take the idea of welfare dependency, for instance. The Reagan era conservatives had long pushed that people were becoming increasingly dependent on welfare and that welfare families would cyclically stay dependent unless something was done (Wilson, 1987). During this time, they collected data to support these claims. In review of this information, Wilson (1987) found that other studies from 1968-1978 stated only three percent of people in poverty stayed on welfare for long periods of time, completely contrasting Reagan’s claim.

Another example of this kind of misrepresentation is from conservative Charles Murray’s book, *Losing Ground* (1984, cited in Wilson 1987). Murray argues that food stamps and Aid for Families with Dependent Children (AFDC) have increased black poverty and decreased employment in low-income black neighborhoods. Liberals would argue in opposition that actually, these programs had a positive effect on black families from 1960-1972, but after 1972, the government refused to increase benefits to match inflation rates (Wilson, 1987).

Statistics indicating social dysfunction can also be misleading if they are not situated within broader historical trends. For instance, ghetto neighborhoods with high poverty rates have been consistent throughout the 20th century but, interestingly, “the rates of inner-city joblessness, teenage pregnancies, out-of-wedlock births, female-headed families, welfare dependency, and serious crime were significantly lower than in later years and did not reach catastrophic proportions until the mid-1970s”; right before the Reagan-Thatcher era (Wilson, 1987, p. 3).

The above instances show how perspectives and motives can mislead public rhetoric and in turn, distort “facts” which influence policy and public opinion while expanding a powerbase. The next few sections will demonstrate how this kind of misrepresentation impacts society’s views and how the culture’s economic focus plays a large

role in the manipulation. Harvey (2003) quotes political theorist, Hannah Arendt (1973), who once stated:

A never-ending accumulation of property must be based on a never ending accumulation of power... The limitless process of capital accumulation needs the political structure of so ‘unlimited a Power’ that it can protect growing property by constantly growing more powerful. (Harvey, 2003, p. 34)

In this way, in order to remain in power and continually grow, the state must increasingly rely on the expansion of its dominion (Harvey, 2003).

History, Racism, and Practices that Support Neoliberalism

Race and slavery were constructed for economic purposes:

Slavery is a social institution, but it most particularly is an economic institution. It is a social mechanism for accruing the product of slave labor to the slave master ‘The law’ was used as an instrument of economic exploitation and extraction. (Urie, 2015, para 6)

Slaves were objectified, dehumanized for the economic benefit of the elite. The accumulation of slaves signified an elite form of power and prestige. Slaves were harshly tied to their social positions, continually trapped within the confines of oppression.

Today, racial oppression continues to be real, dehumanizing, and economically tied—just not as obviously as it once was (Albo, 2001; Goldberg, 2009). Racism has become an unspeakable topic, hidden in coded references about those who differ or, in this instance, those who “threaten the fiscal wellbeing of the nation” (Goldberg, 2009, p. 336). These connotations to race can come in various forms but are commonly seen in references related to welfare (like the Welfare Queen) and low income neighborhoods—further exacerbating both the racial and economic divides between people of color and people who are white.

A stark, economic difference between people of color and people who are white is the vast difference in labor wealth. Income from labor is the accumulation of wealth by the means of wage. Historically, this difference has been exacerbated by the influence of slavery but even in the 1990s—30 years after the Civil Rights Movement—people of color were making 70

cents to the white person's dollar and owned 15 cents to the white dollar in wealth accumulation (Oliver and Shapiro, 2006).

In terms of asset ownership, in 2010 only 49 percent of black asset wealth was wrapped up in housing while white housing accounted for 28 percent of asset wealth. Coincidentally, the worth of middle class black households averaged to 75,040 dollars compared to the white household's 217,150 dollars (Pew Research Center, 2013).

Income from capital often sustains itself from a more exclusive path of accumulation—inheritance. Passed down from generation to generation, capital includes property, interests, profits and other sorts of capital gains that accumulate wealth by merely existing within the system (Piketty, 2014). This is where inequality becomes most evident in determining the future livelihood of a person.

The bias of property rights in the US have certainly benefitted whites to a greater extent than their black counterparts (Urie, 2015). The neoliberal ideology does not take the unequal history into account because of its focus on the present time and free choice. The current racial divide of the economy becomes clearer when one reviews the history of the past.

The next portion of this paper will use Ferguson, Missouri, as a case study for how the rise of globalization and neoliberalism, along with past and current demonstrations of racism, continue to affect underserved populations. Ferguson provides a useful illustration of the fact that even where there are cases that are widely known, the hidden factors may be a more telling story than the most obvious of motives.

Case Example

Entrepreneur William B. Ferguson donated land on the north side of St. Louis for the purpose of building a railway and in turn, founded Ferguson. In the late 1800s, the railway was built and the city of Ferguson was founded (City History). Ferguson was a mostly white suburb until 1968, when Larman Williams defied conventions and purchased a home in the city. Williams had visited the city multiple times in the 1960s. At that time, he was only able to be there during the day since Ferguson was a “sundown town” where African Americans were not allowed to be outside after dark. Williams, in love with the city, became one of the first black homeowners to live in Ferguson (Rothstein, 2014, p. 2).

After the time of Williams' arrival, the city of Ferguson's racial demographics changed

drastically. By 1970, only one percent of Ferguson's population was African American. By 1980, African Americans made up 16 percent of Ferguson's population; “by 1990, 25 percent; by 2000, 52 percent; and by 2010, 67 percent” (Rothstein, 2014, p. 3) This population change can be partially attributed to the 1970 demolition of public housing in St. Louis (Rothstein, 2014).

Even though the racial composition in the St. Louis area is constantly changing, Richard Rothstein (2014) highlights how racial isolation is obvious. Rothstein (2014) concludes that communities that appear to be racially diverse are most likely in transition. Adel Allen's testimony, given to the 1970 hearing of the United States Commission on Civil Rights, provides an excellent example (Rothstein, 2014). Allen—a black, middle aged engineer—moved to St. Louis in 1962 for work. Even with a good income, Allen struggled to find housing for himself in the suburbs of St. Louis. Since none of the realtors were willing to sell to him, Allen had his white friend place a bid on a home where the true buyer remained unknown—also known as a “straw purchase.” When Allen received the opportunity to obtain that home, he had to borrow money from friends, most likely because the Federal Housing Administration and the banks would not give mortgages to African Americans in this neighborhood. When Allen first moved into this neighborhood, he had the highest income and was one of two black homeowners amidst 30 white homeowners. He recalled the peculiarity of hourly police visits, unsure if they were there to protect him from his neighbors or his neighbors from him (Rothstein, 2014). Allen also remembers the condition of the neighborhood at this time, which was well maintained by the city (Rothstein, 2014).

But, by the time of the 1970 Civil Rights hearing, Allen's community had completely flipped (Rothstein, 2014). In terms of demographics, Allen was now one of 30 black homeowners to two white homeowners. He termed his area as a “ghetto in the process,” explaining that city maintenance and street lighting were now subpar. The other sections of the town were also using his neighborhood as a dumping ground. Allen (1970) explained the racial profiling practices of the local police force:

I don't think there is one black man in South St. Louis County that hasn't been stopped at least once if he's been here for more than 2 weeks... There's an almost automatic suspicion that goes along with being black... There is an obvious attempt toward emasculation of the

black man. (as cited in Rothstein, 2014, p. 5)

Allen's story points out a multitude of struggles that African Americans have had to face. His story illustrates racial zoning, as the bank refused to give mortgages to black residents; he discussed restrictive covenants, in which white homeowners refused to sell homes to African Americans in order to keep them away; he talks about white flight insofar as eight years after moving in, almost all of the white residents were gone; he talked about the "ghettoization" of his new community, where the City services ignored his neighborhood; and he talked about racial profiling in which police officers target men of color, not because of an act but because of their race (Allen, 1970, as cited in Rothstein, 2014).

Allen did not discuss the racial division of wealth, which is and has been another major issue for African Americans; but what Allen's story does point out is that the fate of the African American community has been "inextricably tied up with the structure of the American economy" (Wilson, 1987, p. 9). Historical analysts agree that the concentration of African Americans in ghetto communities is inseparable from the racial history of the United States. As one of the latest examples of this reality, we can look at the Department of Justice's report on the Ferguson Police Department.

Department of Justice's Report on Ferguson

On August 9, 2014, conflict surfaced in Ferguson, Missouri; Michael Brown—an unarmed, 18-year-old, black man—was shot six times by a 28-year-old, white officer, Darren Wilson. Brown died and lay dead in the streets for four hours before the removal of his body (Bosman & Goldstein, 2014). Witnesses claimed the act was a form of injustice and an unnecessary attack by Wilson. Wilson claimed he was only doing his job. Ultimately, on November 24, 2014, the St. Louis County grand jury chose not to indict Darren Wilson on any of the five charges introduced (Fires, vandalism, gunfire follow grand jury decision in Ferguson, 2014). But, Michael Brown's death led to further investigation of the police department.

On September 4, 2014, the United States Department of Justice (DOJ) opened an investigation of the Ferguson Police Department (FPD) under the Violent Crime Control and Law Enforcement Act of 1994, the Safe Streets Act of

1968, and Title VI of the Civil Rights Act of 1964 (Civil Rights Division, 2015). Released on March 4, 2015, the DOJ report established that the FPD was unlawful in its practices, violating the First, Fourth, and Fourteenth Amendments of the United States Constitution. The DOJ's findings lent credibility to the suspicion and mistrust felt by the black citizens of Ferguson toward the FPD. The report revealed that the FPD's police and City municipal practices were significantly motivated by the generation of revenue and racial bias.

Discussion of DOJ Report

With the focus on generating revenue, police practices became redirected from their primary objective: the safety and well-being of the community (Civil Rights Division, 2015). The Chief of Police had pressure from the City Finance Director to promote revenue accumulation. From there, the Chief put pressure on his team. Productivity, or the amount of citations issued, was the determining factor for evaluations and promotions. As a result, police practices became overly aggressive and, at times, unnecessary. These practices included, but were not limited to, the excessive enforcement of city law, manipulation of citizen intentions, and apparent disregard of civilian grievance.

The municipal court was also shown to take up an unwarranted role in revenue generation (Civil Rights Division, 2015). The court often overlooked the judicial rights of the person, emphasizing the necessity of fine and fee payment. For example, for missed court appearances and late fine payments, the court would often issue arrest warrants. The court also increasingly imposed harsh penalties for these missed appearances or late fees without regard to alternative forms of payment. This increasingly led to the deterioration of domestic justice within the Ferguson community and severely impacted the most vulnerable populations with crippling debt and jail-time, which could then impact employment sustainability.

Additionally, the DOJ investigated law enforcement efforts with regards to race, concluding that the FPD's practices were both targeting African Americans and reinforcing racial biases (Civil Rights Division, 2015). For example, African Americans made up 67 percent of Ferguson's population but accounted for 90 percent of citations and 93 percent of arrests. African Americans were found twice as likely to be searched once stopped compared to white

drivers, while white drivers were found with possession of contraband 26 percent more frequently, implying that race played a factor in an officer's decision to search. On 73 occasions, African Americans were given four or more citations in one incident while non-African Americans were only given four or more citations twice. Certain citations seemed to be given almost exclusively to African American residents, like Manner of Walking in Roadway charges and Failure to Comply charges. Similarly, force was almost exclusively used on African Americans as they made up 90 percent of documented force cases and 100 percent of canine bites. African Americans represented 96 percent of arrests based off of an outstanding municipal warrant. In addition to the above examples, the DOJ supported these racially discriminatory accusations with documented emails between the police and court systems reflecting racial prejudice.

The DOJ debunked the City officials' claims about the results of the report weighing heavily on the citizens' lack of "personal responsibility," and instead concluded that the issue lies outside of the control of the citizen and within the FPD (Civil Rights Division, 2015, p. 5). The DOJ requested that the City restructure the law enforcement system in order to regain protection and justice for the people, regardless of their race:

Our investigation has shown that distrust of the Ferguson Police Department is long standing and largely attributable to Ferguson's approach to law enforcement... The confluence of policing to raise revenue and racial bias thus has resulted in practices that not only violate the Constitution and cause direct harm to the individuals whose rights are violated, but also undermine the community trust, especially among many African Americans. As a consequence of these practices, law enforcement is seen as illegitimate, and the partnerships necessary for public safety are, in some areas, entirely absent. (Civil Rights Division, 2015, pp. 5-6)

Reflections

In my findings, Ferguson, MO, is just one example of the multitude of instances in which neoliberalism and racism play a distinct role in objectifying a group of people.

Neoliberalism widens the wealth gap—distorting the obtainability of the American dream for everyone. An increase in the wealth gap means the suppression of more people. Impoverished communities have higher needs, and neoliberalist policies cut social services in the name of monetary savings.

These funding cuts exacerbate tax cuts, which ultimately redistribute more cash to the wealthy, not only affecting social services but also the services that are provided by the state. Prasad (2012) states, "[t]ax cuts affect everything that the state can do, by threatening the state capacity itself" (p. 352). This reduced capacity directly influenced the Ferguson Police Department by reducing funds and incentivizing police activity.

The community was most definitely impacted by racial injustices, but I would argue that the injustices were intertwined with and further intensified by neoliberal ideologies and practices—like the militarization of police departments in result to the 9/11 attacks. This was shown more discretely through the reallocation of resources and the seeming need to focus on defense above the welfare of the community.

Rob Urie (2015), a political economist, reflected upon the case of Ferguson and stated that this is one of many instances of the "growing lawlessness of the police" (para 3). Urie (2015) begins by stating that the inability of white Americans to connect the police repression of Ferguson to capitalist democracy is the foundation of the problem at large. The Ferguson Police Department blatantly refused to focus on public safety in order to increase the economic benefits they were obtaining. Neoliberalism indirectly replaces a civil focus with an economic focus, giving precedence to the well-being of the economy over the well-being of the people. The state's objectives are increasingly becoming economic objectives, decreasing public trust and safety while increasing revenue and power.

Neoliberalism can be seen as increasingly similar to the unjust, economic institution of slavery (Urie, 2015). It benefits the few who hold power, while exploiting the majority who remain oppressed. In Ferguson's case, like in many cases throughout the country, the police explicitly exploited the black community while white communities enjoyed the benefits. Actions of individuals no longer played the central role in determining criminal activity. Instead, race became a more determinative factor, proving racism is still alive and well in our community. According to Urie (2015) "Race

based law enforcement criminalizes race, not nominally proscribed acts” (para 9).

Michael Brown’s case is a specific example of how state regulations no longer apply to everyone in a neoliberalist state (Urie, 2015). The Ferguson police used “law as a weapon,” while those in power remained exempt from the subjugation. Whites and conservatives who argue that Michael Brown was guilty because he “stole a box of cigars takes this same law at face value. This view of the law depends on a similarly improbably separation of political and economic realms as neo-liberal theory” (Urie, 2015, para 6).

The intent of this paper is not to focus on blaming or shaming anyone for the current dilemma within the FPD. Neither is it the intent to pose a solution, but rather to shed light on how this situation may have been formed and exacerbated. Ferguson can be seen as one of many examples of the idolatry of the neoliberalist system, supporting the economy over the well-being of the people.

Meaning for the Social Work Profession

The greatest takeaway for social workers is the importance of understanding these multidimensional issues and the imperative need

for social workers to become involved in policy decisions. Unethical situations and unjust acts are not always the result of bad people or unjust organizations that are clearly acting unethically; they may be engrained in the larger context of an issue based off of ideologies that we unreflectively hold as truth. Ideologies, such as neoliberalism, need to be continually evaluated and observed. We can no longer hold on to these values but need to be re-evaluating them—recognizing that these structures, created by human beings, are malleable and can be adjusted as such. As social workers, we need to become consistently aware of the systemic makeup of these problems and the need within the profession to develop a more critical approach to our work—ensuring that we are not exacerbating the problem.

Situations, like the injustices in Ferguson, build metaphorical fires and create momentum. It is up to social workers to take that momentum and redirect it into action. We must do this by refusing to become comfortable in our organizations and continuously challenging ourselves to think critically. By effective engagement with the community, we can become a source that drives political social action. This responsibility cannot be fulfilled unless we remain informed.

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The Debate over Early Medical Interventions for Transgender Youth Seeking a Gender-Confirmed Body

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Abstract

This article addresses the debate over early medical interventions for children and adolescents who identify as transgender and wish to live in a more gender-confirmed body than that which they were born. The article presents statistics about this growing population and discusses both reversible and irreversible options, as well as the World Professional Association for Transgender Health's (WPATH) recommended standards of care. Finally, ethical considerations and implications for social workers are presented. Findings indicate that puberty suppression provides transgender pubescent youth emotional and physical relief and "buy time" to allow the child to make a fully informed decision regarding more permanent medical interventions.

Keywords: Transgender, youth, adolescents, gender-affirming surgery, gender dysphoria, gender identity, puberty suppression

Introduction

Transgenderism has been the topic of significant debate over the past few years in societal, psychological, and political arenas. Although there have been considerable gains in reaching equal rights for people in the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ) population in the United States, there is still much controversy surrounding the societal treatment, mental health, and basic human rights of those who identify under this acronym. Those who identify as transgender as children or adolescents face additional concerns, as they are often the victims of bullying, occurring both in and out of school (Milrod, 2014); experience homelessness at high rates due to issues such as family rejection (National Center for Transgender Equality, n.d.); and are unable to consent without

parental approval to medical treatments, such as gender-confirming treatments and genital surgery (Milrod, 2014).

In this paper, background information will be presented, as well as statistics on transgender children and adolescents. Currently accepted medical protocol for helping transgender youth begin the process of transitioning to his or her gender-confirmed body will then be discussed. Next, ethical considerations both for and against early medical intervention for gender-dysphoric youth will be presented. Implications for social workers who work with transgender youth, including helping youth and their families make decisions regarding early medical interventions, working with youth who are currently undergoing such treatments, and continuing to work with youth and families into the launching phase of the family life cycle will be discussed. Finally, the paper will conclude with a short summary of the previously discussed findings.

Background and Statistics

According to Fuss, Auer, and Briken (2015), "[t]ransgender is an umbrella term for gender dysphoric people and those with an incongruence of natal gender and gender identity" (p. 431). People who possess this incongruence identify in various ways, including transgender, transsexual, genderqueer, gender-blending, gender nonconforming, gender variant, and gender neutral (M. Dentato, personal communication, August 27, 2015). Some people who identify under the umbrella term of transgender choose to live what is considered to be a gender-neutral existence, preferring to be called by the pronouns "they" and "them"¹. Others feel most comfortable presenting as their gender-confirmed self but choose not to undergo any medical or surgical treatments. Some individuals choose to participate only in selective

¹ Due to the limitations of this paper, the author will focus on the issues of gender fluidity and transgenderism from the perspective of the individual's choices to adjust their body to

fit their gender identity or not. The reader should be made aware that there are other social and economic issues affecting these decisions that are not addressed in this paper.

medical interventions, while others decide to pursue every medical option available to live in a body they believe to be gender confirming.

The prevalence of transgenderism as a whole has been difficult to calculate in the United States and worldwide. Few studies have been able to utilize representative samples or to verify the limiting impact of response and selection bias, as respondents decide how they choose to identify (Fuss et al., 2015; Unger, 2014). The data on transgender youth are even more scarce (Unger, 2014). However, a 2011 study of 2,730 middle school students in San Francisco found that 1.3% of the respondents identified as transgender (Unger, 2014). According to Unger (2014), this is the best data currently available on the prevalence of transgender adolescents. Another study conducted in New Zealand in 2014 with more than 8000 secondary school students found similar results. Of the 8000 respondents, 1.2% identified as transgender, while 2.5% of respondents were unsure of their gender identity at the time of the survey (Fuss, et al., 2015). These studies, although not without bias, provide clinicians a glimpse into the existence and prevalence of transgender youth throughout the world.

The number of children and adolescents who identify as transgender and who seek medical interventions to achieve their gender-confirmed bodies is increasing, and the age of those seeking treatment is decreasing rapidly (Milrod, 2013). Youth, both pre-and post-pubescent, are beginning to present for medical interventions, and doctors and the social workers serving as consultants are forced to make the difficult decision of when and how it is appropriate to intervene (Milrod, 2013). One of the questions doctors and social workers must consider is the reason the youth is seeking treatment and how deciding to provide or withhold medical intervention will impact the youth, both physically and psychologically. Further ethical considerations will be discussed in a subsequent section of this paper.

In the New Zealand study mentioned above, 20% of those who identified as transgender experienced weekly bullying, 40% experienced symptoms of depression, and 20% had attempted suicide within 12 months prior to responding to the study (Fuss, et al., 2015). Two related studies conducted in both the United Kingdom and the United States found that self-harm behaviors were also highly associated with transgender youth (Fuss, et al., 2015). Many transgender children and adolescents seek medical treatment in order

to achieve gender-confirming bodies and combat these negative effects of untreated transgenderism in a continually transphobic society (Milrod, 2013; Roen, 2011). This desire might stem from resolving the internal incongruence mentioned above or to “pass” among the youth’s peers as his or her confirmed gender (Milrod, 2013).

Fully passing can be a protective measure, as those who are accidentally discovered to be transgender and thus “discredited” to their peers, risk “being injured with weapons, being punched, raped, or otherwise assaulted” (Milrod, p. 340, 2013). Those who are discredited among their peers also face the possibility of cyber-harassment (Milrod, 2013). Additionally, the continuing incongruence one feels between his or her confirmed gender and his or her body and the resulting fear of being “found out” can lead to feelings of low self-esteem and low self-acceptance, drug abuse, and the desire to leave school (Milrod, 2013).

Finally, the desire for adolescents to begin dating those of the gender(s) of his or her choice might lead the transgender youth to seek early medical interventions (Milrod, 2013). The transgender youth might fear disclosing his or her genital incongruence because of the above-mentioned potential for physical violence (Milrod, 2013). However, delaying sexual development until adulthood can lead to high levels of frustration and impatience and can delay the youth from learning about healthy relationships during this crucial stage of human development (Milrod, 2013). This delay also has the potential to lead to unsafe experimentation with anonymous partners in order to alleviate the youth’s frustration and natural curiosity, which Unger (2014) states results in a higher risk of contracting HIV or other STIs for transgender females, in particular. In fact, transgender females have the highest rate of infection among sexual minority youth; the highest risk factor associated with this infection rate is unsafe sex behaviors (Unger, 2014).

Current Protocol for Transitioning Youth

In order to receive medical treatments for gender incongruence, individuals who identify as transgender, including children and adolescents, must first receive a diagnosis of persistent gender dysphoria, as outlined in the Diagnostic and Statistical Manual for Mental Disorders 5 (DSM-5) (Unger, 2014). This

diagnosis must be given by a licensed mental health professional and “is used to describe the distress felt by individuals whose physical appearance does not match their gender identity” (Unger, 2014, p. 348). The mental health professional must determine that the client’s feelings of gender incongruence are not influenced by other mental illnesses (Abel, 2014) and that the client is certain of the longevity of these feelings (Roan, 2011). According to those with gender dysphoria, the ages between 10 and thirteen are considered to be the crucial ages for gender identity (Fuss, et al., 2015). However, as children and adolescents do not yet possess the same executive functioning skills as adults do (Fuss, et al., 2015), this certainty is more difficult for them to prove to mental health providers in order to obtain the needed diagnosis.

Those whose gender dysphoria persists until the age of 13 are able to assent to receive medical interventions to alter their physical sex characteristics (Unger, 2014). The Standards of Care that have been developed for the ethical treatment of youth who wish to pursue these treatments were created by the World Professional Association for Transgender Health (WPATH) (Milrod, 2013; Unger, 2014). These guidelines state that irreversible interventions, such as genital surgeries, should not be implemented until the youth reaches the legal age of majority in his or her respective country (Milrod, 2013). The Endocrine Society holds the same position regarding genital surgery (Milrod, 2013; Unger, 2014).

However, before reaching the age of majority, the youth has the option of reversible medical interventions in order to begin the process of transitioning as early as the pre-pubertal stage, summarized by the Dutch protocol (Fuss, et al., 2015). Beginning at age 12, transgender youth wishing to receive medical interventions are able to begin puberty suppression with what are known as gonadotropin-releasing hormone analogues (GnRHa), which inhibit the onset of pubertal changes (Fuss, et al., 2015). According to the protocol, transgender adolescents between the ages of 16 and 18 are eligible to receive cross-sex hormones to begin to develop physical characteristics of their confirmed gender (Fuss, et al., 2015). These standards are only guidelines for doctors and mental health professionals; clinicians must use their professional judgment and ethical standards to determine what course of action to take, if any, and how early to begin such action.

Ethical Considerations

Arguments for Early Intervention

One of the most referenced arguments for early medical intervention for transgender youth is harm reduction. Because of the many negative psychological effects related to gender dysphoria discussed above, many medical and mental health clinicians believe that not treating transgender youth before puberty begins is more harmful than any potential physical side effects of the medical interventions themselves (Milrod, 2014; Fuss, et al., 2015; Abel, 2014). Not allowing children and adolescents to receive the treatments they need to pass as their confirmed gender can be both physically and psychologically harmful, while intervening at an early age can have positive psychological effects, such as increased self-esteem and decreased symptoms of depression and anxiety (Milrod, 2014; Fuss, et al., 2015; Abel, 2014). Additionally, withholding treatment can delay youths’ sexual development, which, in turn, can “cause a delay in healthy, age-appropriate emotional development” (Milrod, 2014, p. 340).

Abel (2014) also specifically addresses the concept of respect for the autonomy of children and adolescents. In fact, the author believes that this is the most compelling factor clinicians have in administering puberty suppressing and cross-sex hormones (Abel, 2014). As Abel (2014) states, withholding these treatments has a profound effect on the transgender individual, as he or she will not receive the same physical results if made to wait until the age of legal consent.

Fuss, et al. (2015) cite a previous study to make a further claim for respecting the autonomy of these clients; they report that transgender “children are not confused, delayed, showing gender-atypical responding, pretending or oppositional – they instead show responses entirely typical and expected for children with their gender identity” (Olson, et al., 2015, as cited by Fuss, et al., 2015, p. 433). This connection between the youth’s gender identity and their responses compared to their cisgender counterparts reflects the certainty with which transgender youth request treatment and further justification for respecting transgender youths’ autonomy. Milrod (2014) further summarizes this idea of respect for autonomy by suggesting that individuals of age 14 or greater possess the ability for logical and abstract thought, therefore

allowing them to consent to such treatments at an early age.

One of the reasons often cited against pre-pubertal medical interventions for transgender youth is the potential for long-term, unwanted physical effects; however, much of the research shows that there are few, if any, known harmful effects upon receiving puberty-suppressing (Fuss, et al., 2015) or cross-sex hormones (Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Cohen-Kettenis et al., 2011; Abel, 2014). The studies that have been completed indicate that transgender individuals who begin medical interventions as children or adolescents fall within normal ranges for general and sexual health characteristics, blood levels, bone density, height, and weight (Cohen-Kettenis et al., 2011; Cohen-Kettenis et al., 2008). Additionally, Fuss et al. (2015) found that puberty suppression had no effect on the youths' executive functioning or brain development in general. Despite these promising findings, most clients who receive cross-sex hormones are left sterile (Abel, 2014). However, Abel (2014) points out that, for many, this sacrifice is worth the gender congruence they will finally feel within their own bodies.

Another important consideration in the early medical intervention of transgender youth is the efficacy of these particular interventions. Two long-term studies have been done and have shown that those who undergo such medical treatments are pleased with many of the results and do not express any feelings of regret for their decisions of early intervention (Cohen-Kettenis et al., 2011; de Vries et al., 2014). One outcome noted as a concern in the study by Cohen-Kettenis et al. (2011) was genital reconstruction; however, the concern lay in the limitations of current surgical procedures, rather than in a change regarding the individual's confirmed gender.

Finally, administering puberty-suppressing and cross-sex hormones is a reversible procedure, unlike genital reconstruction (Unger, 2014; Cohen-Kettenis et al., 2011; Milrod, 2014). Intervening with these reversible treatments allows medical and mental health professionals to continue work with their young clients to help them fully understand the ramifications of having gender-confirming surgery (Abel, 2014; Cohen-Kettenis et al., 2011; Roen, 2011). This concept of "buying time" to help transgender youth further explore their feelings of gender incongruence and make decisions in their long-term interest has been supported by many researchers and clinicians

(Abel, 2014; Cohen-Kettenis et al., 2011; Roen, 2011). Without these carefully monitored interventions, many transgender youth might seek risky, alternative actions on their own in order to decrease their feelings of gender incongruence (Cohen-Kettenis et al., 2011).

Arguments against Early Intervention

Despite the above-mentioned arguments for early medical intervention with transgender youth, there is still much debate over the ethics of its practice. As mentioned above, early cross-sex hormone treatments are associated with a high risk of resulting infertility (Abel, 2014). Although the desire of many transgender youth to resolve their gender incongruence outweighs their desire for fertility, many do not want to risk this loss (Abel, 2014). Some clinicians believe that the adolescent does not yet have the ability to make this decision and objectively consider the pros and cons of such a choice, especially due to the infancy of the surgical procedures some are seeking (Cohen-Kettenis et al., 2008). Because of this uncertainty of outcomes and the inability for adolescents or their parents to give informed consent under such circumstances, some clinicians question if not waiting to medically intervene until the client is of legal age is an ethical choice (Sadjadi, 2013).

Many clinicians on both sides of this debate agree that the long-term consequences of such treatments are not yet fully understood. Studies have followed transgender youth post-medical intervention for up to 22 years and have found positive outcomes for these clients (Cohen-Kettenis et al., 2011). However, these studies are scarce and, when beginning a study in pre-pubescence, researchers might not encounter significant long-term effects unless a sufficient number of subjects are studied with detailed, consistent follow-up (Abel, 2014). Because of this, some clinicians believe that longer-term research of the effects of puberty suppression is imperative in order to guarantee that the ethical standard of "do no harm" is upheld when treating transgender children and adolescents (Sadjadi, 2013).

The final argument some clinicians have against early medical intervention with transgender youth is the fact that gender is often seen as fluid (Roen, 2011; Cohen-Kettenis et al., 2008). Although this concept is currently growing in acceptance among clinicians, who see this as a positive step in accepting those who identify under the umbrella of transgender, some hold this

as a reason not to intervene medically with transgender youth (Roen, 2011; Cohen-Kettenis et al., 2008). Some believe that it is this fluid nature that makes early medical interventions inappropriate (Cohen-Kettenis et al., 2008). In fact, Cohen-Kettenis et al. (2008) state that gender incongruence seen in pre-pubertal stages often decreases or disappears during the early stages of puberty in 80-95% of subjects. Therefore, children who receive treatment, even reversible, before puberty, might have lasting psychological effects. According to an argument cited by Cohen-Kettenis et al. (2008), “any intervention in childhood would seem premature and inappropriate” (p.1895).

Implications for Social Work

There are many ways in which the debate over early medical intervention affects social workers. As stated earlier, individuals who identify as transgender and seek medical treatments are not eligible for these treatments unless they are first diagnosed by a mental health professional with persistent gender dysphoria (Unger, 2014). Holding the power of this decision for those individuals seeking medical intervention comes with great responsibility. Clinicians must be sure that they are acting as objectively as possible and in the best interest of the client, regardless of their personal biases or opinions. This can be difficult for any clinician, as many hold strong opinions on either side of this debate. However, each decision clinicians make affects an individual’s life course, both physically and psychologically.

Making such a crucial decision regarding the diagnosis of a client and recommendation for his or her medical treatment takes time. The clinician must balance the pressure transgender children and adolescents often feel to begin puberty suppression or cross-sex hormones as soon as possible (Milrod, 2014) with the time it takes to build trust and rapport with clients (Unger, 2014). Diagnosing clients with persistent gender dysphoria should only be done once the clinician has established these key features of the therapeutic relationship. It is at this point that young clients can truly begin to explore and understand their feelings of gender dysphoria in the long term and the consequences of starting irreversible or potentially harmful medical interventions (Roen, 2011). As discussed earlier, recommending the young client for puberty suppression once trust and rapport have been established is a way of “buying time” for the client

and clinician to continue exploring these questions (Abel, 2014; Cohen-Kettenis et al., 2011; Roen, 2011).

Because the mental health professional often acts as the “bridge” between the medical team and the client (Milrod, 2014), it is imperative for him or her to be knowledgeable about medications, surgical procedures, and potential consequences of each. With trust and rapport being at the forefront of the client-social worker relationship, clients will often depend on the mental health professional to share and help clarify this information (Milrod, 2014). Therefore, psychoeducation should be a standard part of treatment when working with transgender individuals who are considering or seeking transition. The clinician should make no assumptions about what the client does or does not know regarding medical interventions; the clinician is also cautioned against making any assumptions about the client’s sexual behavior or sexual orientation (Unger, 2014) and should be prepared to help the client explore these topics in the context of the potential interventions.

Roen (2011) stresses the importance of using a strengths-based, LGBTQ-affirmative perspective when working with transgender youth, as being diagnosed with a mental illness in order to receive the treatment needed can be psychologically damaging in and of itself. She also discusses allowing transgender clients the freedom to question both their natal and confirmed gender without fear of losing the ability to transition if and when they are ready (Roen, 2011). Finally, physical monitoring and supportive counseling should be available to transgender youth throughout the course of their medical treatment, as well as into adulthood, as needed (de Vries et al., 2014). The clinician should not view hormone therapy and gender-confirming surgery as a cure (Sadjadi, 2013); rather, it is part of the multidisciplinary process through which some transgender individuals go in order to achieve gender congruence.

Conclusion

Throughout the past few years, transgenderism has grown in its visibility as a human rights issue, and clients presenting for medical interventions to alleviate their feelings of gender incongruence are steadily decreasing in age (Milrod, 2014). These recent changes present mental health professionals with new and increasing challenges, as they are the ones assigned the role of “gatekeeper” between

transgender youth and the services they seek (Unger, 2014). Those on both sides of the debate over early medical interventions with transgender children and adolescents present valid and compelling arguments. However, what both sides seem to agree on is that puberty suppression appears to be completely reversible and can “buy time” for clients to further explore the issue of gender incongruence before making decisions regarding irreversible procedures (Abel, 2014;

Cohen-Kettenis et al., 2011; Roen, 2011). It is imperative that clinicians build trust and rapport with their clients and allow them time to discuss their feelings and concerns openly and honestly (Unger, 2014). Only then can the clinician offer a true holding environment for the client, while making appropriate medical recommendations.

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Perspectives of Empowerment throughout History- Using a Case Study to Form Understanding

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Abstract

This paper explores the historical roots and the present implications of the Empowerment Perspective. In order to better understand the clinical impact of the empowerment approach within the school environment, the author uses a case study to analyze school success by two students.

Keywords: empowerment, empowerment perspective, school social work

Introduction

Social work is a growing profession that adapts to the needs of the current community and social inequities (Payne, 2005). The profession has shifted to meet the needs of both the professionals contributing to the field as well as the clients utilizing social work services and outcomes. However, throughout the profession's history, the notion of 'empowerment' has remained one of the critical groundings of all social work. This is seen throughout social work services delivered in hospitals, agencies, private practices, and schools.

This paper will examine how the notion of empowerment has changed, adapted, and developed over time. In doing so, a case study about two middle school students is interwoven throughout the theoretical information in order to demonstrate how the theory directly affects social work practitioners as well as the clients they serve.

What is Empowerment?

The overarching idea of empowerment reaches back to the beginning of civilization. Major events in history demonstrate the ideas of empowerment: the Civil Rights Movement, feminism, and growth of the LGBTQ movement and community, etc. These large, systematic movements demonstrate growth by the people and for the people. Vulnerable, dissatisfied people wanted to 'stand their ground,' and feelings of

marginalization were no longer accepted by members of these populations. Therefore, the ideology surrounding the notions of empowerment has become strong and necessary within the social work profession.

Various definitions of empowerment describe the intentions well. In the context of social work, professionals understand empowerment to be a multi-faceted, necessary objective in client-centered advocacy work. Graham (2004) states the idea well:

Empowerment as a guiding philosophy in social work is largely defined by professionals and often located in conventional meanings tied to individual or collective strategies. The unmasking of various understandings and interpretations of this contested conceptual ideal reveals an exclusion of the socio-cultural perspectives of oppressed communities that it claims to address. (p. 44)

This idea introduces the concept as a philosophical theory that addresses the needs of marginalized people. These marginalized groups may include people within a minority group such as race, SES, disability, etc. Graham (2004) continues this explanation by stating that,

While recognizing that empowerment is a contested concept in social work, this process seeks to enable individuals and communities to gain greater control over their life worlds. In this context, people participate in their own empowerment that emerges from self-defining processes. (p. 45)

This means true empowerment can strengthen individual people through realization and self-defining moments, or moments that enhance personal identity and self-concept. Students are at the ideal age to work toward this self-improvement. They learn from positive, adult role models around them. Therefore, empowerment can be a significant approach within the school setting.

Other scholars note similar ideas in relation to empowerment within the social work

profession. Many definitions of empowerment work off the basis of 'social justice'. Miley and DuBois (2007, p. 31), for example, state that "[Empowerment] focuses on social policy, indirect practice, and macro-level interventions, [and] is to protect social rights by ensuring that society provides the resources and opportunities needed by all for full social participation". The authors generalize this exact idea by explaining that "ultimately, empowerment social work ensures the realization of the social justice contract between individuals and society" (Miley & DuBois, 2007, p. 30). Geldof (2011, p. 37) has a similar notion of empowerment, saying that "social work has to become a cosmopolitan profession in order to become more relevant for the empowerment of all citizens". However, Geldof's (2011) focus is more on the ethnic disproportions within the United States. He believes that cultural implications play a large role in attempting to understand the means of empowerment. He explains this by stating that "increasing awareness of ethnic and cultural aspects and causes for social problems should be part of a structural and empowering approach, using the ethnic and spatial/urban dimensions of the problem in order to improve social work and policy approaches to empower people and groups" (Geldof, 2011, p. 35).

Each of these authors speak to the notion of social justice within the policy of a country. Secret, Jordan, and Ford (1999) also include policy implications in their idea of empowerment practice. More importantly to them, however, is the assurance that empowerment programming is seen across all levels of professionals—from the researchers to the direct practitioners, so that the ideas pertinent to vulnerable populations can be discussed among these groups themselves. According to Secret, Jordan, and Ford (1999):

The intent to transfer research evaluation knowledge from the researcher-expert to program stakeholders for the explicit and ongoing use and benefit of the programs serving disenfranchised populations is a major distinction between empowerment evaluation and other collaborative or participatory models...[e]mpowerment evaluation is 'illuminating' and 'liberating' to program stakeholders. (p. 121)

Regardless of the motive or specific aim for empowerment techniques, the general idea of the philosophy or approach is to support the betterment or upward mobility for people that are

generally more oppressed or vulnerable than the average person. Browne (1995, p. 363) gives a strong, general guideline for those attempting to use an empowerment approach within social work practice, "[f]or empowerment to be effective, social work must move toward a concept and understanding of the term that combines certain elements of varying definitions, and, ultimately, one that helps more than hinders". Browne (1995) is not the only one to recognize the need for a multidimensional, flexible definition of the empowerment terminology. Askheim (2003, p. 237) also states that "professional social work based on an empowerment approach can most of all be described as a balancing act on a slack rope". This statement recognizes the need for 'give-and-take' in order for progression toward the empowerment approach to take place at all. Graham (2004, p. 54) says, "existing paradigms of empowerment are constrained by definitions of empowerment, which are located in dominant social realities that often render marginalized groups' perspectives and understandings as invisible or insignificant". Askheim (2003) sums up many of these ideas well,

[I]f we try to dissect the concept there is still a common core which most people can agree on. The conceptual construction of empowerment shows that it deals with the transmission of power. The power should be given to or taken back by those disempowered. (p. 230)

Empowerment throughout History

Unfortunately, *disempowerment* is not unique in this situation. The following case study, for example, will demonstrate disempowered students within a public school. Students can easily feel disempowered when they fall behind their peers academically and/or socially. Therefore, in order to understand where the empowerment approach within social work might lead to in the future, it is best to understand its progression throughout history thus far. Simon (1994) portrays the influences behind and from the idea of empowerment well in her book *The Empowerment Tradition in American Social Work*. She dates the roots of empowerment back to the Protestant Revolution within the sixteenth and seventeenth centuries, arguing that this is when the ideas of people being, "bound by duty to help shape their own earthly state" (p. 34).

Around this same time, Quaker settlements were creating a movement. Simon

(1994) says that Quaker communities worked hard to ensure that they sought out, “community consensus through extended dialogue,” which is a notion currently in practice today through basic community organizations or self-help groups. When attempting to think back in order to put forth the practices of the Quaker settlements, members of all groups would attempt to negotiate and understand one another so that everyone could be content in the end; in the same way, schools attempt to service all students and their families to their liking.

Similar ideas continued to grow throughout the movement of history. Industrial capitalism, for example, is yet another separate movement in history that worked to combat injustice. These two frameworks (empowerment and industrial capitalism) are not specifically, intricately linked but they are similar in meaning. When the majority of the population found themselves without land or assets, they turned to each other to share the misery together. Upon recognition that this was a social concern instead of only an individual problem, merchants decided to act together to end oppression and gain power within the society around them (Simon, 1994). Similarly, teachers or other school staff members can and should be advocates for the potentially oppressed students.

As time progressed, political movements continued to grow, change, and create the formation of new ideas/movements. The nineteenth century introduced anarchism to the society. Simon (1994, p. 40) explains that, “belief in mutual aid as a basis for social life proved to be the defining theme of anarchism...that created and instilled into the ethos of the United States principles and preferences that made their way eventually into the core of empowerment-based social work practice”. Despite the popular negative connotation that anarchism carries, Simon (1994) writes to express its original positivity and purposeful enlightenment. She says that in general, people do not understand its true meaning because the media worked to portray anarchism in a brutal, violent manner in the past. Once again, the positive aspect of the notion of anarchism is easily relatable to current day situations. Group and/or community members frequently and consistently seek significance by stabilizing a high social status. Within the model of anarchism, there would be no centralized authority or power to whom these group members would report.

The context and content of ‘empowerment’ is easily relatable to various

social work settings. The following section brings to life the history and current ideals of empowerment through the use of a clinical case study. This case study will introduce two students who demonstrate differently dependent upon their feelings and knowledge of empowerment.

Danny and Gaby- A Case Study

Danny and Gaby are brother and sister. They left Mexico with their mother about two years ago, ending up in Chicago, Illinois. Currently, Danny is in seventh grade and Gaby is in eighth grade. They attend a school that does not have a significant Latino population, therefore needing to learn both American culture and the English language without familiar Latino peers or adult models. Their single mom works the night shift for twelve hours straight, from 6 p.m. until 6 a.m. in order to keep them clothed, housed, and fed. She loves her kids and they know it. All three of them have a close-knit relationship, but often get frustrated with each other as well. When this happens, they exchange bad words and call each other names. Even still, they love each other in the end.

In a similar way, the teachers at the children’s school have created a love-hate relationship with the family—but it takes a different form. The middle school teachers say they really like Gaby but dislike Danny. According to the teachers, Gaby does her homework, stays quiet, and is respectful, while Danny rarely turns in his homework, is a class clown, and ignores his teachers. Because of their perceptions, Gaby and Danny receive different support services. The teachers work hard to support Gaby’s difficulties in learning, yet they struggle to find ways to support Danny.

On the surface, Gaby is receiving the same academic support as Danny. The difference is that she also receives motivational words and supportive moments from the adults around her. She is told that she will succeed if she continues to offer the effort she is currently showing at school. Danny, however, is sent to the principal’s office for discipline when he does not participate in class or turn in his homework. When he says he does not understand the material being taught, he hears the teachers telling him to “just start paying attention”. In sum, Gaby feels empowered and therefore aims for success. Danny feels lost, clueless, and unintelligent; he feels disempowered, and is therefore starting to give up.

How Does Empowerment Work?

Danny's mother explains that she moved her children to the United States so they can get a good education. She works hard in order to ensure that her children can stay within the district of a school she likes. When she hears from the teachers about Danny's often "goofy" behavior, she feels frustrated that she had to move away from her family only for her son to once again avoid the learning process, as was easy to do in Mexico. In a meeting with the principal and the social worker, she asked what she and Danny can do in order to move forward. The response: teach Danny about the wonders of learning while showing him that he can succeed, that he has the ability, and that he can change his reputation. The mother did not understand.

In order for Danny to succeed, he had to know that he *could* succeed, that it was not too late, and that he deserves a strong academic career just like every other student in the building. It is common to tell students to believe in themselves, but it is not common to teach students how to believe in themselves. Therefore, the first plan of action was to show Danny his possibilities. In order to do this, the social worker has to work with the rest of the school professionals in order to provide a welcoming and comforting place for all students, regardless of ethnicity or culture. According to Olivos (2009), "[i]ndeed, all too often, Latino families are characterized as passively participating in schools because of the cultural traditions that encourage them to defer professional decisions to the educators" (as cited in Thorp, 1997, p. 111). With Danny, however, the social worker realized that he would need to decide for himself that he wanted to succeed. He and his mother could work together to create his goals within the school environment.

The social worker would help Danny reach his goals after he and his family decided for themselves what should happen. Olivos (2009, p. 114) suggests "a more useful approach is for educators and parents to work together to reflect on existing policies and practices and propose actions based on their findings and their particular circumstances. This entails scrutinizing what practices work with Latino families and in what contexts". Giving Danny's family the option to come up with these goals was unusual for them. They were unsure where to begin, as no school had ever asked them to do such a task. Olivos (2009, p. 114) further stated, "this reflection should not include only institutional practices, however, but personal beliefs as well. That is,

educators and parents should examine their personal beliefs and biases to see how these may be affecting their relationship with each other". Danny was clearly affected by his relationships with his teachers. He truly wanted for them to appreciate him, but he believed that his poor academic skills would always be in the way of this support. Based on general social work practice and the literature surrounding empowerment in schools, these beliefs would seemingly only create struggle. Olivos (2009, p. 112) defends this position by stating, "School policies and practices must be structured so that they can, to the greatest extent possible, minimize these inequities in home-school relations".

Empowerment works on both the structural and independent levels; this is especially true for Danny and his family. Danny himself needed to feel empowered in order to improve his behaviors and feelings in and towards school. Askheim (2003) suggests,

The individual's dimension deals with activities and processes with the aim of increasing the individual's control over his life, and to equip the individual with more self-confidence, a better perception of oneself, and increased knowledge and skills. With such qualifications, the individual will be better able to identify the barriers which reduce self-realization and control over his life. (p. 230)

This means that Danny would need to believe in himself so that others could also believe in him. Askheim (2003) explains that empowerment can create change, but that it must come from both outward and inward forces in order to be successful. The inward success would come from Danny's personal motivation. The outward force would mean the school structure needed to adapt to better understand Danny and his life. Askheim (2003) goes on to say,

The structural dimension deals with social structures, barriers and power relations which maintain differences and injustice, which decrease the individual's opportunities to take control over one's life. To include both the individual and the structural dimension in the empowerment concept implies that empowerment is seen both as a goal and as a means of attaining that goal. It is a goal in itself that disempowered groups should get out of their disempowered situation and be able to establish or rebuild their status as equal, competent citizens in the society. At the

same time empowerment is a means to change the power relations. It is in other words both an ideology and a methodical approach. (p. 230-231)

In the context of this case study, Askheim's (2003) work lends the idea that if school staff members did not practice their ideology in a methodological style, then Danny would not be able to assert any confident or optimistic beliefs about himself. Empowerment comes from individuals, but the individuals must work together in order to create a general culture that emits feelings and techniques of empowerment to those who need it.

Social Citizenship as Part of General Citizenship

To many scholars, one of the most important contributing factors to empowerment-based work is the concept of 'citizenship'. More and more, definitions of citizenship tend to exclude vulnerable groups of people—these definitions have surfaced due to restrictions of members in political or social groups (either written or unwritten) and basic limitations to access of goods. Included in the various ideas circumventing the exact definition of citizenship comes the concept of 'social citizenship'.

Even this phrase of 'social citizenship' comes with variations, flexibilities, and controversies. One documented philosophy, the Marshallian Social Democratic Model of Social Citizenship, contends that non-materialistic assets should be accessible for those who do not have the economic means (White & Hams, 1999). Therefore, financial ability should not dictate social ability. White and Hams (1999, p. 5) describe Marshallian perspective as, "Regardless of a citizen's status in the market, indeed in part to compensate citizens for market-derived inequalities, Marshall argued that citizens had responsibilities for meeting each other's social needs through agency of the state". In other words, social mobility and economic mobility would exist as separate ideas.

In her book, Simon (1994, p. 43) explains 'social citizenship' as one aspect of the overarching idea that citizenship in general is the "dynamic and socially constructed concept of participative membership in a community or society, membership that carries with its rights and status that reflect the time and place in which members live and the degree of success enjoyed by those members, in combination with their

peers". Simon uses Marshall's distinctions that social participation is just one element of citizenship that is separate from the elements of civil or political citizenships. Only within the last twenty years has this idea of social citizenship fully formed to create a dominant force within the economic and social marketplaces.

'Social citizenship' would include the cultural assets that Danny and Gaby feel they have that would help them be included with the rest of their peers and members of the school body. Perhaps they could use their Spanish-language abilities to increase their social status through providing Spanish lessons or making friends with other Spanish-speaking kids; this would allow them to use their given strengths in order to actively participate within the building. If Danny and Gaby were true 'social citizens,' then the fact that they were living in a basement frequently flooding with water due to being economically disadvantaged should not necessarily affect their social status and involvement; however, as research and experience both show, one aspect does greatly affect the other.

Feeling empowered economically would likely allow for more optimistic feelings socially, and vice-versa. Unfortunately, human potential/human stamina and the systematic school system so far established within the United States puts a damper on the idealistic notion of 'social citizenship'. Olivos (2009) states,

[A]s for any other racial or ethnic group in the United States, cultural capital, cultural perspective, and life experiences mediate how Latino families view their child and how they relate to the U.S. educational system, that is in charge of servicing their needs and the needs of their children. (p. 110)

This shows that the various attributes of a family can lead to multiple perspectives a family can have of the school and the people at the school can have of the family.

Thinking optimistically about empowerment, however, means that social workers and clients should strive for 'social citizenship' as a true value. In a review of Simon's (1994) book, Lee (1996) helps to explain Simon's (1994) contention that 'social citizenship' is a powerful aspect of empowerment. According to Lee (1996, p. 329), "Simon sees the aim of empowerment practice as helping people attain 'full social citizenship'. She also recognizes the serious damage that oppression may do to the individual's internal resources and capacities". Simon (1994) gives a clear perspective of the

history of the social work profession in relation to the history of empowerment-based work; she also writes about the current practices and policies relating to the history.

Empowerment and its Implications for Practice

What is the best way to empower Danny in order to ensure the greatest possible success in his school career? Both the good vibes and bad tensions are apparent and persistent with families who feel disempowered. Olivos (2009, 114) suggests, “[e]ducators and families have the same fundamental goals for a child, although they may have different ideas and ways on how to get there. They view the world differently based on their culture, their knowledge, and their positions of power”. There is not a ‘right’ or ‘wrong’ culture. However, “these differing views and social positions may cause distrust” (Olivos, 2009, p. 114).

The word ‘facilitate’ carries significance within the empowerment tradition. Instead of instructing clients directly, social workers using the empowerment-based approach would simply uncover ideas in order to allow clients to see for themselves the oppressive barriers that could potentially hinder their success (Payne, 2005, p. 306-315; Simon, 1994, p.174). Lock, Obsenchain, and Abemathy (2003) provide basic ideology surrounding a healthy classroom environment. The authors state, “students of all abilities, ages, and backgrounds benefit from learning in a safe and supportive educational community” and emphasize the importance of facilitating a sense of influence (Lock, Obsenchain, & Abermathy, 2003, p. 55). Lock, Obsenchain, and Abermathy (2003, p. 57) go on to state that, “students learn that they have power and that what they say is important”. In this sense, the facilitator would support Danny in uncovering the fact that he is capable of stating important, profound, funny, or intelligent thoughts; this could then lead to Danny’s healthy growth within the school environment.

Group work is yet another leading strategy within the use of empowerment-based social work. This leads to the discovery of mutual aid or discovering personal self-help ideas (Payne, 2005). Singh and Salazar (2010, p. 97) state, “[g]roup leaders are aware of the potential for interactions to facilitate empowerment, growth, and change”. Strong group leaders use empowerment ideology to create a working

structure between the members. Simply feeling accepted and an equal part of the group allows members of a group to take the acceptance to the outside world and portray positive feelings within other social groups and structures as well. Singh and Salazar (2010, p. 98) continue by stating, “group work is a powerful intervention for promoting empowerment and healing of individuals who were often at society’s forgotten edges”. Adolescents especially are a group that can benefit from mutual connections and shared experiences. Throughout this emotional time in life, group membership can provide a safe place that allows for the strengthening of confidence that can then be transformed throughout other aspects of life as well—especially in the context of school (Malekoff, 2008). Students from minority groups may not feel a sense of belonging, therefore feeling as outsiders of the group.

Concluding Comments

Empowerment comes in many forms that together can work to strengthen oppressed groups of people. Lee (2001) names three primary concepts to empowerment’s success. First comes ‘developing a more positive and potent sense of self’. Helping Danny to better understand his strengths and weaknesses will then allow him to move further forward in creating his own narrative of school. Second in Lee’s (2001) approach is ‘constructing the knowledge and capacity to achieve a critical perspective on social and political realities’. Enabling Danny to see where in Mexico he came from, where in Chicago he is, and the differences between the two will help Danny to understand the social and political realities. He can understand the opportunities that he has in Chicago that he perhaps did not have in Mexico. He can understand why his mother brought him to the United States in the first place. Understanding the reality of his mother’s thoughts could give Danny more motivation to then strive for his potential as a student. Third in Lee’s (2001) description of empowerment is cultivating strategies, competencies, and resources to attain personal and collective goals. For Danny, this can be easily facilitated by the social worker, as she can show Danny where to find the help he may want or need.

Overall, working to ensure that Danny can feel as equal as the other students will then give him the tools to move forward with his academic learning. Feeling disempowered will only create more struggle when attempting to

learn challenging academic curricula. Empowerment-based social work can support Danny in dealing with his new Chicagoland environment, the other students, teachers, and his family. Despite the political and economic

barriers Danny may feel or experience, it is important that Danny understand himself and know how to navigate his environment in order for him to succeed.

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