PRAXIS

Where Reflection & Practice Meet

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

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Praxis: Where Reflection & Practice Meet 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 practice, policy, research, education, and other areas relevant to social work practice. Opinons and letters to the editor are also encouraged. Submissions are accepted throughout the year and the priority deadline for the annual Fall publication is the last day of January. The editorial board anonymously reviews submissions and edits accepted papers with permission from the authors. Papers should be no longer than 20 double-spaced pages and submitted on a disk as a Microsoft Word document file (.doc). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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Editorial

"At the beginning I was only a little mass of possibilities. It was my teacher who unfolded and developed them. When she came, everything about me breathed of love and joy and was full of meaning."

~Helen Keller , The Story of My Life, 1903

Seventy years ago, a study conducted by staff at the Mary Crane Nursery at Chicago's Hull-House challenged a prevailing assumption that poor children had innate defects in intelligence by comparison with children born into socially and economically privileged families (Kawin, 1933). The 1933 study, entitled *Intelligence and Poverty*, is a compelling example of how social work ideals, coupled with reflective clinical practice and solid scholarship, can change attitudes and change lives.

Studies on intelligence and socio-economic status conducted by other researchers at the time had purported to substantiate the defective intelligence of poor children by showing that they scored lower on Stanford-Binet intelligence tests than children from more privileged backgrounds. Based on their extensive experience working with children from both the Hull-House nursery and a nursery school in Winnetka, Hull-House researchers hypothesized that poor children's lower test scores had more to do with language handicap and limitations of the home environment than with differences in intelligence. And when they analyzed previous studies, the Hull-House researchers identified that other researchers' implicit and negative biases about underprivileged children's mental capacities had caused them to choose tests of intelligence, such as the Stanford-Binet, that did not account for cultural and language differences. The Hull-House researchers addressed this bias by administering both Stanford-Binet and Merrill-Palmer tests in their own comparison of a group of sixty-two Hull-House toddlers from poor families and a group of sixty-two privileged Winnetka children. This second set of tests emphasized performance, as opposed to language, and was generally accepted as a reliable measure of mental development for preschool children at the time. As the researchers had predicted, the Hull-House study found no significant difference between the two groups of children on the performance-based tests. And while children from higher socio-economic groups performed markedly better on language-based tests, Hull-House children were found to perform better on certain non-verbal tests.

This finding provided the empirical basis on which to challenge the prevailing knowledge about the relationship between poverty and intelligence. According to the Hull-House researchers, with the exception of one study on infants, all other studies of intelligence that had been published at the time – including studies of children *and* adults – had found superior intelligence for groups of people at higher socio-economic levels. The author of the Hull-House paper rebutted this fallacious belief that perpetuated social inequalities:

> [We] question a social philosophy which sees the poor and their progeny as groups inevitably destined for inferior roles in society because of their own inadequacy. Any clear view of the place of education in a democracy…includes the task of discovering the real disabilities of the under-privileged and of giving them the opportunity to overcome, as far as possible, those handicaps which can be modified by training and environment (Kawin, 1933, p. 504).

An accompanying photograph of Jane Addams with Hull-House nursery children beautifully captures the humaneness of this research. Addams, 73-years-old when the picture was taken, devoted her life's work to making the world a more compassionate, just, and peaceful place in which these vulnerable children could thrive. She believed that all children deserved the chance to pursue their unique potential, and she inspired others with similar ideals to use their own talents to speak this truth to the world.

Seventy years have passed since this study was published and the snapshot taken, yet the ideals that inspired Jane Addams and the authors of this research endure. Indeed, what continues to draw social workers into the profession is our deep conviction of the innate value and potential of every human being, and our desire to help our clients see and embrace this potential within themselves. We know that every human being discovers their identity – the answer to the question "who am I?" – through her/his experience in relating with others. And through these relationship experiences s/he comes to believe that "who I am" is "who *you* think I am." Considering identity in this way, it is profoundly moving to know that when the children in the Hull-House photograph looked into Jane Addams' eyes, they got a reflection for their identity – for "who am I?" – and also for who they could become, that was radically different than the reflection they got from the world outside of the Hull-House nursery in 1933.

In this third edition of *Praxis,* student authors once again express their passion for these very ideals, and this composite of articles portrays an understanding of human development that is a particular strength of social work. As social workers, we understand the

Double Bind: The Case of Jeremiah Green
Schizoid Personality Disorder and Parkinson's Disease

by Autum Elizabeth Lum

Abstract

Individuals with mental illness are not immune to physical sickness and disease. However, little attention has been paid to the coping challenges and therapeutic treatment of those who suffer from this double bind. Of such studies that do exist, fewer still focus specifically on the unique challenges faced by older adults in this population. This paper presents the case of a 58-year-old man diagnosed with schizoid personality disorder and Parkinson's disease. The particular coping challenges he faces are addressed, as well as the clinical issues that emerged in the therapeutic treatment.

Introduction

Individuals with mental illness are not immune to physical sickness and disease. However, little attention has been paid to the coping challenges and therapeutic treatment of those who suffer from this double bind. Of such studies that do exist, fewer still focus specifically on the unique challenges faced by older adults and the elderly of this population. Indeed, the first study designed to assess the needs of older patients with schizophrenia was undertaken only recently, and documented only one other study that focused specifically on older psychiatric patients, most of whom were diagnosed with dementia and depression (Auslander & Jeste, 2002). The need for research on personality disorders in the older adult population has also been identified (Akhtar, 1987). In a descriptive study on schizoid personality disorder, Akhtar (1987) drew on Bergman's (1978) study of neurosis and personality disorders in the elderly in which he found that patients with personality disorders are able to adapt to the changing demands of old age better than might be expected. Although these studies are informative, their small numbers make clear the significant need for research on mental illness and aging.

This single-case study attempts to contribute to our understanding of the complex needs of older individuals who suffer from the double bind of chronic mental and physical illness by presenting the treatment of a 58-year-old man with schizoid personality disorder and Parkinson's disease. The client's particular coping challenges are addressed, as well as pivotal issues that arose during the course of treatment. In order to understand the case more fully, brief discussions of both Parkinson's disease and schizoid personality disorder are presented.

Parkinson's Disease

Parkinson's disease (PD) is a chronic, neurological, progressive and degenerative disease that affects approximately 1% of people over 55 years of age (Frazier, 2000). Although the incidence of the disease increases with age and onset is rare before the age of 30, PD can occur at any stage of life (Parkinson's Disease Foundation, 2003). In addition to physical symptoms, PD affects cognitive and psychosocial functioning as well. Physical symptoms manifest predominantly in the form of tremors, rigidity and slowness of movement in the limbs (Cummings, 1996). Typical cognitive problems associated with PD are memory impairments and dementia (Frazier, 2000; Cummings, 1996). Psychosocial functioning is often compromised by the many challenges posed by changes in physical appearance, social roles and interpersonal relationships (Kai & Crosland, 2002; Frazier, 2000).

Extensive research indicates a strong link between PD and depression, with approximately 25% of PD sufferers affected at some point (Cummings, 1996). In a recent article examining the relationship between PD and depression, Jeffrey L. Cummings states that depression can occur as the result of both psychosocial stressors and physical impairments to the brain stem region (Cummings, 1996). He reports that suicidal ideation is high among patients with PD, but few attempts are executed. Cummings notes that anxiety is common in PD sufferers as well. Drug therapy is often used to treat depressed patients, although these remedies sometimes exacerbate neurological symptoms and subsequently must be discontinued (Cummings, 1996). The physical symptoms of PD are treated with various drugs as well, all of which have potentially serious side effects, including urinary retention, constipation, blurred vision, nausea, insomnia, and in some cases, hallucinations and delusions (Cummings, 1996). For these reasons, it is essential that individuals with PD be monitored closely by their neurologists as well as their psychiatrists and other health care providers, such as social workers and internists, when appropriate.

Schizoid Personality Disorder Through the Lens of Object Relations Theory

According to the DSM-IV-TR, the "essential feature" of schizoid personality disorder is "a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings" (American Psychiatric Association, 2000). In addition, diagnostic criteria requires the presence of at least four of the following: (1) neither desires nor enjoys close relationships, including being part of a family; (2) almost always chooses solitary activities; (3) has little, if any, interest in having sexual experiences with another person; (4) takes pleasure in few, if any, activities; (5) lacks close friends or confidants other than first-degree relatives; (6) appears indifferent to the praise or criticism of others; and (7) shows emotional coldness, detachment, or flattened affectivity (APA, 2000).

While this criteria establishes the formal basis for diagnosing schizoid personality disorder, the disorder is more complex than would appear at face value. In 1908, the term "schizoid" was first introduced by Eugen Bleuler (Akhtar, 1987). For Bleuler, the term indicated an intense, though non-psychotic preoccupation with one's inner world. Since he introduced this concept, numerous theorists have expanded on its definition. Among various portraits of the disorder, a common feature is the tension between the schizoid individual's contradictory inner emotional states (Akhtar, 1987). In addition, these states are considered to be defensively hidden behind a seemingly detached facade presented to the outer world. The consensus among theorists is that the inner emotions that are in conflict are a deep-seated longing for care and affection juxtaposed with a profound fear that if such love were received, one might consume it out of such hunger that the self of the giver of that love might be completely destroyed (e.g. Akhtar, 1987; Berzoff, 1996).

Object relations theory provides a solid base from which to better comprehend this tension (Applegate & Bonovitz, 1995). The theory is fundamentally concerned with the subject, or self, and how it relates to others as both people and as objects of desire, fear, or however the self perceives and experiences them. Object relations theory is rooted in the notion that relationship, or more specifically, attachment, is a basic and primary need. Psychological harm is thus born out of this need being inadequately met.

Donald Woods Winnicott focused on the complex dichotomy of the need for both attachment and separateness for healthy psychological development. Winnicott's notion of the "holding environment" pointed to a relational quality between the infant and caregiver (Applegate & Bonovitz, 1995). If the caregiver was "good-enough," he or she would provide the infant with a sense of security, without being overly protective (Applegate & Bonovitz, 1995). However, if the environment was one in which the infant was neglected or, conversely, smothered, the infant would likely experience the caregiver as either rejecting or suffocating. There are multiplicities of ways in which important objects can be perceived. These perceptions ultimately dictate how one comes to know the world and oneself in it. The mind's representation of both the self and others becomes the content of one's internal world and lays the groundwork for later relatedness (Berzoff, 1996).

A significant contributor to the study of schizoid personality disorder, object relations theorist Melanie Klein, considered "splitting" to be the major feature of the disorder (Berzoff, 1996). Klein viewed splitting, that is, the division of self and object representations into two separate camps - good and bad - as a defense. The function of this defense is to ward off infantile anxieties that one might damage or destroy important objects through one's intense neediness. Since the loss of such objects is feared, as is the fantasy that these objects might seek revenge, splitting becomes one of the major ways in which the individual with schizoid personality disorder is able to cope. When splitting occurs, the schizoid individual experiences others as fragmented, or "part objects," instead of as whole people (Berzoff, 1996). Splitting is adaptive to the degree that it provides a way of managing, or sometimes controlling, incompatible aspects of the self and others when one is not able to synthesize them into a whole.

Adding to this discussion, W. R. D. Fairbairn asserted that by relating to others as less than whole beings, the schizoid individual often becomes exhausted by the challenge of social interaction (Berzoff, 1996). Since one fears the possibility of destroying others with one's neediness, intimacy becomes frightening. Through projection of this fear, others come to be regarded as dangerous. For this reason, the schizoid individual tends to create ways of interacting with others that feel less threatening. Sometimes these efforts are translated into literary, artistic or intellectual pursuits – activities that allow the individual to express his or her needs and desires in a safe way. However, when feeling threatened and afraid, the schizoid individual attempts to create even more distance by appearing indifferent to others or even rude and spiteful.

Object relations theorist Harry Guntrip regarded fear as the primary characteristic of psychological distress (Berzoff, 1996). Excessive fear, he believed, creates a sense of being related diminutively to a terrifying world. In these terms, one feels powerless to cope with life in general, much less with the world itself. Guntrip attributed the etiology of schizoid personality disorder to one of three experiences in early life: 1) refusal of early caregivers to meet the infant's basic needs; 2) real physical threats from hostile objects; or 3) "emotional desertion by parental figures which necessitated seeking gratification within oneself" (Akhtar, 1987). Guntrip called the schizoid individual's simultaneous deep yearning and fear of closeness "love made hungry" (Berzoff, 1996). In addition to trying to protect important objects from destruction, Guntrip believed that this sought-after love is also rejected out of the schizoid individual's fear of being swept away in love's current, drowning any sense of autonomy.

According to object relations theory, treatment of individuals with schizoid personality disorder must begin with the therapist creating a safe space in which the client feels held, cared for and understood. In other words, the therapist must create a "good-enough holding environment." Among other things, the therapist can do this by providing his or her full attention to the client, being reliable and steady and, most importantly, by being open and empathic (Applegate and Bonovitz, 1995). For the individual with schizoid personality disorder, one of the major goals of treatment is to help her or him learn that it is okay to care about others – and to be cared for – without fear. To combat this fear, it is also critical for the therapist to be in tune with the client's alternating needs for closeness and space (Berzoff, 1996). When these experiences are adequately and consistently provided over time, the therapeutic relationship should provide the client with a new frame of reference – a new way to see him or herself in relation to another.

Case Presentation

The following case is that of Jeremiah Green, a 58-year-old, Caucasian man with schizoid personality disorder and Parkinson's disease. Identifying information has been changed in order to protect the client's confidentiality. In September 2002, Jeremiah contacted the agency where I currently work as a second-year social work intern. He was looking for both case management and counseling services. He stated that he had been feeling extremely depressed and anxious regarding his health condition, to the point of experiencing periodic suicidal ideation. After several sessions with Jeremiah, it appeared that his psychological symptoms fit the DSM-IV-TR criteria for schizoid personality disorder. The aim of sharing Jeremiah's case is to highlight some of the challenges that he has experienced in coping with the double bind of mental illness and the disabling disease of Parkinson's. Implications for the treatment and care of such individuals will be underscored as well.

Jeremiah was born in 1944 to a middle-aged couple who had been married for 11 years. He was the only child of his father and the second child of his mother (she had had a daughter sixteen years prior to Jeremiah's birth, but he had never known her because she had been placed for adoption). Jeremiah described his parents as "apartment dwellers" who moved frequently and never owned a home. Although his father owned a business, Jeremiah deemed him a "miserable failure" because he was unable to manage his money and "died with only $300 in his pocket." His mother worked as a saleswoman to make ends meet, but the family always seemed to struggle financially despite her contributions. Although Jeremiah cared about his parents, he never felt close to them since they "worked all the time." To this he added, "I've had to fend for myself for as long as I can remember." In light of Guntrip's discussion on the causes of schizoid personality disorder, it could be argued that his parents' inadequate care was the genesis of Jeremiah's disorder. In the mid-1980s both parents died within a short period of time, leaving Jeremiah with no known living relatives and a sense that no one else in the world cared about him.

Growing up, Jeremiah had no close relationships with either relatives or friends. During high school some boys had tried to pressure him into "finding a girl to have sex with," but the anxiety this produced only resulted in him feeling more estranged from his peers. Jeremiah defended against this saying, "I never felt the need for friends anyway." Indeed, throughout college and up until recently, Jeremiah considered himself to be a loner with no need for friends. However, with the onset of Parkinson's disease two years ago, Jeremiah found it difficult to manage his needs without such supports. Naturally, this vulnerability has been extremely frightening for him.

The first signs of Jeremiah's Parkinson's disease manifested as slight tremors in his right hand and difficulty walking steadily. By March of 2001, he decided to retire early from his job as a pharmacist because he could not steady his hands to properly dispense pills. Although he misses his work, he does not believe that

anyone at the pharmacy where he worked misses him. This is evident to him in that, with one exception, none of his former co-workers have called to see how he is doing. For Jeremiah, this is further proof that no one cares about him.

At our first visit in September, he presented as disheveled and poorly groomed and avoided eye contact with me. Although mild tremors in his right arm were evident and he appeared to have some difficulty walking, he did not seem seriously disabled. During our session, I explained to Jeremiah that I was a social work intern and would be leaving the agency the following May. However, I assured him that he could continue with another therapist at that time if he so desired. Jeremiah stated that he would probably be dead by then, so he was not concerned about finding another therapist. Jeremiah then shared with me that he had been feeling depressed and isolated and he feared he might die soon due to his deteriorating health.

In order to better understand the severity of his health condition, I asked Jeremiah for more details. More specifically, I wanted to know what the diagnosing physician had told him regarding his prognosis. Although his neurologist had told him that he was in the early stages of Parkinson's, Jeremiah believed that his condition was much worse than the doctor was aware and that it was progressing at an unusually rapid pace. He stated that it was critical for me to understand the acronym TRAP, used to describe the symptoms of PD. That is, T for tremors, R for rigidity, A for akinesia (difficulty initiating movement) and P for posture instability. Although there are many ways in which to talk about Parkinson's, the acronym TRAP seemed to perfectly sum up how Jeremiah was really feeling, and he wanted to be sure that I understood this clearly.

For Jeremiah, one of the most disturbing aspects of the Parkinson's was the need to be dependent on others. He mentioned a pen pal, Janice, who he had been corresponding with for a few years. However, he was careful to point out that she had basically "abandoned" him after his diagnosis of PD. When I asked Jeremiah to say more about that, he explained that Janice was too pushy and "didn't give a damn" about his welfare. The next week he brought in a letter in which Janice had offered examples of things she had done to improve her quality of life; Jeremiah felt that Janice's letter indicated that she was "self-absorbed," but he said he would continue to write to her to give himself something to do. Over time, I have learned that Jeremiah responds best to empathic listening

above all else. As is the case with most people, he does not want me to try to solve his problems (as Janice was attempting to do). By providing an environment in which Jeremiah feels safe and held (the opposite of abandoned) he is able to work towards healing.

Throughout the course of treatment, Jeremiah has resided at the local YMCA. Prior to his stay there, he lived for a short time in a retirement community, which he found depressing because everyone was "old and senile." He was especially bothered by the fact that no one there could remember his name. During our first session, Jeremiah stated that he hoped to find a room to rent in a private home. He explained that he had lived in these types of home-share arrangements since college, but was currently having difficulty finding something suitable. He noted that his last home-share had been arranged by a woman named Dawn who ran an agency called New Beginnings that matched homeowners with renters. The arrangement did not last long because Jeremiah "didn't get along" with the homeowner. He told me that Dawn had taken the homeowner's side, claiming that "owners have the power," and he didn't think that Dawn would be willing to help him out again. I questioned whether we should call her and request her assistance again, but Jeremiah was adamantly opposed. He stated that he would look for something on his own, but requested that I also offer him alternative options to consider.

Over the next several weeks, I presented Jeremiah with numerous housing options, including private apartments, shared housing, group living, nursing homes, assisted living facilities and various SROs (single room occupancies, such as the YMCA). For one reason or another, each suggestion was met with an objection and the statement, "there are no options." After a while I came to understand that what Jeremiah was actually saying was that there were no options that he was willing to consider, other than home-sharing. I brought up the option of contacting Dawn again, but Jeremiah was sure that she would be unwilling to help and admitted he felt powerless about gaining her support. Despite his reluctance, Jeremiah agreed to let me contact her. After several unsuccessful attempts to reach her by phone, I began to become suspicious myself. Perhaps she really would be unwilling to help. After leaving several messages, Dawn eventually returned my call and invited me to come with Jeremiah to her office in order to update his file. Considering Jeremiah's apprehension in dealing with Dawn and my own suspicions, I decided that such a visit would be a good idea. To my delight the visit went well and Jeremiah seemed more

hopeful than I had seen him in a long time. In fact, after the visit he carried himself more confidently and seemed to walk with less difficulty than normal.

Client advocacy and case management efforts like this have been an important part of my work with Jeremiah. Among other things, he has sought support from me in locating a Parkinson's support group and a lawyer to create a living will, as well as obtaining mail-order prescriptions and transportation assistance. While these concrete supports have been important, the most significant effect they have had on Jeremiah cannot be measured quantitatively. That is to say that this support has helped Jeremiah to feel as though he is a valued person worth caring about. For example, after our visit to New Beginnings, Jeremiah thanked me for my help and stated I was the first person in his life to have ever come through for him. In ways like this, our relationship is providing a new frame of reference for Jeremiah. He is learning that it is okay for him to be cared for and about – without negative repercussions.

However, throughout the course of our work together, Jeremiah has struggled with doubts about his worthiness and fears that his neediness will engulf those who try to offer him care. These feelings have been so troubling and intense for Jeremiah that he often sinks into suicidal pits of despair. One instance in which Jeremiah expressed such feelings of hopelessness occurred in response to my two-week holiday break in December. Per his request, preparations were made well in advance to have Jeremiah seen by another therapist while I was gone. In our last session before the break, Jeremiah stated he didn't know whether he could survive our separation. Even though he felt relieved to know that someone else would be available in my absence, he struggled with feelings that I must not care about him and was abandoning him. In response, my counter-transference manifested as guilt, but my studies in school and discussions in supervision about holidays and separations helped me to both understand what this meant to Jeremiah, and to trust that he would indeed survive.

When I returned from break, Jeremiah called to say he was glad I was back, but that his health condition had deteriorated significantly while I was gone. He requested that I come to his room at the YMCA since he was feeling too weak to come to the office but did not want to miss our session. Since our agency provides periodic home visits for invalids, this request was an appropriate one and I agreed to visit him at the YMCA. When I arrived at his room, he was feeling miserable and spent most of the session lying down on his bed with a washcloth over his eyes. The following is part of our conversation during that visit:

J = Jeremiah; SWI = Social Work Intern

J: I'm sorry that you have to see me like this.

SWI: Don't worry about me – I'm fine. I just want to make sure that *you're* okay.

J: That means a lot to me. But it's hard for me to be like this. I've always been a loner and never needed anyone.

SWI: It's okay to need people. Everybody does at one point or another in life.

J: But I don't even feel like a man anymore – I'm turning into a vegetable. <*Begins to cry*>

SWI: I know that you're not as healthy as you used to be, but you're still a man.

J: I used to be a gentleman. I never used to curse and now I do it all the time. You shouldn't have to hear me talk like that.

SWI: It's only natural to be like that when you don't feel well. You can talk any way you want to with me and I won't think less of you.

J: I just don't understand why I have to suffer like this. I've been asking God for a sign, but nothing ever comes. And every day I pray: Even though I walk through the valley of the shadow of death… <*He recites the rest of the 23rd psalm while sobbing*> I just don't understand why God is letting me suffer like this!

SWI: That's a really hard thing for anyone to understand.

J: I don't know if I'll go to heaven.

SWI: Does that worry you?

J: A little bit…I'm just afraid of so many things. I want to show you something.

SWI: Okay.

J: <*Sits up and reaches for a piece of paper next to the bed.*> Here, this is what I wrote at the library yesterday:
I am afraid to drive
I am afraid to pay my bills
I am afraid to stay in my room at night
I am afraid to talk to Dr. Ziegler
I am afraid to eat out
I am afraid to talk to the desk clerk at the

YMCA
I am afraid to take my medicine
I am NOT afraid of dying
I am afraid I will die like my mother, *alone with nobody to care**
I am afraid I will go broke
I am afraid to walk
I am afraid to talk to people
I am afraid people don't care about me*
I am afraid that I will fall and hurt myself
I am afraid to brush my teeth
I am afraid of any noise
I am afraid to return my library books
*Italics added for emphasis.

SWI: This is quite list. *<Reading it over>* When you say that you're afraid to pay your bills or return your library books or brush your teeth, do you mean that you're afraid that you won't be able to do those things because of your illness?

J: Yes, that's exactly what I mean.

SWI: I noticed that you also wrote that you're afraid that people don't care about you and that you're afraid you'll die alone like your mother.

J: Yes, I wouldn't worry about the other things as much if I had a caregiver, but I'm all alone. *<He starts crying>* I don't think I ever told you about how my mother died, did I?

SWI: Not exactly. You told me that she went into a nursing home and died there.

J: Yes, but it's the way she died.

SWI: Can you tell me about it?

J: She fell down in her room and nobody noticed right away. I don't know how long she lied there without anybody to help her up – it could've been hours. Finally, someone found her and they called me. So, I went out there right away…*<starts crying harder>* When I got there I went up to her and said – "Ma, it's me, Jeremiah. I'm here now." But all she did was go…"uuhh…" *<makes a grunting sound>*. Then the nurse came in and told me not to bother because she was brain dead. They told me that she was in a coma and asked me what I wanted to do. I told them that she didn't want to be kept alive on machines. So they told me they would just monitor her and call me when she died.

SWI: That must've been really hard for you. You didn't even get a chance to say goodbye to her.

J: Yes, it was terrible. But, the worst thing was waiting for her to die. Every time the phone rang I wondered if it would be the hospital calling to tell me that she had died. It took two weeks. It was the longest two weeks of my life. *<starts sobbing and talking louder>* I'm afraid that I'm going to die like my mother! God, No! I'm going to die like my mother! All alone! *<He was crying so hard when he said this that he kept gasping for air.>*

After assuring Jeremiah that he was not alone and that I cared about him, he was able to regroup and seemed quite relieved. The session was pivotal in that Jeremiah had grown to feel safe enough with me to disclose deep emotions and cry out for help. But Jeremiah's list of fears was presented above in its entirety in order to illustrate how frightening it is for him to face the challenges of Parkinson's in light of his mental illness.

The session was also particularly draining for me, since Jeremiah's helplessness reminded me of what my grandfather had gone through in his struggle with Alzheimer's disease. In addition, his theological questions around the meaning of his illness aroused strong feelings in me since I am a divinity student, as well as a social work student. However, as his therapist, I was determined to let Jeremiah work out those feelings in his own way. Processing this experience in supervision was critical for me and helped me to sort through the strong feelings that Jeremiah had evoked in me.

Perhaps the issue that most consumed Jeremiah's thoughts over the course of our treatment was his healthcare. During our first session, Jeremiah complained incessantly about his neurologist, Dr. Ziegler. Although he felt that his health was "deteriorating rapidly," he didn't feel as though this was taken seriously by his doctor. He explained that he could talk until he was "blue in the face," but would never get a satisfactory response. He was especially put off by what he called Dr. Ziegler's nurse's "condescending manner." He described this as insincere flattery and dishonesty (e.g. statements like, "You're doing great!" which Jeremiah found demeaning). When I spoke with the nurse I found her to be quite warm and accessible. She informed me that most patients in Jeremiah's condition only needed to be seen a few times a year, but that Dr. Ziegler had been willing to see him almost once a month per Jeremiah's request.

Over time I tried to assess what bothered Jeremiah most about his healthcare. Was it his physical state or the fact that he did not feel listened to? At one of our visits I asked him to explain how he had felt when he first went to see Dr. Ziegler. He responded, "The day I walked into that office was the day the first nail went into my coffin." When I asked him to elaborate, he said, "There is a total lack of understanding in that office." He added that he felt as though Dr. Ziegler was a "cold, calculating, inhumane man." Jeremiah felt that Dr. Ziegler had promised to help him, but hadn't come through. When I asked him what "coming through" meant to him, he responded, "You have to be near death to speak to him…and his nurse, that son of a bitch is the guardian of the gate – she won't give you the time of day either!" During one session, Jeremiah confessed having fantasies about killing Dr. Ziegler. In response to my questions about the sincerity of those sentiments, Jeremiah stated, "Actually, I wouldn't really want to kill him. But I'd like to scream and yell at him. I'd probably get so upset that they'd have to sedate me."

As I listened to Jeremiah's feelings over time, I came to believe that Dr. Ziegler was a capable physician with perhaps an unfortunate bedside manner. It seems that what bothered Jeremiah most was Dr. Ziegler's inability to reflect Jeremiah's concerns in an empathic way. For this reason, I encouraged Jeremiah to seek out a new neurologist. In exploring the subject, I asked him to suppose that he could find another doctor. What would he hope his treatment to be like with someone else? Jeremiah's first response was, "You're really dealing with insurance companies, not doctors." Despite this answer, I pressed him to think about what qualities he would want in a doctor. Finally, he said that he would want a doctor with "a little compassion." To this he added, "Dr. Ziegler sees poor puny me and thinks it's okay to push me around…he doesn't care."

In January, Jeremiah was admitted to the hospital by his psychiatrist after expressing great anxiety over the state of his health and his inability to cope with the stress. This was his second psychiatric hospitalization within approximately a year. Upon discharge a few days later, Jeremiah was released to a nursing home for a brief respite stay. When I spoke to him in the hospital, he promised to call me from the nursing home when he got settled. After a few days had passed and Jeremiah had not called, I decided to go ahead and contact him myself. When I reached him he explained that he hadn't called since going into the nursing home because he felt that he was becoming a burden. "I was afraid that you would leave me or desert me," he said. I reassured him that I cared and that he had not become a burden to me.

The following month, Jeremiah got up the courage to see a new neurologist. This move was fraught with anxiety as Jeremiah worried excessively about whether this new doctor would be "just as bad as Dr. Ziegler." He also worried that this new doctor would be "afraid of Ziegler's power…afraid to contradict him." This was likely a projection of the way in which Jeremiah felt in relation to Dr. Zeigler. Finally, he worried about going to the appointment alone. In discussing these fears, Jeremiah seemed to obsess about the issue of transportation. He told me that he didn't want to take a train because he would have to walk too far between stops, and he didn't want to take a taxi because it would be too expensive. It seemed that everything I suggested was met with an objection. Finally, Jeremiah became angry and said, "So I guess you're obviously not going to take me." Out of this, we were able to discuss Jeremiah's fears that he would not be listened to or taken seriously if I was not there. I asked him why he felt that a caregiver would be listened to, but that he would not. Jeremiah asserted that while he always feels misunderstood, he was "10 million times sure" that I would be taken seriously. As an example, he cited the fact that I had helped him communicate with Dawn at New Beginnings. Although I felt immense pressure from Jeremiah to accompany him to his appointment, I also felt that doing so would start to muddy the waters between therapist and friend. I even began to doubt whether I should have gone with him to New Beginnings. We finally found a middle ground that seemed to work for both of us. He would go to the appointment on his own, but I would call the doctor prior to his visit to inform her of his concerns about being listened to and taken seriously.

At the session following his appointment, Jeremiah was extremely hostile and expressed suicidal ideation. When he first entered the office, his voice was so quiet that it was barely audible. As the session progressed, however, he became more and more agitated and began to yell. He said that he did not wish to discuss his appointment with the neurologist and that he was disgusted with me because "no progress [has] been made on anything since we began working together!" He was on such a rant that it was almost impossible for me to interject. When I managed to say something, Jeremiah barked, "I don't believe that you care! You're leaving in May!" He told me that everyone in his life, including me, had "deserted" him.

When I asked about this, he said he was very upset that I had failed to find transportation to his appointment and he began demanding that I find something affordable for his return appointment in two weeks. When I asked him whether he was feeling upset with me for not going with him to his appointment, he became even more enraged and yelled, "No! That's not it at all!" Following this he began threatening suicide, arguing that his doctors and I would probably be relieved to see him dead so that we wouldn't have to deal with him anymore. I eventually established with reasonable certainty that Jeremiah would not hurt himself in the near future and decided to bring the session to a close.

Later that day I left a voicemail message reassuring Jeremiah that I indeed cared about him and promising to call back later that same evening. When I reached Jeremiah later that night, his voice was almost inaudible again. I believe this reflected Jeremiah's sense of being small and insignificant in relation to a frightening world. He immediately apologized for being "belligerent" with me earlier, and claimed that an imbalance in his Parkinson's medications had made him act that way. I assured him that it was okay for him to feel angry with me and to express those feelings when they came up. The following week, our last session at this writing, Jeremiah came into the office carrying the book, "When Bad Things Happen to Good People." The first thing he said when he saw me was that he wanted to read a paragraph from the book out loud. It went as follows:

> Human beings are God's language. That is, when we cry out to God in our anguish, God responds by sending us people. Doctors and nurses work tirelessly to make us whole. Friends come and sit with us, hold our hands without speaking, without trying to explain away our suffering or diminish it by telling us of other people who have it worse. And though we did not know it, that is exactly what we need, the reassurance that we are not alone and that we are people worth caring about.

In reading this excerpt, Jeremiah was able to express his gratitude and tell me how much I have meant to him in a way that felt safe. The passage also sums up what I believe is the most critical aspect of therapy with "double bind" clients like Jeremiah. That is to say that what people who face such challenges need most is to know that there is someone out there who cares about them and is willing to listen. That person may not be able to physically heal their afflic-tions, but can offer them a relationship experience that provides healing of an equal, if not greater, significance. As this study concludes, my work with Jeremiah continues. I suspect that termination will be difficult for both of us, but I hope that our relationship has given Jeremiah something to hold on to – the belief that he is worthy of being cared for and the knowledge that love is not dangerous.

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Autum Elizabeth Lum received her MSW from the School of Social Work in May 2003. A dual-degree student in social work and ministry, she will graduate with a Masters of Divinity from McCormick Theological Seminary in May 2004. Her first-year internship in clinical social work and ministry was at Interfaith House, a respite and rehabilitation center for homeless adults recovering from illnesses and injuries. In her second-year social work internship at a counseling center in Chicago, she provided individual, couples, and group counseling to children, adolescents and adults. This paper received 1st place in the School of Social Work Distinguished Writing Awards 2003.

Elder Abuse: Problem in Search of a Policy

by John U. Baker

Abstract

Despite more than 25 years of discussion, research, legislation, social programs and law enforcement activity, little is clear about the social problem of the abuse and neglect of older adults. This article provides an overview of the phenomenon of "elder abuse" and explores some of the controversies surrounding the phenomenon. It reviews the history of federal legislation designed to protect older adults, then discusses Illinois statutory protections for older adults as provided through the state's Adult Protective Services agency. The article closes with a brief description of the current federal legislation that addresses elder abuse and neglect.

Introduction

There is a widespread belief that abuse of the elderly is a real and troubling social phenomenon in this country. Yet this most rudimentary of observations sustains little agreement among either professionals or laypersons. In fact, since the problem was first "discovered" in the late 1970s, the field continues to be plagued with uncertainties born of a lack of definitive, empirical research. Even the most basic questions concerning the nature and extent of the mistreatment of older adults remain unanswered: What is "elder abuse"? How widespread is it? What causes it? Who are the perpetrators? Who among the older adult population are the most likely victims? (Wolf and Pillemer, 1989 as cited in Bonnie, 2002).

The term "elder abuse" is generally understood to include a broad litany of mistreatments involving older adults, including physical, psychological and financial abuse, neglect, and self-neglect. One leading authority defines the term this way:

> In its common usage, elder abuse is an all-inclusive term representing all types of mistreatment or abusive behavior toward older adults. This mistreatment can be an act of commission (abuse) or omission (neglect), intentional or unintentional, and of one or more types: physical, psychological (or emotional), or financial abuse and neglect that result in unnecessary suffering, injury, pain, loss or violation of human rights and decreased quality of life (Hudson, 1991, as cited in Wolf, 2000, para.6)

The very breadth of this definition points to a fundamental difficulty in the field. As Callahan has observed, "…[A]buse, like beauty, is in the eye of the beholder" (Callahan, 1988, p. 454).

Elder Abuse: A Brief History

The mistreatment of older adults is both a relatively new social problem and a problem as old as society itself. Over the past 35,000 years in which humanity has existed, the question of what to do with the older, frail members of society has had a broad range of answers. Those answers vary in part according to how a society values its elders. In more traditional societies, the elder members of a community are often viewed as repositories of cultural wisdom with a continuing, critical value for their communities which entitles them continued access to that community's respect and resources (Gutmann, 1994). Gutman states that this special status has largely been abandoned in contemporary western society.

Those older adults who are no longer wage earners or able to contribute to the material welfare, are perceived as burdens. They are seen as a drain on the emotional, financial and temporal resources of families and communities (Gutmann, 1994).This kind of negative, dehumanizing view is not, to be sure, universal. On the societal level, it is balanced by social values that assert that care of the helpless elderly is fundamental to the realization of a just, moral society. Such care has been a recognized responsibility and specific goal of social policy in English/American society at least since the English Poor Laws of 1601, which are credited with substantial success in creating a system that did a generally good job of caring for English society's indigent elders (Thompson, 1984, as cited in Biggs et al., 1995).

The Magnitude of the Problem

There is no clear picture of either the magnitude nor the incidence of domestic/community elder abuse in the United States. In testimony to the Senate Finance Committee (2002), Richard J. Bonnie, the chairman of the National Research Council's Panel to Review Risk and Prevalence of Elder Abuse and Neglect, characterized the current state of knowledge on magnitude and incidence as a "nearly blank slate, a tabula rasa." He characterized the gaps in current

knowledge as "enormous." Elder abuse and neglect, according to Bonnie, has been given little in the way of research interest or funding from major foundations or the federal government. This deficiency is evident in all aspects of the field, resulting in a lack of hard information about all aspects of elder abuse, from causes to the effectiveness of potential solutions.

Brandl and Cook-Daniels (2002) provide more detail on the serious limitations of research in the field of elder abuse. The authors undertook a massive comparison of key findings in a range of critical areas from major studies in the field of elder abuse between 1988 and 1999, which they reported on in a study entitled *Domestic Abuse in Later Life.* They concluded that "Comparing results across studies is practically impossible," (Brandl & Cook-Daniels, 2002, p.5) noting that the studies varied widely in type and definition of abuse, ways in which the abuse was reported, age of respondents and gender of study subjects. Other methodological problems included small sample size, general exclusion of cognitively impaired elders, and a broad variety of sampling biases.

Given these methodological problems, it is not surprising that in drafting the Elder Justice Act of 2002, Senator John Breaux's Special Committee on Aging was forced to settle for a very broad estimate of the incidence of elder abuse in this country. In its findings, the bill stated that "Each year, anywhere between 500,000 and 5,000,000 elders in the United States are abused, neglected or exploited" (U.S. Senate, 2002). Such an estimate is so broad as to be almost meaningless.

While the dimensions of the elder abuse problem are profoundly unclear, it is possible to get a very general idea of its nature. The largest study to date is the National Elder Abuse Incidence Study (NEAIS), a statistical analysis of elder abuse for the year 1996 issued by the National Center on Elder Abuse. Despite what are described by Brandl and Cook-Daniels (2002) as "serious methodological flaws," including small sample size and short study duration, the NEAIS does shed some insight on the issues of concern to the field (p.4). The study estimated that 450,000 elderly persons living in community-based settings were abused and/or neglected during 1996. It stated that female elders were more likely to be abused than males, and elders 80 years and over (sometimes called the "old old") were most at risk for abuse. Even more disturbing, the study clearly identified family members as the most likely perpetrators of the abuse: "In almost 90 percent of the elder abuse and neglect incidents with a known perpetrator, the perpetrator is a family member, and two-thirds of the perpetrators are adult children or spouses. (National Center on Elder Abuse, 1998, Summary, para.1).

Data on elder abuse cases reported in Illinois provides another perspective. The data shows a steady increase in the number of abuse cases reported to the state's Adult Protection Services, with a leap from 1,082 in fiscal year 1990 to 7,157 in fiscal year 1999. Of the total cases reported, 57% met the state's standards for elder abuse, exploitation and neglect (Illinois Department on Aging, 2002, para. 1). These case reports provide a far more detailed picture of the daily reality of elder abuse in the state and therefore deserve to be described in some detail. They appear to confirm key findings of the NEAIS that a typical victim is likely to be female and more than 80 years old. Like the NEAIS study, they indicate that the abuser is most likely to be a relative. Victims' children accounted for 41% of cases, while spouses were named as perpetrators in 14% of cases. According to the report, financial exploitation is the most frequent form of elder abuse (53% of reports), followed by emotional abuse (42% of reports). Thirty-seven percent of reported cases involved passive neglect, while 20% of reports alleged physical abuse. The report states that more than one type of abuse is usually present in the cases (Illinois Department on Aging, 2002, para. 2).

History of the Current Policy

While the fact of the mistreatment of elderly persons may be as old as society itself, the idea of "elder abuse" as a specific subset within larger concerns about care for the elderly is considerably more recent. In fact, the problem of "elder abuse" as it is now understood appears to have first emerged in the national consciousness in the 1970s (Wolf and Pillemer, 1989; Dunn, 1996).

Wolf and Pillemer (1989) contend that the "discovery" of abuse of the elderly as a social problem stemmed from three primary social factors. The first and most obvious factor was the growth in the elderly population, both in numerical terms and in terms of its political clout. The authors suggest that the emergence of this constituency paralleled the emergence of new ideas spawned by the women's movement of the 1970s which "prompted an examination of myths about family life and an increasing recognition that the family can be extremely oppressive to some of its more vulnerable members" (Wolf and Pillemer, p. 7). This recognition created an awareness that "helped build a foundation for the interest in maltreatment of the elderly" (Wolf and Pillemer, p. 7).

The authors identify "increasing willingness of the state to intervene in family matters" as a third causal factor. They note that during the 1960s, protective services began to be provided on the state level in response to concerns about the mistreatment of children. This emerging state-assumed responsibility set the stage for a new and focused concern for the abuse of other vulnerable members of the family. "Already familiar conducting these interventions on behalf of children, it was but a short step for state protective services to expand the domain of their advocacy to include the vulnerable elderly" (Crysta 1986, Salend et al., 1984, as cited in Wolf and Pillemer, 1989, p.4)

In fact, the idea that the federal government should concern itself with the need for offering specific protections for vulnerable adults was first enacted into law during the 1960s, in the form of a program that mandated states to establish adult protective services. The first tangible policy actions by the federal government in this area were public welfare amendments to the Social Security Act passed by Congress, which authorized payments to the states for purposes of establishing protective services for "persons with physical and or mental limitations who were unable to manage their own affairs…or who were neglected or exploited. Services were to meet the medical, legal, social and psychological needs of this vulnerable population" (Wolf, 2000, para. 2).

According to Byers and Hendricks (1993), adult protective services became a state mandated program in 1974 with the adoption of the Title XX Amendment to the Social Security Act. The amendment covers all adults 18 years old and older without regard to income and focuses on abused and exploited adults. With this federal mandate, most states created adult protective service units in their social services agencies (Quinn and Tomita, 1986 as cited in Byers and Hendricks, 1993, p.6).

In 1978, Congress again visited the issue of the mistreatment of older adults in the form of testimony on the subject presented before the House Select Committee on Aging. The Committee, under the leadership of Representative Claude Pepper, was at the time exploring family violence. Despite the fact that the Committee produced no legislation that was enacted into law, its work was to have a profound effect on the future of elder abuse policy in the United States. Research by Peter Dunn (1996) suggests that Pepper's Committee was directly responsible for elevating concerns regarding mistreatment of the elderly to the status of a national social problem. In fact, according to Wolf and Pillemar (1989) and Dunn (1996), the term

"elder abuse" first surfaced in the 1978 proceedings of this Committee.

Dunn presents a scenario in which a small number of interested persons in and around the 1978 Congress used limited and preliminary data on mistreatment of older persons as the whole cloth from which they consciously created a social problem. He contends that they then exploited the resulting public outcry for their own political benefit. If correct, Dunn's thesis suggests that the continuing lack of an empirical knowledge base upon which to build elder abuse policy was present from the very beginning. It was then, as its critics contend it is now, a policy in search of a problem - a knee-jerk response to a poorly understood social phenomenon without an empirical foundation in solid research. Dunn's research suggests that the chain of events that resulted in the creation of a national awareness of "elder abuse" first originated with social activist James Bergman, director of a Boston-based social service agency called Legal Research and Services for the Elderly (LSRE) (Dunn, 1996, p. 5).

Dunn's research included extensive interviews with Bergman. He quotes Bergman as indicating that his involvement in the issue was at least partially motivated by a desire to raise LSRE's public/political profile. This motivation, according to Dunn, dovetailed with the desire of Select Committee on Aging Congressmen (most notably Chairman Pepper and Cleveland Congresswoman Mary Rose Oakar) to find a hot-button issue with which to raise the Committee's profile and their own political capital. As Dunn puts it, "the ambitious will endeavor to formulate, present, and have proclaimed, legislation on an issue which will be given publicity and notoriety" (Dunn, 1996, p.5,).

Dunn quotes Bergman describing how the term "elder abuse" was consciously chosen as part of a carefully orchestrated campaign to catapult the issue onto the national consciousness: "If LRSE were to create this issue, it needed to promote it, it needed to 'shape the problem,' it had to market the issue so as to appeal first to the media, then to the public and finally, to Congress. Promotion of the term 'elder abuse' was a central component in that marketing effort" (Dunn, 1996, p. 4).

The term "elder abuse," which captured the growing awareness of the social problems of wife and child abuse and applied it to the elderly, is extremely powerful, according to Dunn. Indeed, these two words provide an easily understood, highly evocative label useful for galvanizing public opinion and marshaling public support. Dunn credits Bergman with staging a

series of media events, including "briefings" organized with the help of a local Congressman, which highlighted findings of an LRSE study that confirmed the existence of elder abuse in the community. These findings were the basis for an orchestrated, sensationalized Congressional "hearing" designed to shape public opinion. The hearing was characterized by Bergman, in conversation with Dunn, as follows:

> In presenting elder abuse as we did, we shaped the problem…focused on the physical battering…spilling blood, crisis intervention, provided a visual image in public and policy maker's minds…a victim in a pool of blood. No resistance to mandatory reporting, several states passed laws. The 'spilled blood image' led to a degree of urgency…rush in to save… overlook their rights… National attention came from blood, gore and guts (Dunn 1992 , as cited in Dunn, 1996, p. 7).

Despite the graphic nature of the testimony presented to the House Select Committee on Aging and its widespread dissemination via the national media, no federal legislation was forthcoming to address the problem on a national level, though several unsuccessful attempts were made to pass such legislation throughout the 1980s. Opinions differ as to why this was true. Perhaps lawmakers simply were unwilling to move in the face of a lack of supportive empirical research. Wolf and Pillemer (1989) suggests that the failure was due at least in part to the ascendancy of a new, more conservative ideology in the federal government and the lack of political leadership in the form of a champion to guide the issue home (Wolf & Pillemer, 1989). Biggs et al. (1993) argue that problems with the budget and a lack of available federal money were among reasons for failure to pass legislation in the 1980s.

Though comprehensive federal legislation regarding elder abuse was not forthcoming, some legislation was enacted that strengthened state responsibility for responding to the elder abuse problem. They were, for the most part, based on Adult Protective Service models designed to respond to the problem of child abuse. Wolf (2000) argues that the early linkage of APS with elder abuse was both a natural consequence of the way in which the elder abuse problem was initially conceptualized, and ultimately a serious limitation:

> In the United States, the construction of elder abuse as a social problem was profoundly affected by the alignment of elder abuse with Adult Protective Services (APS) and pre-exist-

ing stereotypes about aging. The images of impaired, vulnerable victims that this association conveyed seemed to fit into the predominant model of how child abuse occurs. Many envisioned a dependent elderly parent being cared for by a well-intentioned but overburdened and guilt-ridden daughter. The analogy extended further. Because there was no model statute and no database on elder abuse, child-abuse law with its mandatory reporting of suspected cases became the prototype for legislation in more than three-quarters of the states. Because the APS system for investigating and reporting cases was already in operation by the time elder abuse became a public issue, legislators could support action on elder abuse without having to call for additional state expenditures. Within a few years, most states had passed elder abuse laws or had amended existing adult protective services legislation to address the issue" (Wolf, 2000, para. 2, 3).

Federal legislation that specifically created a federal (as opposed to a state-mandated) program to deal with elder abuse was not enacted until 1992. Congress re-authorized the Older Americans Act in that year, and included in it new language that addressed elder abuse under Titles III and VII. This legislation created the Vulnerable Elder Rights Protection Program. The program is administered by the Agency on Aging (AoA). It established state ombudsmen offices, promoted abuse, neglect and exploitation prevention programs and created some funding incentives for state-level elderly assistance program development (National Center for Victims of Crime, 1999, para. 1).

Under Title VII, the AoA is empowered to distribute grants that support elder abuse programs by providing professional training, technical assistance, public education and coordination among state service systems and service providers. Under Title IV, the program has funded "more than 30 grants to support a variety of Title IV funded research, demonstration, evaluation and training projects on elder abuse prevention and related topics" (Findlaw for Legal Professionals, p. 2).

The Older Americans Act was reauthorized in 2000 with some amendments. According to Robert B. Blancato, President, National Committee for the Prevention of Elder Abuse, it was funded in 2002 at a grand total of only $3.5 million dollars (U.S. Senate Finance Committee, 2002). This arguably miniscule funding commitment is reflective of the federal government's funding for elderly abuse in general. According to Blancato, "it is estimated that the total

federal commitment being spent today on programs addressing elder abuse, neglect and financial exploitation prevention is $153 million. This is all of .08 percent of the funds currently spent on abuse prevention programs whether for children, women or the elderly" (U.S. Senate Finance Committee, 2002, p. 2).

The major portion of this $153 million flows to the states in the form of Social Services Block Grants (SSBG). According to testimony presented to the Senate Finance Committee by Riker Hamilton, Protective Program Administrator for the Bureau of Elder and Adult Services in Portland, Maine, SSBG funds are the only direct source of federal funding for state APS programs. Thirty-one states (not including Illinois) depend on SSBG funds for some or all of their APS programs (U.S. Finance Committee, 2002, p. 1).

Adult Protective Services

The scope of federal programs addressing elder abuse is extremely limited as are the funds available to them. The real world of actual governmental responses to elder abuse occurs on the state level and is largely driven by the mechanics of the Adult Protective Service system in any given state. This discussion of the government's policy response to elder abuse will therefore focus on Adult Protective Services in general, with a more detailed look at the legislation that governs APS policy in Illinois. All 50 states have some form of an APS system. Mandatory and voluntary reporting requirements are in place that require certain classes of professionals to report suspected elder abuse to state agents who are then required to conduct an investigation and make a determination. Their findings can trigger a response in the form of a broad range of legal, medical and social service options, ranging from court-ordered protections to removal from the home or community and placement in a nursing home.

Quinn and Tomita (1986) define adult protective services as "a multitude of services that draws on nearly every resource available to elders in any given community…A unique mixture of legal, medical and social services that permit the broadest array of interventions" (p. 9) that "exists somewhere between the social service and criminal justice systems" (p.15). Filinson and Ingman (1989) describe it as a "coordinated interdisciplinary service system to respond to both chronic and emergency cases; a set of core services…available to utilize in these cases; and a set of preplanned individual case responses or protocols to guide service providers in responding to emergency and chronic cases" (p. 97).

APS: The Illinois Experience

Each state has its own mandated Adult Protective Services legislation and its own unique approach. Illinois enacted the legislation that established this state's APS system in 1984 (Byers and Hendricks, 1993). In Illinois, APS functions are conducted under the auspices of the Illinois Department of Aging through a geographic network of 13 Planning and Service Areas that cover the state, within which are specifically designated public and private agencies responsible for conducting APS functions (Illinois Department of Aging, Illinois Areas on Aging). APS services are governed by Illinois Statute 320. The statute stipulates that the "provider agencies shall assist, to the extent possible, eligible adults who need agency services to allow them to continue to function independently" (Illinois Elder Abuse and Neglect Act, 1988) The statute identifies APS functions as including receiving abuse reports, assessing them, and referring substantiated cases both to appropriate service providers and to law enforcement agencies if indicated. APS is also responsible for provision of case work and follow-up services on substantiated cases (Illinois Elder Abuse and Neglect Act, 1988).

The statute establishes a statewide mandated reporting system. It names a very broad group of service professionals as mandated reporters, including social workers, psychologists, counselors, psychiatrists, law enforcement officials, educators, doctors dentists, dieticians and nurses. Also included are a broad class of Illinois state employees (Illinois Elder Abuse and Neglect Act, 1988). Mandated reporters under the law are given immunity from prosecution as long as their reports are made "in the belief that the alleged victim's best interests are served" (Illinois Elder Abuse and Neglect Act, 1988). When a report is received, APS workers are required to make an in-person assessment including a visit to the residence of the subject of the report. Workers may also consult individuals or service agencies that may be knowledgeable about the case. If the case is substantiated, the worker is to develop a service care plan, again in consultation with other service agencies as necessary. The plan is to contain alternative options that "involve the least restriction of the eligible adult's activities commensurate with his or her needs" (Illinois Elder Abuse and Neglect Act, 1988).

APS workers must obtain the consent of the individual in order to provide services. If they determine that the individual who refuses needed services is incompetent, they are empowered by the statute to seek the appointment of a guardian who can provide

the necessary consent in the best interests of the incompetent. They can also use court orders to intervene in emergency situations (Illinois Elder Abuse and Neglect Act, 1988). The statute gives workers legal authority to access eligible adults who are the subject of a report of abuse, neglect or exploitation. Should that access be denied through interference by the caregiver or because the eligible adult is under duress, the worker can petition for an expedited court order to ensure access. The court can also freeze assets where financial exploitation is suspected (Illinois Elder Abuse and Neglect Act, 1988).

Moral Dilemmas

Observers have raised a number of fundamental philosophical issues with regard to the APS approach. The philosophical concerns have to do with a perceived conflict between the rights of the abused to autonomy and freedom from interference by the state. These concerns relate directly to concerns regarding the degree to which the abused individual is competent to direct his/her own affairs. According to Wolf (2000, para. 3) these philosophical concerns are grounded in the child-abuse-based conceptual foundation for APS and its mandatory-reporting-based structure. As indicated earlier, adult protective services were essentially conceptualized as an extension of service structures to adults that were initially designed to protect helpless and dependent children living in abusive family situations. Wolf and Pillemar (1989) frame the issue this way: "Critics of mandatory elder abuse reporting believe that in using the child abuse model, proponents are adopting a set of assumptions that are not applicable to older people" (1989, p. 153).They cite Palincsar and Cobb (1982) as arguing that "mandatory reporting laws for suspected incidents of child abuse are based on three assumptions: (1) children are incompetent, helpless and vulnerable; (2) children are at the mercy of their caretakers; and (3) society has a protectable interest in children" (Wolf and Pillemar, 1989, p. 153). The conflict when applying a child-abuse model to elder abuse falls in the tendency to equate all persons over a certain age with helpless children. By applying these assumptions to elders across the board, and regardless of individual capacity, Wolf and Pillemer assert that elders as a class of people are assumed to be "incompetent, and unable to report themselves. Such inferences infantilize the elder's position in society, foster negative stereotypes of the aged and limit older persons' ability to control their own lives" (Lee, 1986, as cited in Wolf and Pillemer, 1989, p. 153).

This lack of autonomy is made all the more serious by the widespread misunderstanding concerning what behaviors actually constitute elder abuse. As a result of this misunderstanding, elders may suffer an unwarranted invasion of privacy in violation of their civil liberties that is triggered by behavior that may not in fact constitute abuse as defined by the statutes (Macolini, 1995).The danger of a potential violation of civil liberties is further heightened by the wide latitude the APS worker has in evaluating cases. Byers and Hendricks (1993) describe APS worker responsibilities as follows:

> An important function which accompanies the role of the adult protective services investigator is making critical decisions regarding social, legal, psychiatric and medical intervention…(it is an)… attempt to fill the gaps between social, medical and law enforcement services…All APS tasks involve decisions, discretion and social judgments…Most of these decisions rest with the personal discretion of the individual unit based on an interpretation of the Adult Protective Services law (1993, p. 11).

Serious as these concerns are, they are only some of the concerns that have been raised about the APS approach to elder abuse. Of more immediate and practical concern perhaps is the question of what happens when the APS trigger is pulled. It is clear that few communities have the resources available to them to offer an inclusive basket of potential solutions. There are very real questions as to whether or not the services that are available represent an improvement (either in reality or in the perception of the abuse victim) to the abusive situation. Citing a "gross insufficiency of resources available for effective individualized follow up and intervention after situations of elder mistreatment have been identified, reported and investigated" (p. 373), Kapp (1995) observes that all too often the only real choices available are remaining in the abusive situation, or involuntary placement in a nursing home. Finally, critics have asked whether the APS mandatory reporting system is the best possible use of scarce social service dollars in the fight to protect elders from abuse (Callahan, 1988).

Elder Abuse Policy Analysis

Is the patchwork of federal and state policy enshrined in the Older American's Act and individual state's APS legislation an effective policy solution to

the underlying social problem of elder abuse? There are actually a number of questions contained within this initial one. Does the existing APS-intensive approach work? If so, what might be done to improve it? If not, what other approach, if any, might produce better results?More broadly, is there any policy of any kind that could solve the problem of elder abuse? Is it a phenomenon amenable to policy intervention?

It appears clear from the brief discussions concerning value conflicts and the practical failings of the APS system that it does not always reliably and consistently provide meaningful protection and care for elders. And yet flawed though it is, it is a critically important part of any proposed solution to the problem. Elder abuse, however defined, is a reality. It is often beyond the capacity of those suffering the abuse to find relief without intervention. It is a legitimate function of the state to provide these individuals protection from their abusers, despite the real and troubling civil rights issues raised by such interventions.

The question then becomes one of what might be done to make the present system more efficient at providing the protections to abused elders for which it was designed. We get insight into at least some of the answers to that question from testimony presented to Senator Breaux's Finance Committee as it gathered facts in preparation for the drafting of the Elder Justice Act of 2002. First and foremost, the testimony indicates that additional federal funding is the APS community's highest priority.Riker Hamilton (2002) spoke directly to this in his testimony asking for the restoration of more than $1 billion in funding for the Social Security Block Grants that has been cut in recent years (U.S. Senate Finance Committee, 2002). Joanne Otto, Executive Director of the National Association of Adult Protective Services Administrators, presented a comprehensive list of the current deficiencies that have been identified with the APS system by its own professional staff in her testimony to the same Committee. These deficiencies included staff shortages, lack of training, inadequate emergency temporary housing and in-home care for abuse victims, a lack of national and state elder abuse data and a shortage of responsible guardians to act on behalf of victims who lack the capacity to manage their own affairs (U.S. Senate Finance Committee, 2002).

Many of the deficiencies identified by Otto found their way into the Elder Justice Act of 2002. When the Act was first introduced in the Fall of 2002 as a bill, it was seen as another wish list, an effort by legislators sympathetic to the issue to lay out their vision of the problem and to craft a somewhat idealistic vision of a potential solution. This vision includes: raising the visibility of the elder abuse problem, promoting training and education, coordinating and improving research into all aspects of the problem, increasing prosecutions, and providing assistance to victims, including shelters (National Center for Victims of Crime, 1999).

Conclusion

Significantly, the Elder Justice Act does not include a price tag. As the Act is worded, there are no specific requests for the funding necessary to support the programs it proposes. Its passage gives no assurance that the envisioned solutions will be funded at levels sufficient to be effective. But even if it were to be enacted in its present form, and funded at whatever level might be required to be fully effective, this legislation cannot be expected to solve the problem of elder abuse. The nature of elder abuse is such that it will never be fully eradicated. That said, it is worth noting that great progress has been made in the 25 years since Representative Pepper's Subcommittee on Aging first served as the catalyst for bringing the problem of the abusive mistreatment of older adults to national attention. Adult Protective Services agencies provide meaningful protections to thousands of vulnerable older adults in Illinois and across the country each year. Research efforts, though still scattered and inconclusive, are beginning to build a body of useful knowledge concerning elder abuse that is providing at least some guidance to both policy makers and practitioners in the field. Perhaps most important of all though, the fact of elder abuse, however defined or understood, has become a matter of widespread public awareness. Professionals in law enforcement and the social services, family members, caregivers, those who have contact with older adults, and the public at large are increasingly aware that the potential for abuse exists. This awareness is the necessary first step in preventive interventions. Elder abuse may never be eradicated, but it can and should be fought.

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John Baker has completed his first year in the MSW Program. His second-year field placement will be in the Older Adult Program at the Stone Institute of Psychiatry at Northwestern Memorial Hospital.

A Study of the Experiences of Students with Disabilities at Loyola University Chicago

by Cristina A. Cortesi, Daniella Levin, Nicole N. Lis,
John Munch and Patricia J. Sullivan

Abstract

The purpose of this study was to interview students with disabilities at Loyola University Chicago (LUC) to ascertain the university's responsiveness to the needs of these students. While all students (fifty-five) who were self-identified with the LUC disability office were invited to participate, sixteen undergraduate and graduate students in programs throughout the university consented to be interviewed. Research has suggested that students with disabilities in higher education face a number of obstacles despite strict federal laws. Students interviewed evidenced a wide variety of disabilities and demonstrated a need for accommodations. Their experiences with university services, faculty responsiveness and disability awareness within the university community were both negative and positive, and some barriers to their education were revealed. The researchers discuss how they used the findings from this study to advocate for increased awareness of disabilities at Loyola University Chicago.

Introduction

Persons with disabilities have a significantly lower mean educational level than the general population (National Council on Disability, 2000). Before the weight of the law prohibited discrimination against students with disabilities, they were often denied admission to colleges and universities. A 1962 survey of 92 Midwestern colleges and universities revealed that 65 would not accept wheelchair-using students (Paul, 2000). Blind, deaf and hearing impaired students were also frequently rejected from college campuses. Recognizing the rights of persons with disabilities to equal opportunity for higher education, strict federal laws such as the historic Americans with Disabilities Act of 1990 (ADA, 1990) have been enacted and students with disabilities are now appearing in increasing numbers throughout college campuses (Paul, 2000). These students face a number of obstacles once admitted to college, resulting in the likelihood that they will pursue a two-year rather than a four-year degree or drop out of college prior to completing a degree (Mull, Sitlington & Alper, 2001). Additionally, they are less likely to pursue post-graduate education than their non-disabled peers (Wolf, 1999). This study examines the barriers students with disabilities at Loyola University Chicago encounter that may prevent them from completing a degree and developing to their highest potential.

Literature Review

There are roughly 43 million Americans who have one or more physical or mental disabilities, and this number will continue to increase (Hall, 2000). Historically, society has tended to isolate individuals with disabilities. While there has been some improvement, discrimination against individuals with disabilities remains a serious social dilemma. Unlike individuals who have experienced discrimination on the basis of race, religion, sex, or age, individuals with disabilities have often had little or no legal recourse to combat discrimination (Hall, 2000). Discrimination against individuals with disabilities continues to exist in most critical life areas, including education. This literature review will focus on the research and anti-discrimination laws that relate to post-secondary education.

Due to strict federal laws, the work of disability groups, positive media coverage, and political support, this country has seen increasing numbers of students pursuing postsecondary education every year since the passage of the ADA in 1990 (Paul, 2000). Individuals with disabilities now constitute the largest and fastest growing minority in the United States (Mull, Sitlington & Alper, 2001). Yet the literature shows that the efforts of congressional legislation and strict federal laws are aimed at eliminating discrimination and are not enough to provide students with disabilities adequate integration into the educational community (Paul, 2000). Wolf (1999) found that reasonable accommodation and appropriate support through a combination of individual and systemic resources are the keys to improving outcomes and achievement for students with disabilities. Lehmann, Davies and Laurin (2000) stress the importance of listening carefully to students' perspectives to identify and eliminate barriers to success, to identify personal and academic needs, and to provide support and a vision for the future. Dilger's (2000) research with students with disabilities identified two major obstacles to academic success and completion of education programs: (1) how the disability personally affects the student, and (2) how the student is affected by the environment due to her/his disability.

Anti-Discrimination Laws

There are several federal laws that address discrimination in post-secondary education; those of primary importance are Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The regulations enacted by these laws prescribe minimum standards for colleges and universities in six areas: admissions and recruitment, treatment of students, academic adjustments, housing, financial aid and employment assistance, and nonacademic services (Milani, 1996).

The Americans with Disabilities Act was signed into law on July 26, 1990, and is designed to protect individuals with disabilities from discrimination in "employment, housing, public accommodations, education, transportation, communication, recreation, institutionalization, health services, voting and access to public services" (ADA, 1990). Title II of the act states: "No qualified individual with a disability shall be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity" (ADA, 1990). This same prohibition applies to private entities through Title III of the ADA, which bans disability-based denial of the benefits of the services, programs, or activities of "public accommodations," including schools (Milani, 1996). The ADA defines discrimination as: (1) A failure to make reasonable modifications when such modifications are necessary and (2) A failure to ensure that no individual with a disability is treated differently than others because of the absence of accommodations, unless making accommodations would alter a program or would result in undue burden.

Without altering a program, these "academic adjustments and reasonable modifications" (e.g. extended time) and the provision of "auxiliary aids and services" (e.g. signers for individuals who are deaf) are vital tools for extending an equal education opportunity to individuals with disabilities (Grossman, 2001). Students may not be charged a fee for accommodations that they are entitled to by law. These devices are instituted to allow for equal access to education, and are known as "reasonable accommodations" (Grossman, 2001).

Once a student is admitted to a program, the school's legal obligation for making accommodations begins when the student discloses his/her disability. When a student receives admittance to a program, the student is responsible for notifying the school of his or her disability, requesting academic adjustments, and providing necessary evidence of a disability - related need for adjustments (Milani, 1996). The duty to accommodate does not begin until the school receives sufficient documentation of a disability and the need for certain types of accommodation.

Barriers to Accommodation

The ADA and Section 504 provide institutions of higher education with a framework of ethical protocol in regard to students with disabilities. However, it is evident that problems do occur and educational institutions are failing to assist these students, despite the legislation. Because of this, colleges and universities have attempted to redevelop their plan for implementing services and accommodations (Simon, 2000). One problem, which will be discussed later in further detail, is that faculty members have negative attitudes toward students with disabilities (Scott & Gregg, 2000). Another problem is that students need to identify their disability through documented proof. In many cases, the required documentation has been quite extensive and difficult to obtain because the disabilities are considered to be "hidden disabilities" (Simon, 2000). Perhaps requiring documentation is not unreasonable, but some of the individualized requirements may be unreasonable, especially if students are feeling uncomfortable with this initial part of the process to obtain services. Another issue is that services and accommodations are not always provided in due time. Finally, colleges and universities may not consider it feasible to make substitutions and adjustments to degree requirements in order to accommodate students with disabilities (Simon, 2000).

Marks (1997) suggests that "attitudinal barriers" can be just as effective at excluding disabled students as a separate classroom or program. The literature on this subject overwhelmingly suggests that students with disabilities are not seen in a positive light (Beilke & Yssel, 1999). Many times there are no noticeable differences between students with hidden or mild disabilities and other students, which leads some teachers to expect them to be able to "behave and perform at the same level as their non-disabled peers" (Cook, 2001, p. 8). Teachers must be able to set attainable and realistic expectations for their students, despite the demands placed on them to produce a classroom full of academically excellent students (Cook, 2001).

There are some extreme cases of prejudice against disabled students where faculty have voiced their opinion that students with learning disabilities should not be allowed to attend college (Boone, 2002). For the most part, faculty members see themselves as being willing to make the accommodations necessary to help these students. Although they are willing to provide support, they do have reservations and con-

cerns. These concerns revolve around being able to adequately accommodate these students while at the same time ensuring that the rest of the class receives the education they expect (Boone, 2002).

Research suggests that universities can afford to shift efforts and funding from preparing university facilities for people with disabilities to educating faculty members to provide the most effective ways to educate students with disabilities. Some studies have found that universities are doing an acceptable job of preparing their buildings and facilities for their disabled students, but are not preparing their teachers for these students (Sheppard-Jones, 2002). One study found that faculty members' disability awareness varied greatly, ranging from the claim that accommodations were merely "common sense," to admitting that they were "woefully ignorant" (Beilke & Yssel, 1999).

Research has identified that students with disabilities are significantly more lonely than non-impaired students (Dilger, 2000; Gambrill, Florian, & Splaver, 1986). One study found that a full 75% of the students with disabilities interviewed rated high for loneliness (Dilger, 2000). And the longer the perceived duration of loneliness, the more affect it had on performance in academic settings as measured by the student's grade point average (Dilger, 2000). Several researchers have emphasized that a support community is key to academic success (Paul, 2000; Bucaro & Kopfstein, 1999; Lock & Layton, 2001), and Paul (2000) found significant differences in student experiences of social support networks. Dropouts indicated a lack of social support as one contributing factor to their dropping out. For many students, the support community includes other students with disabilities. One student with disabilities described it this way:

> [An] immediate sense of community emerged upon meeting my peers with disabilities. There are benefits of being a part of a community of disabled people, including the support of the group, being a part of the disability culture, and shedding years of shame and inauthenticity. When I socialize or work with other disabled people, this acute sense of tuning in is so evident and so refreshing (Bucaro & Kopfstein, 1999).

Mossman (2002), an advocate of disability study and training, posits that study and training can result in the empowerment of students with disabilities. He perceives that the subtleties of discrimination and the complicated processes of building abnormality can be detected and changed. Alperin (1988), Mossman (2002), and Bucaro and Kopfstein (1999) discuss the absence of disability course content in higher education curriculums. Bucaro and Kopfstein (1999) raise the question of why disability is left out of courses that study cultural sensitivity, when persons with disabilities are treated differently than others. They propose that disability is an aspect of diversity with its own culture and subcultures. Mossman (2002) also emphasizes the significance of disability studies in contributing to multicultural research on marginalized groups. He believes that expanding the scope of research on disabilities would articulate commitment to exploring social constructionism, engaging students in lively discussion of the connection between the body and identity, and demonstrating commitment to serve the underrepresented.

Due to the complexity of its nature, many researchers are choosing qualitative methodologies to study the lives of individuals with disabilities. Qualitative methods allow for greater depth in exploration, and frequently result in the emergence of new research questions. Qualitative data collection methods are diverse, and include interviews with individuals or groups, participant journals, focus groups, autobiographies, archival materials and videotaped social situations. Qualitative research can provide rich data about the attitudes and perceptions of individuals with disabilities, allowing for many important issues to arise (O'Day & Killeen, 2002). The new knowledge and insight gained by researchers will allow for further developments regarding the fair treatment of persons with disabilities in higher education.

Research Questions

Our review of the literature led us to many areas of interest concerning our research. The literature gives us an overall look at the way higher education in the United States accommodates students with disabilities. Our goal is to compare LUC's practice of accommodating these students to that of the information found in the literature. The questions we explore include: Is LUC fulfilling the requirements of law regarding accommodation and service? Are they creative and innovative in their response to students with disabilities? What are the personal experiences of students with disabilities at LUC, and how do they impact the student personally and educationally? By listening to the voices of each of these students, practitioners, teachers, faculty, and peers may gain a better understanding of the experiences of students with disabilities. Thus, one of the major goals of this study is to promote disability awareness at LUC and in higher education as a whole.

Participants

The total number of participants was 13, all of whom were undergraduate and graduate students at LUC. Of these students, five were male and eight were female with a mean age of 32.3. Eight of the students were enrolled in an undergraduate program, and five of them in a graduate program. One student experienced a psychological disability, five a learning disability, and seven a communication disability. Seven of these students had congenital disabilities, one was diagnosed as a preadolescent, two acquired their disability in adolescence, and two of the participants stated the age of onset to be in adulthood under the age of 50 years. Six of the participants attended Loyola's Water Tower Campus and eight attended the Lake Shore Campus. The participants' grade point averages were in the range of 1.97 – 4.0 with a mean GPA of 3.85.

Methodology

This research employed a qualitative method in designing this study. A field research design was utilized and data were collected via active involvement with participants in an interview format. Data were then used to identify similarities and trends in the participants' responses.

Sampling

As per LUC policy, students who request accommodations must register with the college or university's office of disabilities. To protect these students' confidentiality, researchers were not able to directly contact these students; however, the office agreed to contact each student by way of a cover letter and consent form requesting their participation. The total number of students registered with this office was 55. Sixteen were interested in participating in this study as confirmed by their email or by returning the self-addressed, stamped envelope. Two of these 16 students later refused to participate. Of the 14 respondents who agreed to participate, 13 students actually participated in the study.

This sample was a non-probability, convenient sample. Some limitations were discovered through this procedure. First, as mentioned earlier, only 55 students are registered with the disabilities office, which is a mere .3% of the total population at LUC. This in itself is a concern, as it is not near the average number of students with disabilities on other college campuses. Second, the small sample size may be useful for gathering detailed student opinions; however,

it is not large enough to be considered representative of the larger population of students with disabilities in higher education. It is important to keep in mind that this sample size merely provides a framework for future consideration in this area.

Data Collection

When each prospective participant responded with the consent form, he/she provided the researchers with contact information. Of the 13 students, ten were interviewed via telephone, and three were interviewed face-to-face. Participants were paired up with researchers randomly. Responses were probed to give participants the opportunity to expand upon their answers. Those responses were then coded into themes developed from the literature: student's positive experiences, student's negative experiences, faculty attitudes/acceptance and university policy and recommendations.

In an attempt to eliminate researcher bias, researchers conducted a content analysis and placed responses with appropriate themes. Avoiding researcher bias was also attempted by constant introspection by the researchers. Content analysis allowed for identifying similarities and dissimilarities and to ascertain patterns of interaction and events that were common among the participants.

Ethical Considerations

Confidentiality of all subjects was protected by the absence of identifying information when data were compiled. This study was blind in the sense that researchers were unaware of which respondents provided specific data. At the conclusion of the research, the interview notes were destroyed. Confidentiality could not be completely controlled due to the limited number of identified students with disabilities at LUC. It is possible that statements could be linked to individuals if further examination occurs. Subjects were informed of the possibility of others deducing the fact that unique responses could only be derived from an individual with one type of disability. Because of this factor, some prospective subjects refused to participate in the study.

The data collection instrument used was developed for the purpose of this research. A standardized instrument that would meet the needs of this research was unavailable. The validity and reliability of this instrument have not been tested in previous research. The fact that it is not a standardized tool is cause for concern because we do not know the implications of

the questions, phrasing, order and length of time. Another limitation is that, in its original form, it assumed each student would be able to answer the questions. Modifications would have to be made if the need arose for a student's specific disability (e.g. TTY). When necessary, appropriate accommodations were made throughout this research.

Results

This research yielded a diverse array of results. This variance can be clearly seen in the reported experiences of students. A number of students reported that the Office of Services for Students with Disabilities was helpful and friendly. Conversely, numerous students reported that this office was disorganized and messages were not relayed; one student perceived office personnel to be more interested in playing computer games than helping the student. Some students reported that all of their requests for services were granted, while others stated that accommodations did not meet the students' needs, and some accommodations were not met. A number of students found LUC faculty to be responsive and understanding of their disability. However, various students responded that professors acted as if accommodating them was a burden, acted coldly towards them, and were skeptical of the students' need for services. One student reported that "the services provided were empowering and were a key to [my] success," while others stated they "felt shamed, pitied, overwhelmed, and like an oddity" as a result of their experiences at LUC.

There are a number of possible explanations for their varied reports. All of these explanations are questions for future research to gain a better understanding of which factors contribute to providing positive experiences for students with disabilities. One of the potential reasons for such diverse findings may be that there are a number of different professors and staff members interacting with these students and providing their accommodations. The variance in faculty's levels of understanding of disability issues would presumably have an impact on how sensitively and effectively they deliver their services. The majority of students interviewed perceived that their professors' knowledge of their disability, and how to best accommodate it, was insufficient to meet the students' needs. Findings from this research suggest that developing faculty and staff education and awareness on disability issues would enhance the experience of students with disabilities. These findings support the literature reviewed earlier, which revealed that negative interactions with faculty were a key factor in stu-

dents' failure to complete their educational program (Scott et al., 2000).

Some of our findings seemed to suggest that LUC may serve these students solely because of federal requirements, without a strong commitment to creatively and innovatively do all it can to accommodate individuals with disabilities. In fact, several students reported that they "perceived that LUC did the bare minimum to fulfill legal obligations and nothing more." Participants perceived that some school policies are detrimental because they expect students to fit into the already existing accommodations and buildings that are not welcoming or helpful to students with disabilities.

Our review of the literature revealed that the average university enrollment of students with disabilities is between 8 and 12%, yet at LUC only **.3%** of the student body is registered with the Office for Services for Students with Disabilities (Wolf, 1999). This discrepancy could be the result of a number of factors: some students with disabilities may choose not to identify themselves; some students may seek accommodations from professors without identifying with the disabilities office; and some students may not be aware of the availability of services due to poor information dissemination by the university. It is also possible that LUC may not make adequate efforts to recruit, welcome, include and/or serve students with disabilities.

Students may also report varied experiences because their accommodations represent a wide variety of needs. Some accommodations are more easily met than others, so faculty reaction to accommodating may differ, and some students may feel more satisfaction in their needs being met than others. Furthermore, prior experiences impact both the students and the faculty. The student's prior experiences influence their assertiveness and sensitivity to faculty attitudes and responses. The faculty's prior experiences also impact their current perceptions, as evidenced by the reported skepticism that some professors have concerning the legitimacy and fairness of accommodations.

Participants reported that disability issues were discussed minimally, if at all, in coursework. Surprisingly, even graduate students within the School of Social Work and the Christian Ethics programs reported that disability awareness was rarely covered. The lack of attention to disability issues suggests that LUC does not rank this issue as a priority. Of particular interest to us as social workers was the finding that a number of students with disabilities at LUC do not feel a sense of belonging or acceptance. They report a feeling of

"other," and some experience loneliness, isolation, and low self-esteem. Some report blatantly negative and discriminatory remarks from faculty:

"Everyone has some type of learning disability," (Loyola professor to her student with a learning disability, belittling her need for accommodation).

"I actually had one professor ask me if I thought I could 'survive' her class," (from a Loyola student who is blind).

Participants showed interest in a networking/support group with other students with disabilities that could provide them with needed support and a sense of belonging. Six of the participants said they were interested in such a group, four said they may be interested, one said she/he was not interested and two did not respond to the question.

While there was a wide range of experiences reported by students, a recurring theme was that students' negative experiences outweighed positive experiences. Twenty-seven positive experiences were reported as compared to forty-five negative experiences. This suggests that there is substantial room for improvement in serving students with disabilities at LUC. Collaboration between university officials and students with disabilities could have a significant impact on the educational and emotional experiences of the students in our study.

Though the predominant findings were that students' experiences were often negative, some students did report that they were pleased with the services provided and had no complaints. In an effort to make the learning experience for all students satisfactory, the narratives of students with disabilities warrant a closer look so that what has been beneficial and effective for some can be applied to other students and situations. The following are some statements of positive experiences at LUC.

"Staff has been very, very helpful . . . they'll go that extra yard as well."

"I am highly satisfied with the services I've received from learning assistance at Loyola."

The students interviewed made the following recommendations for LUC and for other students with disabilities: increasing the amount of time spent in coursework on disability issues, development of a networking/support group for students with disabilities, and education and training of faculty and staff on how to best educate and interact with students with disabilities. A poignant piece of advice to other students with disabilities from one student we interviewed was, "If you have a problem, seek help. Don't be afraid or feel ashamed like I did. You can't get help until you seek it."

Our findings were very consistent with what we found in the literature. The issues and difficulties that LUC students reported represent the particular challenges that this population of students in higher education face. This study demonstrates the need to educate faculty and staff on disabilities awareness issues and to promote a more welcoming and engaging environment for all students. This study sheds light on some areas that need additional research; for instance, why students' experiences are so varied, the correlation between a teacher's understanding of disability issues and the manner in which they treat these students, what support services are helpful to students with disabilities, and why there are so few students at LUC registered with the Office for Students with Disabilities are just a few of the possible focuses for future research.

Limitations

Relevant limitations to this study are addressed in previous sections where appropriate; additional limitations will be addressed here. Confidentiality was a concern for a number of possible participants. Respondents may have censored their answers due to confidentiality concerns. Additionally, due to confidentiality it is impossible to obtain information regarding students who chose not to participate in this study. This information would have been helpful in characterizing the students at Loyola who claim a disability. Without this information the study is only able to report information about the students who consented to participate. The study is also unable to explain why these students did not wish to contribute. This information could have provided important data to this research study.

Many of the respondents had a great deal to say during the interview, but it is important to remember that interviews are verbal reports and therefore subject to problems of bias, poor recall, and poor or inaccurate articulation. Finally, the institution in which the research was conducted may have also posed a limitation. This study was conducted at a private institution, which is not accountable to the same standards at public institutions. A public school may have varying guidelines and regulations, which may produce very different experiences in students with disabilities.

Implications for Social Work

Our review of the literature and interviews of LUC students with disabilities has had a powerful impact on us as researchers. As we read the research and listened to the voices of students we developed a new awareness and sensitivity to issues of disability. We began to see that increased knowledge, awareness and sensitivity could greatly enhance the experience of students with disabilities, and positively impact our community as a whole.

One of the researchers in our group is a person with a disability. On a personal level, this student came to the realization that some difficulties that she had experienced in higher education were not so much personal issues as common issues of persons with disabilities. As our group as a whole began to understand some of these common issues, we developed increased empathy for persons with disabilities and could begin to see simple ways to include and accommodate. We also recognized the tremendous impact issues of ability/disability may have on the development of the self. We recognized that despite a strong emphasis on acceptance and encouragement of diversity in the field of social work, the reality is that knowledge, recognition and acceptance of differences in persons with disability are often ignored. We began to recognize ways that school policies and environments, including our own student and faculty communities, often fail to be sensitive to persons with disabilities.

We saw change occur within our own group. The student with a disability experienced understanding and acceptance on a level different from experiences with other students, and others in the group became ardent advocates for increasing the knowledge and awareness concerning how our society views and responds to persons with disability. The semester following the completion of our research project, our research colleague who has a disability took an opportunity to speak to the Dean of the School of Social Work about the student's personal experiences and the findings of our group. The Dean was very receptive and encouraging, and later asked this student to inform our group that he carefully considered our concerns, and that the school is developing disability awareness workshops for faculty and students for the upcoming school year. He also said that the curriculum committee was reviewing the overall curriculum to ensure the inclusion of issues of disability.

Our group was awed by the impact of our research. We had personally been influenced by our study and research, and we could see the potential of our project to effect change for students with disabilities at LUC, and consequently to enhance the lives of not only students and faculty, but future clients of social work students as well. Through our research, we increased our personal knowledge, gave voice to students with disabilities, and shared our findings with people who have the power to make their lives better. Our group participated in a research project because it was a requirement in our course work, but we did not anticipate the project's potential for activating policy that would enhance the lives of individuals and our community. Our hope is to make our community at LUC increasingly aware of the needs and experiences of students with disabilities, to further increase the knowledge and awareness concerning how our society views and responds to persons with disability, and to become increasingly inclusive regarding persons with differences in ability. We hope these changes will have further impact on LUC as a whole, will foster a more welcoming and inclusive environment, will increase enrollment of students with disabilities and also increase the number of students who graduate from undergraduate and graduate programs.

As social workers, these findings also have clear implications for our work. Increasing the number of services to persons with disability and understanding their needs for acceptance and accommodation are a great concern for our profession. Advocacy for persons with disabilities, the organization of support and services, community awareness of disability issues, and individual adjustment to disability are just a few of the areas of concern. The social construction of normal/abnormal and the inclusion of disability in our concern for diversity is of great impact to persons with disabilities, and therefore of concern to social workers.

Social workers are trained to be sensitive to the issues of their clients. This research may contribute to this sensitivity in relation to practice and theory with students with disabilities. Acquiring professional education is important in many professions, and students with disabilities face a number of obstacles that are unique to this population. Social workers may engage in conducting training seminars for faculty, staff, and administration of colleges and universities. This type of training helps to facilitate awareness, which in turn affects the overall climate of the environment, and the experiences of individuals with disabilities.

Social workers are also involved in lobbying for changes in policy. Effective social policy regarding the rights of individuals with disabilities normalizes the experiences of those with disabilities. Three spheres of

policy can be affected via research. These spheres include university policy, social policy, and government policy. At the university level, the curriculum can be changed to include diversity education, which would include the experiences of individuals with disabilities. The three spheres represent circular causality because a change in one assists the change process in others, which impacts the experiences of this population. All three levels of policy can effect the treatment of this population and the accommodations they are given. Policy change helps to normalize experiences of individuals, but facilitating changes in policy is difficult without research.

The research presented lays the groundwork for additional research, as it just scratches the surface of the issues and obstacles experienced by individuals with disabilities. Additional research should be conducted in multiple universities that represent a cross-section of our society. Long-term studies will be beneficial in documenting the experiences of students through their college careers. Ultimately, if research can make a difference in university policy, the lives and experiences of individual students will improve.

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The authors of this paper received their MSW's from the School of Social Work in May 2003. Cristina A. Cortesi's field placements were at Lake County Health Department and Glenbrook South High School; she is now a school social worker at Attea Middle School in Glenview. Daniella Levin's internships were at North Shore Senior Center and Arlington Heights School District 25; she is currently a school social worker at Elm Middle School in Elmwood Park. Patricia J. Sullivan's field placements were at the Counseling Center of Lakeview and Community Care Options. John Munch's internships were at River Edge Psychiatric Hospital and Cossitt Elementary School in LaGrange; he is now a school social worker at Pleasantdale Elementary in Burr Ridge. Nicole N. Lis completed her field placements at Maryville Scott Nolan Center and Edgar Allan Poe Elementary School in Arlington Heights; currently, she is a therapist at Cyd Lash Academy (SEDOL) in Gages Lake.

Caregiving in Case Management: An Application of Intrapsychic Humanism in the Case Management Setting

by Jeffrey J. Bulanda

Abstract

Case management has become an increasingly popular means of maintaining mentally ill adults in the community. This paper examines the role of the case manager and the importance of a guiding theoretical framework in conducting interventions using the case management model of treatment. The new psychology, intrapsychic humanism, is applied to the case management relationship using a case example from the author's fieldwork experience with a client suffering from mental illness. Intrapsychic humanism is particularly valuable in understanding the client's motives and developing a genuine caregiving relationship between the consumer and case manager.

Introduction

Case management services have increased in recent years with the commencement of a movement toward increasingly less restrictive services for homeless and mentally ill clients (Curtis & Hodge, 1994; Walsh, 2000). In addition, high profile legislature, such as Kendra's Law[1], has brought about a push for increased supervision of persons with mental illness and minimal social support. Indeed, "…case management is recognized as the 'glue' which holds together the continuum of services that are needed by individuals with severe mental disorders and has become a mainstay of state-of-the-art community mental health services" (Williams & Swartz, 1998, p. 299). With the increasing prominence of case management services, it is important to consider the various treatment models that can be useful in building the case manager-client relationship.

One such treatment model, intrapsychic humanism, has been applied to a number of clinical settings, including standard adult and child psychotherapy, residential centers for the mentally ill, and treatment centers for violent youth (Pieper & Pieper, 1992; Pieper & Pieper, 1999; Tyson, 2002; Tyson & Carroll, 2001). However, its applications have not yet been fully explored with regard to case management services provided to clients who are homeless and mentally ill. Thus, this paper will explore differences and similarities between psychotherapy and case management, explain the basic tenets of intrapsychic humanism, and consider applications of this theory to the social worker's role as a case manager.

Differences and Similarities between Psychotherapy and Case Management

Psychotherapy and case management involve different boundaries within the social worker-client relationship and, often times, hold different functions in the client's life. These differences between the psychotherapeutic and case management relationship can be conceptualized by four key themes of the case management relationship, first noted by Curtis and Hodges (1994) and further explicated by Williams and Swartz (1998).

First, case management relationships tend to be multidimensional in nature. The function of the case manager changes with the needs of the client. Duties may include advocacy, education, medication monitoring, crisis prevention, counseling, transportation, assistance with housing, assistance with entitlements, providing companionship, management of the client's finances, job-training, and psychosocial services which include training in social skills and self-maintenance (Johnsen et al., 1999; Curtis & Hodge, 1994). For instance, on a typical home visit, a case manager may help the client clean his or her apartment, assist in filling out paperwork to appeal a decision made by Medicaid, provide them with medication monitoring, deliver the client's weekly grocery check, and engage the client in conversation using supportive, active listening. Thus, it is necessary for a case manager to be flexible in his/her interventions with the client.

While a therapeutic relationship can be multidimensional (i.e. the therapist may make referrals or may advocate for a client), the therapist's functions tend to be more limited and focused than a case man-

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[1] Kendra's law, set forth in Section 9.60 of the Mental Hygiene Law passed in New York, provides for assisted outpatient treatment for certain people with mental illness who, in the view of mental health professionals and the court, are unlikely to survive safely in the community without supervision. It was named after Kendra Webdale, a young woman who died in January 1999 after being pushed in front of a New York City subway train by a person who failed to take the medication prescribed for his mental illness.

ager. Throughout the course of their relationship, a therapist's primary function is to talk with the client in working through problems and psychopathologies. A case manager's function changes as frequently as the client's needs change. Case managers may also have more direct opportunities to educate their clients due to the setting. For example, a case manager will be able to teach a client how to cook a meal as they may have access to a kitchen in the client's apartment; a therapist would not have access to this teaching opportunity.

Another key difference between the case management and psychotherapeutic relationship is the amount of power held by the professional. A case manager tends to have more power over a client's life than a psychotherapist, especially over a client's basic needs such as money and housing. For instance, often, a case manager is the payee for his or her client; the case manager may determine how much money a client receives each week from their check. Case managers also hold power in making referrals to housing units and may have power in monitoring the client's medications. Psychotherapists, on the other hand, do not tend to have direct control over the client's basic needs.

Third, the amount of self-disclosure may also be different in a case management as opposed to a psychotherapeutic relationship. Interactions in a case management relationship tend to be less formal than in a psychotherapeutic relationship due, in large part, to the settings in which the respective interactions take place. Case managers tend to interact with clients in informal settings, i.e. the client's home, the case manager's vehicle, a coffee shop, or a public aid office; psychotherapists almost exclusively interact with clients in a formal office setting. Thus, in informal settings, there are increased opportunities for "small-talk," such as discussing a TV show playing at the client's home, the news, or the weather. In the process, a case manager may disclose what he/she enjoys watching on TV, his/her reactions to the news, as well as his/her outside interests. Despite the increased amount of self-disclosure in the case management relationship, it is expected that professional boundaries are maintained and the relationship is still one-sided - focused on the client.

Fourth, the case management relationship may include after-hours involvement, which is not usually seen in a psychotherapeutic relationship. This may involve conducting a home visit in the evening or on the weekend, taking the client to a meeting, such as Alcoholics Anonymous, at night, or taking a client on a social outing, such as a weekend rally for mental illness advocacy. A therapist, on the other hand, tends to keep more stringent business hours. It is expected that any case management activity occurring after business hours is relevant to the treatment plan of the client.

Despite differences between the two relationships, there are significant similarities between case management and psychotherapy (Carey, 1998). Both are relationship-based and both are one-sided, with the focus on the client and with clear professional boundaries. Further, both are committed to the welfare of the client and have the goal of improving the client's current level of intrapsychic and social functioning. Also, both use a psychosocial assessment in understanding the client's current level of functioning and in determining the best way to utilize the therapeutic or case management relationship. With the assessment, the therapist or the case manager will individualize treatment for the client in meeting their needs. Thus, a relationship-based intervention committed to the client's welfare and using an assessment and individualized treatment is utilized in both case management and psychotherapeutic relationships.

Further, it has been argued that case management relationships have a greater therapeutic component than is generally acknowledged. Williams and Swartz write, "The psychotherapeutic relationship is often a core aspect of case management, although almost paradoxically most case managers do not perform and do not think of themselves exclusively as psychotherapists" (1998, p. 305). Indeed, conversations over coffee or even while the case manager is driving the client to a therapist appointment may be more substantive and meaningful to the client than the actual conversations with the therapist. Since they clearly provide a therapeutic intervention with clients, case managers need to have an understanding of and access to key theoretical perspectives on human behavior and therapeutic intervention. One particularly helpful perspective is intrapsychic humanism.

Case Example

As the concepts of intrapsychic humanism are applied to the case management relationship, a case example will be utilized from the author's field work. The client, Tony, works with a Chicago-based Assertive Community Treatment (ACT) team comprised of eight case managers. All eight workers alternate visiting Tony at home twice a week. Tony also comes to the psychosocial rehabilitation day

program that is offered by the same agency. The author serves as Tony's primary case manager.

Tony[2] is a 52-year-old white male diagnosed with paranoid schizophrenia and has a history of homelessness. Tony's life has been devastated by loss. Tony never met his mother, who departed soon after his birth, and he has never been given an explanation for his mother's departure. While growing up, Tony lived with his father, his grandfather, his aunt, and two cousins. He reports an "average" childhood with an average number of friends and an average performance in school. Tony's first encounter with mental health professionals came when he had been traveling out-of-state and was arrested for public intoxication at age 21. His subsequent stay at a mental hospital lasted several days, at which time his father, grandfather, and uncle picked him up. This incident was never addressed within the family and Tony did not receive follow-up mental health care.

During his early 20s, Tony traveled throughout the United States, primarily by hitchhiking. During his travels he dreamt that his father was in the hospital. Tony immediately returned home to find his father hospitalized and diagnosed with paranoid schizophrenia. Tony moved in with his father and became his father's primary caretaker until his father died when Tony was 25. During this time, he also attended a junior college to obtain his associates degree. Tony states, "I really was trying to make something of my life." While in school, he reports dating many women, resulting in at least two children whom he never met. He regrets not being involved in his children's lives, saying that his actions were "rotten."

As he graduated from junior college, Tony married his first wife and attempted to start a contracting business, which failed after his first assignment. This marriage was also complicated by his wife's heroine addiction and her interfering parents. This marriage ended three years later when Tony's wife left him. He moved away again at age 30, holding a series of short-term jobs. During this time, Tony met and married his second wife. Also at age 30, Tony was hospitalized for a second time and was in and out of the hospital sporadically during the 10-year marriage. His marriage brought the birth of two daughters. This marriage was stressed because Tony and his family lived with his in-laws, which included a verbally abusive alcoholic father-in-law. The marriage ended when Tony's wife left him; he was 40-years-old.

After his marriage ended, Tony became suicidal and began hearing voices, "cursing heaven, earth, everything." He was placed in a residential living center for six months. For the next ten years, he traveled across the U.S. via hitchhiking. He had very limited contact with his daughters for fear of "being a burden." Tony most recently ended up in Chicago in July 2002 and originally did not plan on staying. He stayed at a shelter until he was arrested in the beginning of August for hugging a woman he did not know. He spent two months in the hospital and was discharged to a transitional living program at the end of September 2002, when ACT services began. Tony currently believes that he will die soon and that he is "damned to hell for not listening to the Lord." At the present time, Tony has no contact with his family.

Intrapsychic Humanism Applications to Case Management

Intrapsychic humanism is based on the premise that all individuals are born with an innate desire to experience pleasure in conflict-free caregiving relationships. However, many people have not experienced such a caregiving relationship and subsequently perceive their abusive or neglectful relationship with their parents as ideal. In idealizing that early relationship, they may have developed motives for painful experiences that have the unconscious meaning of pleasure. Thus, the therapeutic intervention involves the social worker providing the client with a conflict-free relationship with the aim that the client will eventually develop a consciously self-regulated and conflict free inner well-being (Pieper & Pieper, 1992; Pieper & Pieper, 1999; Tyson & Carroll, 2001; Tyson, 2002). The social worker practicing intrapsychic humanism will use an individualized treatment intervention that includes advocacy, concrete service provision, reflective listening, and a focus on the client's strengths in order to develop the capacity for self-caretaking (Tyson & Carroll, 2001).

The caregiving relationship promoted by intrapsychic humanism provides an unconditionally positive relationship, an intervention that has proven to be successful with homeless, mentally ill clients. Brun and Rapp write that "…one of the characteristics of being oppressed is having one's story buried under the forces of ignorance and stereotype" and that research has shown that clients respond positively to being asked about their strengths and being allowed to set the agenda of a discussion (2001, p. 278). Since

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[2] All identifying information has be masked to maintain client confidentiality.

homeless mentally ill clients are dehumanized by the greater culture, a genuine caregiving relationship offers an opportunity to address their feelings of worthlessness and hopelessness.

Intrapsychic humanism can be applied to a case management relationship in a number of ways. The ultimate case management goal for many homeless mentally ill clients is to develop a capacity for autonomous self-caretaking needed for independent living and fulfilling lives - the same goal of intrapsychic humanism treatment. In addition, the case management relationship may provide more opportunities for caregiving than the standard psychotherapeutic relationship as the case manager ensures the client meets his/her basic needs and provides direct instruction on independent living skills such as cooking or laundry. It has been found that helping a client do laundry, go grocery shopping, or advocating for them in the community provides a nurturing experience and helps to develop the caregiving relationship between the social worker and client (Tyson & Carroll, 2001). Utilizing intrapsychic humanism, the case manager can gain greater insight into the client's healthy and unhealthy motives. Intrapsychic humanism describes three such motives, each of which leads to a particular kind of experience: motives for constructive pleasure, motives for self-destructive pleasure, and motives for self-destructive unpleasure. These three motives are always present in the client's mind; however, the client's previous relationship experiences determine which motive is the most dominant and pervasive (Tyson, 2002). Thus, self-destructive motives are likely to be manifested during experiences of pain and loss, while constructive motives are stimulated by a caregiving and meaningful relationship. These motives, along with other key concepts of intrapsychic humanism, will be further delineated and examples will be used based on interactions with the primary case example, Tony.

The first motive that the theory of intrapsychic humanism identifies is the motive for constructive pleasure. This motive operates when an individual takes part in self-caretaking behaviors and is necessary for therapeutic intervention to occur (Tyson, 2002). Generally, this motive is minimized for the homeless, mentally ill client who has probably experienced significant trauma; hence, this is the core motive that the case manager is trying to develop. Several examples of motives for self-caretaking that Tony has shown include complying with rules at his transitional living program and the case management team, going to the doctor and following the doctor's

recommendations, asking the case manager for help to develop a low-salt diet, allowing case managers to take him out for coffee or lunch, and openly sharing his fears of going to hell and his regrets from the past.

The next motive to consider is the motive for self-destructive pleasure. This motive causes the client to seek experiences others would consider unpleasurable, but that to the client represent conscious pleasure (Tyson, 2002; Tyson & Carroll, 2001). An example of a self-destructive motive from Tony's past includes his alcohol abuse; fortunately, his self-caretaking motives overrode his motives for self-destructive pleasure as he has been sober for a number of years. Motives for self-destructive pleasure in the form of trying to obtain the case manager's approval can often interfere with the caregiving relationship (Tyson, 2002). For instance, consider the two examples of dialogue between Tony and his case manager.

#1

Case manager: *I have been looking forward to going out to lunch for your birthday all week!*

Tony: *Why? I don't have anything. Well, if you want, I have two pairs of shoes. You can have my other pair of shoes.*

#2

Tony: *People do not think about the lives they lead until it's too late. It's too late for me. God gave me the tools and I cursed the Holy Spirit. If I could do it all over again, I would read the bible, go to church and hand out pamphlets about the Lord to everyone on the streets. Are you listening to me? You still have hope. Are you going to read the Bible tonight? It's too late for me, but I want you to learn from my mistakes.*

Case manager: *Tony, I really appreciate you sharing your feelings with me. I think you gave both you and I a lot to think about.*

In both of these cases, Tony is trying to take care of the case manager by offering compensation for spending time with him and then by worrying about his case manager's faith. Both may seem pleasurable to Tony, but both obstruct the sharing of underlying pain and endanger the one-sided therapeutic relationship. Instead of utilizing the relationship to reflect on his own inner pain, Tony is switching the attention to the caseworker and concerns about the worker's

well-being.

Another destructive motive is the motive for self-destructive unpleasure. This involves self-sabotaging experiences that clients recognize as unpleasurable but do not realize they are self-caused or that they can be stopped (Tyson, 2002; Tyson & Carroll, 2001). Such motives lead to experiences of self-harm, e.g., cutting, nightmares, delusions, or hallucinations. At age 40, Tony experienced auditory hallucinations in the form of "cursing the Holy Spirit," which led to his current delusions that the devil is in him and he is going to spend a "billion, trillion years in a fiery hell." Tony does not believe that his destiny can ever be changed. He also does not concede the possibility that the hallucinations could have been self-caused as a means of reacting to his divorce and subsequent homelessness, which occurred right before the voices started. Thus, the treatment goals include developing his self-caretaking motives, which will allow him to control his destiny and then prevail over these self-destructive motives.

Another helpful concept to the case manager is the aversive reaction to pleasure. Individuals who have become accustomed to experiences of unhappiness may become uncomfortable in response to feelings of happiness. An aversive reaction occurs when a client sabotages feelings of happiness. The most powerful aversive reactions occur when a client experiences conscious caregetting pleasure, because this experience causes a loss to the unconscious motives for unpleasure. The client may create unpleasure or sabotage the caregetting situation in order to satisfy learned needs of unhappiness (Pieper & Pieper, 1999).

Consider the following example with Tony.

Case manager: *Well, we had a long and frustrating day at the social security office. Are you ready to relax and just enjoy a nice lunch?*

Tony: *Yeah. Finally, no social security. No talking about feelings or assessment. We can relax.*

Case manager: *Yeah, well, what would you like for lunch?*

Tony: *Thank you for getting me lunch. I really appreciate it.*

Case manager: *No problem. I enjoy listening to you talk about your experiences and working through some of that.*

Tony: *What's your IQ?*

Case manager: *I actually don't know. That's an interesting question to ask.*

Tony: *You seem smart. I probably have an IQ of 3 or 4. I can't do anything.*

In this case, Tony was experiencing pleasure as his case manager took care of him by helping him at the social security office, taking him to lunch, and then complimenting him. Tony had an aversive reaction to this pleasure by making a self-deprecating statement, which made him unhappy. His unconscious motives for unpleasure brought Tony back to his learned state of unhappiness.

Another concept that will aid in understanding how to understand and respond to clients is the reaction to loss. The case manager will need to understand the nature of the loss (i.e. loss in the caregiving relationship if therapist is on vacation, a death in the family, loss in housing, etc.) and what this loss means to the client and his/her likely response to the loss (Tyson, 2002; Tyson & Carroll 2001). Tony's reaction to losing his family after the divorce included a suicide attempt and auditory hallucinations. In addition, Tony, at times, shows reactions to prospective loss when his case management sessions are ending:

Case manager: *Good Morning, Tony! How are you?*

Tony: *I'm fine.*

Case manager: *Good to hear. Now, Tony, I'm not going to be able to stay as long as I usually do today. We only have 10 minutes. I'm sorry, but my day is crazy today.*

Tony: *OK. <Lays on bed and closes his eyes>*

Case manager: *Gee, I would like to use our short time together to talk about your week.*

Tony: *I'm fine. <Still has eyes closed>*

Case manager: *Maybe you are tired and want to take a nap?*

Tony: *Yeah. I will see you next week.*

Case manager: *Ok. I know it may have been disappointing not to get our full session today. I was disappointed too. But, next week, we will have an hour. OK?*

Generally, Tony sits up during home visits and it could be argued that he was disappointed that the home visit was going to only last 10 minutes, so his reaction to the loss of his full session was to avoid the session altogether.

A way for the case manager to assess the level of the client's engagement in the caregiving relationship is by looking for process meanings in the context of each session. Process meanings provide the case manager with insight into how the client conceptualizes the caregiving relationship, which indicates the level of closeness or distance between the client and case manager (Pieper & Pieper, 1999). Process meanings take the form of observed behaviors or dialogue in the context of the therapeutic relationship. As the following extracts from meetings with Tony highlight, Tony's process meanings changed significantly over six sessions:

Second interview with Tony:

Case
manager:
Before we start the rest of the [psychosocial intake] assessment, I was just wondering something. I know you have been in several hospitals and have probably seen many different counselors and doctors. How do you feel about the questions?

Tony:
It gets old. So many people. Doctors, interns, case workers, interns, doctors, more interns. It gets old. I'm sorry. I can't answer any more questions. I just can't!

Case
manager:
Why don't you take a drink of water? Just take your time, ok? There's no hurry.

Tony:
Ok, I'm sorry. Go on.

Sixth interview with Tony-at the end after two hours together where Tony talked almost nonstop:

Case
manager:
<Dropping Tony off at his home> You know what? Here we are at your place. So, I must get going. You did a real nice job of sharing your feelings and experiences.

Tony:
Thank you. You know I haven't talked about this stuff with anyone in a long time.

Case
manager:
How are you feeling? I know we talked about a lot of intense stuff.

Will you be alright the rest of the day?

Tony:
Yeah, I feel better.

Case
manager:
Good. Well, is it alright if I come to visit you next week and we can talk some more about these things?

Tony:
Yeah. I appreciate it.

The process meaning changed from initial resistance to the caregiving relationship due to numerous other ineffective service providers in Tony's past, to an appreciation and utilization of the caregiving relationship that included Tony acknowledging feelings of pleasure from the relationship. It is important to pay attention to the client's process meaning as the caregiving relationship is the primary instrument of change.

Indeed, on many levels, intrapsychic humanism can be applied to the case management relationship as a means of gaining a greater understanding of the client's motives. These concepts develop a framework through which the caregiving relationship can be understood and enhanced. It is also important to recognize the limitations of the case management relationship and how intrapsychic humanism could be applied in response to the limitations.

Limitations of the Case Management Relationship

The first limitation is the limited resources available to many case managers. A case manager may have a caseload of 15-50 clients, and effectiveness of the case manager decreases when caseloads exceed twenty clients (Walsh, 2000). With such high caseloads and unending paperwork, case managers simply do not have the time to fully develop the caregiving relationship. With the current emphasis on medicating psychoses (Walsh, 2000), the case manager may be content with watching the client take their medicine. As a result, home visits often become ten-minute drop-in visits limited to superficial conversation about the weather. Clients do not have the opportunity to increase their self-caretaking motives. Some case managers may be content with maintaining the client's existence instead of enhancing it.

Another limitation is the structure of the case management team. Intrapsychic humanism is ideally implemented using a primary relationship model as opposed to a team model, which generally results in superficial relationships between clients and staff

(Tyson & Carroll, 2001). However, in a misguided understanding of efficiency, many ACT case management teams take on a team approach whereby any one of six or seven team members may visit a client on any given day. Thus, a client does not consistently see one case manager and this hinders the development of a stable caregiving relationship. The client's experience with the case management relationship will likely be unpredictable and chaotic using the team approach, which actually reinforces the client's unconscious views that relationships should be unpredictable and chaotic.

Intrapsychic humanism can be used to minimize the burnout, or compassion fatigue, of social workers caused by high caseloads (Pieper & Pieper, 1999). Pieper & Pieper argue that compassion fatigue occurs when a social worker does not truly understand a client's motives. However, intrapsychic humanism helps the social worker understand and reframe the client's motives and thus be more apt to stay motivated in working with the client. The adoption of intrapsychic humanism would also help social workers better understand the hazards of a team-based approach in providing services and how such an approach may actually lead to greater levels of compassion fatigue because of the minimal improvements observed in the relationship between client and worker.

As discussed earlier, case managers tend to have greater power over the client than a therapist would. For instance, a case manager may control how much money the client receives. So, if a client is a substance abuser, the case manager may limit the client to receiving three dollars a day so the client does not use all of their check on drugs. In the ideal situation, the person providing the caregiving relationship for the client should not be responsible for losses relating to issues such as money and removal from housing. Rather, the case manager should be available to support the client during times of such loss. Unfortunately, the case manager tends to be in charge of these losses which again limits his or her ability to develop a conflict-free caregiving relationship.

However, the social worker can use intrapsychic humanism to help the client mourn such losses. No therapeutic intervention is completely free of conflict; scheduling conflicts and expectation of payment are two sources of conflict in a typical therapeutic relationship. Thus, the goal of all therapeutic relationships is not necessarily to create a conflict-free worker-client relationship but rather to create a conflict-free inner well-being for the client. Intrapsychic humanism allows the worker to be attuned to the client's inner motives and needs and, thus, will likely increase the effectiveness of the intervention.

Conclusion

Case managers have a huge impact on the lives of their clients and, unfortunately, their therapeutic impact is minimized by high case loads and an emphasis on doing tasks for clients instead of talking with them. Thus, case managers would clearly benefit from training in intrapsychic humanism and would likely gain an increased awareness of the importance of the caregiving relationship with their clients. Further understanding of this theory would likely give case managers "peace of mind" when working with homeless, mentally ill clients who are known to be paranoid about and mistrustful of service providers (Walsh, 2000). Case managers would be able to understand their clients' motives in resisting help or in self-sabotaging relationships, and the worker could intervene with their clients using this perspective.

Additionally, intrapsychic humanism can be utilized in response to the losses that occur in the case management relationship, such as worker time restraints, requirements to confront clients, and power differentials - all of which will likely lead to some conflict and instability in the case manager-client relationship. Intrapsychic humanism emphasizes that the caregiving, trusting relationship with the client is the cornerstone of any intervention. Using this relationship, case managers will be able to increase their clients' constructive motives, limit their own compassion fatigue, and overcome the limitations inherent in the case management relationship.

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Jeffrey J. Bulanda completed his first year in the MSW program. His field placement was in a day program at Chicago Health Outreach providing case management services to the mentally ill. He has since become employed by Chicago Health Outreach as a mental health worker in a residential treatment center for mentally ill adults. His second year field placement will be with the Chicago Public Schools working with elementary school children. This paper received a School of Social Work Distinguished Writing Award 2003.

Smoking Gun: Nicotine Use and Recovery from Chemical Dependence

by Carolyn Schaefer Placko

Abstract

Smoking has long been socially accepted, if not encouraged, in alcohol and other substance recovery programs, including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). This acceptance comes despite the fact that, while drug and alcohol abuse has immediate consequences on the lives of abusers and their loved ones, the consequences of tobacco use are more subtle and long-term. Tobacco-related deaths cut short the lives of recovering people who could continue to pass along their wisdom and example. We as social workers have a duty and obligation to make sure that we do not ignore nicotine addiction in treating the chemically dependent.

Introduction

Smoking is very much a part of the recovering community. It is true that non-smoking meetings exist in communities around the country, and some recovering programs encourage participants to kick both habits - alcohol/drugs and nicotine - at the same time. Nevertheless, smoking has long been socially accepted, if not encouraged, in alcohol and other substance recovery programs, including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). This acceptance comes despite the fact that, while drug and alcohol abuse has immediate consequences on the lives of abusers and their loved ones, the consequences of tobacco use are more subtle and long-term. Tobacco-related deaths cut short the lives of recovering people who could continue to pass along their wisdom and example.

Historical Context of Smoking and Recovery

Smoking and AA have been linked since the early days of the organization. The Oxford Group, the forerunner of the AA movement, was "actively against sin." Excessive drinking was included in the category of "sin," and the list of vices considered sinful by the Oxford Group also included smoking. In New York, the Oxford Group encouraged its members to give up smoking even if they did not drink. Members were labeled "maximum" when they were "truly on the program" and had quit smoking, drinking and other behavior the group considered vices. AA cofounder Bill Wilson, an early member of the Oxford group and a smoker, had no interest in giving up smoking,

despite regularly being called to account on his nicotine use by other Oxford Group members (Hartigan, 2000). In contrast, AA cofounder Dr. Robert Smith ("Dr. Bob") was not pressured about his smoking habit by members of the Akron, Ohio chapter of the Oxford Group with which he was involved (Hartigan, 2000).

Wilson had a singleness of purpose while in the Oxford Group, which was to carry the message of recovery to other alcoholics. This sharp focus did not sit well with the founders of the Oxford Group, and the broad purpose of the Oxford Group to convert sinners from a variety of vices did not fit Bill Wilson (Hartigan, 2000). Wilson's focus on recovery is reflected in two of AA's central Traditions. The Fifth Tradition states that "Each group has but one primary purpose - to carry its message to the alcoholic who still suffers" (Alcoholics Anonymous, 2001). This Tradition has been a part of the movement since Bill Wilson's first efforts to pass along what he had been given, and AA as an organization has helped countless individuals because of this singleness of purpose (Twelve Steps and Twelve Traditions, 1952). But the organization has nothing to say about smoking and recovery in keeping with Tradition Ten: "Alcoholics Anonymous has no opinion on outside issues, hence the AA name ought never be drawn into public controversy" (Alcoholics Anonymous, 1952, p. 562).

In the 1950s and 1960s, Wilson experimented with a variety of therapies for alcoholics, including LSD (it was legal at the time) and megadoses of the vitamin Niacin (Kurtz, 1991). He suffered from depression and appeared to be looking - desperately - for a way to relieve this malady. Niacin in particular seemed to relieve his suffering, and he began to promote it. Many AA members believed this conflicted with Tradition Ten, and the organization's leaders or "trustees" asked Wilson to move the work of promoting Niacin from AA offices to his home, and not to identify himself with the promotional efforts (Kurtz, 1991).

Hartigan (2000) goes so far as to suggest that it would have been a different world if, instead of promoting Niacin, Wilson had quit smoking himself, and had spent the remainder of his days helping other AA members to do the same. By the 1940s, Wilson's health had begun to show the effects of smoking. Some suggest that he may have been trying to quit since that time. By the 1960s, he knew that he had

emphysema, yet he continued to smoke. He was believed to have quit smoking in 1969, but several people confirmed that he continued to smoke, hiding cigarettes in his car. The last few years of Wilson's life were not easy for him because of his health, and his scheduled appearances suffered; either he was unable to attend them, or he attended but could only speak briefly (Hartigan, 2000). On January 24, 1971, pneumonia and emphysema killed Bill Wilson. Hartigan (2000) says it well:

> It seems beyond comprehension, but the evidence is inescapable. The man who pioneered the approach to addictive illness that has helped millions free themselves from alcoholism and a myriad of other addictive problems - including smoking - literally smoked himself to death (p. 208).

One wonders how many other recovering alcoholics died from smoking-related illnesses. To be fair, smoking was not popularly believed to be detrimental to one's health until the 1964 Surgeon General's report. AA as a movement was less than 30 years old at the time. But Wilson's unsuccessful attempts to quit smoking, possibly for as long as 20 years, speak to the addictive nature of nicotine. At the time of his death, Wilson had enjoyed 36 years of sobriety. He was clearly successful in kicking one addiction, even if the other killed him. The fact that the founder of AA was unable to give up nicotine may also indicate that quitting smoking may be more difficult than quitting drinking.

The Problem Today

Research suggests that between 80-95% of alcoholics smoke cigarettes - three times the percentage of the general population that smoke. About 70% of alcoholics are heavy smokers (more than one pack of cigarettes a day), compared to 10% of the general population who are heavy smokers. Varner claims that "the leading cause of death for recovering alcoholics is tobacco-related illness" (Varner, cited in Van Wormer, 1995, p. 103). A recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) survey supports this contention. The survey found that of 845 people who had been treated for alcoholism and other drug addictions, 222 had died over a 12-year period. Of these 222 deaths, one-third were attributed to alcohol-related causes, but *one-half* were related to smoking (emphasis added) (NIAAA, 1998).

Many treatment professionals have refrained from addressing both addictions because of the commonly held belief that many addicted persons would not be able to handle the stress of abstinence from both alcohol and nicotine. Research now offers evidence that both can be treated simultaneously without endangering recovery from alcoholism (NIAAA, 1998). One recent study supports both the success of simultaneous treatment and the health risks associated with nicotine use (Van Wormer, 1995). Richard Hurt, M.D., of the Mayo Clinic, followed a group of 101 patients who were treated for drug or alcohol dependence. Fifty of those patients were in the control group, and received no special attention for their tobacco use. The intervention group of 51 patients received treatment for both smoking and the drug or alcohol problem that brought them to treatment. After one year, both groups had identical outcomes for the drug or alcohol problem. None of the control group had stopped smoking, while six in the intervention group had stopped. The only three to have died were in the control group, and two of the deaths were from diseases that can be caused by cigarettes (Van Wormer, 1995).

Of course, there are differences in the effects alcohol and nicotine addictions have on one's life. Alcoholism, while it may be harmful to the health, also causes chaos in other areas of life, and can be the source of social, employment and legal problems for the alcoholic (Kinney, 2000). This chaos creates an immediacy and priority for treatment. As noted earlier, the serious, negative health effects of tobacco use, though well-documented, are more subtle and long-term. Tobacco use, though it is known to be highly addictive (Shallit, 1991), does not generally drag the addicted person's life into chaos. This lack of chaos creates less of an urgency to treat nicotine addiction than is present for alcohol addiction.

Nevertheless, efforts are being made to help alcoholics quit both drinking and smoking at the same time. One widely respected approach is offered through Hazelden, an international organization that offers a treatment model in both inpatient and outpatient settings that is based on AA's 12-step approach. Hazelden's Inpatient Program does not allow smoking within the hospital, but patients can smoke outside at certain times. Patients are asked to bring a 28-day supply of cigarettes with them, as cigarettes are not sold at Hazelden. In addition, Hazelden requires patients to attend at least one smoking-cessation group. Mona, a representative of the Information Center at the Hazelden Center in Illinois, explained that many patients return after their inpatient stay and participate in smoking-cessation programs. However, she also indicated that Hazelden's research department does not have data on how many former inpatients try to quit smoking by returning for smoking-cessation assistance (personal communication, April 1, 2002).

A review of two other treatment facilities' web sites, the Menninger Clinic and the Betty Ford Center, did not reveal much about treating both smoking and alcoholism. Menninger's site (www.menninger.edu) states only that smoking is allowed outside. Betty Ford' website (www.bettyfordcenter.org) says that many receive help breaking other addictions, but it does not specifically state that the clinic will address nicotine addiction at the same time.

The author has professional experience in one Chicago hospital's psychiatric ward, where smoking is not allowed. Patients who smoke and are admitted for psychiatric disorders or alcohol/drug detoxification are given a nicotine patch but no smoking-cessation counseling. In addition, an internet review (http://findtreatment.samhsa.gov) of other Chicago-area treatment centers does not specify whether the facilities allow smoking or include smoking cessation in their treatment programs.

Non-Smoking in AA

The AA meeting directory for both Chicago and the surrounding suburbs lists non-smoking meetings. This is compared with similar data from other cities as cited in Table 1 below. California cities are not included, as only two meetings in San Francisco were named "non-smoking," yet the state has passed legislation banning smoking in all public buildings which may include AA meeting locations as well. New York City did not specify whether meetings were non-smoking, and this, too, may have been a factor of local laws prohibiting smoking in public places. Note that this information was gleaned from meeting lists or directories; some meetings may not report that they are non-smoking meetings. In addition, some meetings listed in the Chicago and suburban directories were not listed as non-smoking when, in fact, they were held at hospitals or other locations that prohibit smoking on the premises. Non-smoking meetings may also allow participants to take a break for smoking outside of the meeting area.

Some believe that recovering alcoholics are simply substituting one addiction for another - alcohol for nicotine and/or caffeine (Abbott, 2000). Van Wormer (1995) proposes that psychological dependence on alcohol may be more devastating than physiological dependence. He suggests that there may be an underlying psychological predisposition to behavior in the extremes, which may be a factor in compulsive cigarette smoking and coffee drinking, as well as other addictions.

Kathleen F., age 48, speaks to the phenomenon of substituting addictions. She is a recovering alcoholic and non-smoker who has not had a drink for seven years:

> Sometimes I find myself substituting addictions. Like when I was drinking, I was never obsessed about the cleanliness of my house the way I am now. Even in recovery I spend too much money, and although I'm not ready for debtors anonymous, I don't think I'm doing the emotional damage toward my family as I was with my drinking. But it's something I'm aware of. I've come to the conclusion that I'm human and I will probably struggle with these other addictions for the rest of my life (personal communication, March 30, 2002).

In other cases, people who quit smoking before they quit their addiction to alcohol or drugs begin smoking again when they're in recovery. Dr. Hurt's study also showed that, "during the study period, when smoking was permitted in a designated area on the unit, at least four patients who had been abstinent from tobacco for years relapsed to smoking while they were in residence" (Van Wormer, 1995, p. 282). Consider the experience of 44-year-old Dee T., a two-year recovering addict, who was an ex-smoker (she had not smoked for two years) until the day she got out of treatment. She reports that in a moment of weakness

Table 1: Comparison of Non-Smoking 12-Step Meetings

CITY	TOTAL # OF MTGS.	SMOKING	NON-SMOKING	NON-SMOKING AS % OF TOTAL
Chicago (city only) [1]	1230	756	474	38.5%
Chicago (suburbs only)[2]	1545	1105	440	28.5%
Akron, OH [3]	274	120	154	56.2%
Dallas, TX (metro area)[4]	929	600	3295	35.4%
Philadelphia, PA (city only)[6]	615	34	581	94.5%

[1] Source: October 2001 Chicago (City) Complete Meeting Directory (weekly meetings only)

[2] Source: October 2001Chicagoland Suburbs Complete Meeting Directory (weekly meetings only)

[3] Source: www.akronaa.org

[4] Source: www.dallas-aa.org

[5] Includes 120 smoking meetings with alternate non-smoking room.

[6] Source: www.sepennaa.org

she felt she had a choice - smoke a joint or smoke a cigarette. She chose the cigarette, and is now trying to quit smoking again. Dee said that during detox, she had no urge to smoke, and four years ago she was able to quit smoking "cold turkey." Now she says she is finding quitting harder than she ever imagined. She believes that not having the other crutches of alcohol and drugs is what makes quitting nicotine so difficult. Dee is a member of NA and reports that no NA meetings allow smoking during the meeting (although there may be a cigarette break for smokers to go outside the building); she also cannot smoke at her job. Her goal is to quit smoking so she can announce both her clean time and the time she has been off of cigarettes (personal communication, April 1, 2002).

Smoking Cessation and Recovery

Carol Southard, Smoking-Cessation Specialist at Northwestern Memorial Hospital in Chicago, reports that 20-25% of her clients are people in recovery. She says that a popular protocol suggests that people in recovery wait at least three months after addressing their alcohol or drug addiction before they give up smoking. "The norm is to do one, then the other," she says. Southard goes on to say that many of her clients, as well as research she has seen, indicates that "it's really hard [to quit smoking in recovery]. It's hard enough withdrawing from one [addiction]." She believes it may be harder for recovering addicts to quit than it is for the general population, and suggests that further research is warranted.

Unfortunately, managed care reimbursement practices are another issue in smoking cessation. Insurance companies are erratic in their treatment of smoking cessation. If they reimburse for it at all, they often limit reimbursement to once a year. Southard reports that, currently, most people must pay out-of-pocket for smoking-cessation programs. She indicates that the expense may be prohibitive for some people and may be a factor in people not seeking assistance when they try to quit smoking (personal communication, April 1, 2002).

Implications for Social Work

Smoking is a serious health issue in the recovering community. While nicotine addiction may not have the chaotic effects on users' lives that alcohol or drug abuse does, it can cut short the lives of addicts and alcoholics whether in recovery or not. Perhaps most importantly, social workers and other treatment pro-

fessionals should not ignore the smoking problem simply because it is not the most immediate fire the individual in treatment must put out. Social workers and other counselors could begin to address the issue by increasing their own awareness of the marriage of chemical and nicotine dependence. They could also make it a point to ask about tobacco use in interviews with clients and apply substance abuse therapies to helping clients get off nicotine. Taking it a step further, treatment professionals could increase efforts to prohibit or limit smoking during treatment. They might at least offer nicotine education, if not full-fledged cessation programs, during treatment. Resources in the community are available to help smokers quit, whether or not the smokers are recovering alcoholics.

More data is needed on the extent of the smoking problem among recovering alcoholics. For example, AA does not currently track smoking in its membership survey. More research on smoking and recovery can be hoped for as more people become aware of the problem and include tobacco dependence in treatment programs.

Conclusion

Long-time sober members of AA are an extremely important resource in the fight against alcoholism. Their lives are important not only to themselves but to others. They can be meaningful examples for newer members and for the active alcoholic unsure if s/he wants recovery or not. There is an axiom in AA that says that if you want long-term sobriety of 25 or more years, then "don't drink and don't die." While this may seem crass to some, it fits with the premise of this paper: that nicotine cuts short the lives of recovering alcoholics and addicts. Recovering alcoholics/addicts can find hope and wisdom in the long-term sobriety of those who have traveled the road of recovery longer. Living life to its natural end is a way to honor the Fifth Tradition, that of carrying the message to other alcoholics. To die prematurely because of cigarette smoking is a loss not only for the recovering community but for all of humanity as well. We as social workers have a duty and obligation to make sure that we do not ignore nicotine addiction in treating the chemically dependent.

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Carolyn Schaefer Placko received her MSW from the School of Social Work in May 2003. Her second-year internship was in adult inpatient psychiatry at Northwestern Memorial Hospital's Stone Institute of Psychiatry. Presently she is working for Hospice Partners in Hillside, Illinois.

A Foot in Each World: The Development of Identity Complexity in Impinging Environments

by Jacqueline R. Anderson, L.C.S.W

Abstract

This paper explores the concept of identity complexity as it applies to people who experience their environment as hostile and impinging. The work of object relations and intersubjective theorists are considered, and a case illustration is utilized to conceptualize problems with identity complexity and their effect on intrapsychic and interpersonal functioning.

Introduction

Leanita McClain (1986) was an African-American journalist who committed suicide at the age of 32. The product of a south-side Chicago housing project, McClain defied the so-called odds by achieving all of the pearls of an upper-class existence. She had, by most accounts, achieved the American dream. She existed among the elite during the day, feeling very different as an African-American in a world of Whites. She attempted to remain true to her roots despite feeling different among her Black family members and friends who had not achieved her level of material success. However, the torment of living a dual existence ravaged by feelings of guilt, isolation, and disengagement, rendered her incapable of enjoying her success. Over time, she came to believe that both of her environments were hostile and alien. She was a person for whom life had no meaning and no appeal. I came to understand McClain's barren existence in terms of problems with identity complexity, which is defined as a highly developed capacity to create meaning with the sense of self being highly differentiated, articulated, and integrated (Saari, 1993).

During a class session in October 2002, the following questions were posed: "Can a person's identity be too complex?" and "Is there a point and are there conditions under which any of us would 'go nuts?'" I have come to believe that the point at which we no longer experience our environments as safe and we are unable to regulate our affect within this environment, we are in grave danger of losing our sense of self, our identity, and our ability to create meaning. What has intrigued me about the concept of identity complexity are the necessary components of articulation, differentiation, and integration of selves (Saari, 1993). Leanita McClain (1986) wrote, "I have a foot in each

world, but I cannot fool myself about either." McClain's chameleon-like false self reflected her environments without integrating them and without creating meaning around her experiences in a way that would make them tolerable for her. McClain's different selves were articulated and differentiated but not integrated. The ambivalence of her fractured multiple lives became intolerable for her, and she became depleted by the burden of trying to manage an inconsistent existence. This powerful example of problems with identity complexity fuels the need for further exploration of its development and maintenance.

Mead (1934) says that there is a need for participation in a community. For various reasons, people are often participants of multiple communities and have to negotiate and integrate the symbols of each. Considering the climate and time in which Mead made this assertion, it is not likely that he was referring to the so-called sub-cultures or other marginalized groups of people who are expected by both the mainstream community and the sub-culture community to understand and comply with the demands of each community. Mead, Saari, Basch, Winnicott and others provide a framework for exploring the integration of multiple selves and the role that integration plays in the development of a healthy self. This framework offers many possibilities and ways to think about people who, because of environmental impingement or exclusion from an environment, set about the task of developing and maintaining identity complexity.

This paper explores the nature of identity complexity for individuals who are part of two or more environments that are dissimilar in nature, alien to their sense of self, and difficult to bridge. I explore the concept of self and examine how others have defined and explained concepts related to self and environment. I utilize a case study to illustrate how I understand the concept of identity complexity in a practice setting.

Review of Theory

The integration of selves, roles, and environment can be a daunting process even for people who feel engaged with and supported by their environment(s). However, people who feel excluded, alienated, and disengaged from their environment(s) undoubtedly face extreme barriers to developing and maintaining

identity complexity. The person-in-environment perspective is an identifying focus of the social work profession, yet this concept often remains "conceptually elusive and difficult to apply" (Applegate & Bonovitz, 1995, p. 8). Exploring the role of identity complexity and goodness of fit may offer a unique opportunity to examine the person in, outside of, and between his or her environment(s), focusing on the processes of integration and creation of meaning over time.

What conditions are necessary for people to effectively and consistently understand and manage their selves? How do these conditions vary when life roles are chosen as opposed to assigned? According to Mead (1934), we are different selves and have a different self for every environment in which we participate. One of the tasks, then, is to integrate the various selves by way of internalizing symbols and gestures of the environment to which we belong. As it becomes more and more evident that Hartmann's (1939) "average expectable environment" is neither average nor expectable, but may be hostile and impenetrable, the question of adaptation and identity complexity becomes crucial.

According to Siporin (1983), identity is a core element of the self-system, as well as of group and of social institutional structures. This understanding of identity is consistent with Erikson's assertion that an identity outside of membership and participation in a social group is not possible (Saari, 1986). However, neither is the maintenance of identity possible without a constant interrelationship with the rest of reality (Saari, 1986). In *Acts of Meaning*, Jerome Bruner (1990) asked,

> [B]y what processes and in reference to what kinds of experience do human beings formulate their own concept of self, and what kinds of self do they formulate? Does "self" comprise (as William James has implied) an extended self incorporating one's family, friends, possessions, and so on? Or, as Hazel Markus and Paula Nurius suggested, are we a colony of possible selves, including some that are feared and some hoped for, all crowding to take possession of a now self? (p. 100).

The Paradox of Self

An exploration of identity complexity would not be complete without an examination of the concept(s) of self. The term "self," so ambiguous in nature that it defies a single, simple definition, lies at the core of identity complexity and yet it has eluded many great thinkers of our time.

William James considered the self from three distinct aspects: (1) the material, bodily self which he called the empirical self, (2) the social self, and (3) the spiritual self, which he described as the core of the self, a "palpitating inward life, a central nucleus" (Modell, 1990, p. 33). James grasped the self as a mental structure and the self as consciousness that much to his dismay presented a paradox he could not solve. He noted that despite our dependence on social affirmation there is a portion of the self that enables us to become autonomous and free of such social dependency. There is an I that is witness to the Me as well as the Not Me (Modell, 1990). For the spiritual or core self, this poses a dilemma: what makes the self continuous over time?

Modell (1990) states that if there is indeed a hierarchy of human aspirations, self-actualization through the emergence of personal values and personal interests (private self) takes precedence over social affirmation. Noting this paradox, Mitchell (1993) writes:

> Is there something problematic or difficult to grasp about regarding mind in both intrapsychic and interpersonal terms? Some writers (such as Arnold Modell) have suggested that this amounts to bringing together two essentially incompatible frames of reference and therefore constitutes a paradox. Since Winnicott (1989) has made the concept of paradox acceptable (even fashionable) maintaining both the intrapsychic and the interpersonal in a contradictory but complementary juxtaposition is thought to be possible (p.143).

Gerald Edelman, a neurobiologist, addressed this paradox, although in a somewhat narrow manner (Modell, 1990). Edelman views the self as nearly coterminous with consciousness: consciousness implies the capacity for self/nonself discrimination. This biological self has evident survival value and rests upon structures of the nervous system that are different from those that mediate the perception of the external world. The continuity of the experience of self is linked to the homeostatic function of the nervous system. The self is the repository of special value-laden memory systems. By identifying the function of memory as something that allows the self to persist over time, Edelman (Modell, 1990) alludes to the notion that the self has some structure and is more than illusory in nature.

Ideas about the nature of memory are central to understanding the nature of internalization processes and of the content that is internalized. Without memory, human beings would have no sense of organiza-

tion across time or of endurance, which, as Erikson emphasized in his concept of identity, is extremely important for psychological health (Modell, 1990). Loewald (1980) has attributed the experience of fragmentation of the self to an "inability to order a given event in a context of the present, past and future, with the result that the moment stands alone, not embedded in a time continuum. The temporal ordering of experience is a basic and critical function for human beings" (p. 144). In clinical theory, there has been considerable debate about whether therapy is or should be focused on an understanding of the past or the here and now. This argument, however, seems to be based on the misconception that time unfolds in a simple, linear fashion (Modell, 1990). Loewald (1980) asserts that "memory is not just content but is also an activity" (p. 150), and while the content is concerned with the past, memorial activity always occurs in the present. Taking Edelman's ideas about memory as a requisite for the maintenance of self over time quite further and incorporating a relational focus, Saari (1996) writes,

> The content of consciousness is constructed either following or concurrent with activity or experience; it does not pre-exist as biologically inherited meaning. Experience may be represented in the individual's cognitive system (which includes perception, memory and the schematic representation of events as well as concepts and categories) without being either linguistically or consciously accessible. Such inaccessible experience will still have an effect on behavior even though it remains pre- or nonverbal (p. 154).

Harry Stack Sullivan, in contrast to Edelman, felt that the uniqueness of self is an illusion. According to Sullivan, we have an "almost inescapable illusion that there is a perduring, unique, simple existent self, called variously 'me' or 'I,' and in some strange fashion, the subject person's private property" (Mitchell, 1993, p. 108). Inasmuch as the self is defined by others, individuals do not exist. In a relational vein not unlike the writings of Winnicott, Sullivan believed that the idea of uniqueness each of us maintains is the greatest psychological impediment to constructive living and that an appreciation of our commonality with others, not our distinctions, holds the key to a richer life (Mitchell, 1993).

Freud managed to sidestep the complications of defining self by objectifying it and describing only the structural attributes and their purposes. Freud did not consider the self as a center of consciousness perhaps because such a consideration would prove impossible to study empirically. In an attempt to incorporate the notion of self into drive theory, Heinz Hartmann used the concept of self-representations to describe the self as no different from any other object of perception, in that self is an outside observer's inference of the subject's self experience (Modell, 1990).

Paul Federn, perhaps in an attempt to bridge the false dichotomy of self and environment, thought that in healthy individuals the bodily self and the psychological self are unified (Modell, 1990). The differentiation of self from non-self is a very fluid process that is negotiated through ego boundaries. It is not clear if in his writing Federn was speaking of person-in-environment as we understand it now. However, it appears that he was questioning the feasibility of person separate from environment. Winnicott (Modell, 1990) illuminated the whole notion of the inseparability of person from environment when he wrote, "[E]ach individual is an isolate, permanently non-communicating, permanently unknown, in fact unfound." He went on to say that "there is no 'self' except in relation to others" (p. 42).

Winnicott recognized the existence of both private (true) and social (false) selves. The true self is the source of authenticity, psychic aliveness, and the assurance of the continuity of being. The false self responds compliantly to others in order to protect the true self from non-acceptance and exploitation. Winnicott acknowledged that the true self is paradoxical in that it enables the individual to be alone but requires initially the continuity of the external environment. However, he did not view the paradox as alarming or problematic. He seemed to embrace the notion that to become autonomous, one needs the presence of another and that we possess both autonomous private selves and dependent social selves, which appear to have opposing aims (Modell, 1990). It is through the work of Winnicott that there begins to be some understanding of how identity is constructed, and how it is maintained over time.

While Winnicott (1989) espoused a self inextricably linked to others, he dispelled the notion of separateness, and highlighted the false dichotomy between self and others while acknowledging that there is something that occurs in the space between self and others which Saari (1996, p. 149) calls the interpsychic space, and Winnicott called the transitional space. This notion of a space that is neither I nor You, but We, provides us with a concept to begin exploring identity complexity, and how the understanding of self is rooted in relationships with others. The self psychol-

ogy of Heinz Kohut (1984) might have provided a nice segue into this exploration had he not posited the self-object as a tool used solely for the development and maintenance of the intrapsychic, thus disregarding its relational value. If we are to understand the selfobject as someone who feeds the self and to whom the self does not feed back, there exists no reciprocity and therefore no relationship. In his writings on affective attunement, Daniel Stern says that affect not attuned by others in the caretaking environment cannot be shared with others (Saari, 1996). This attunement connotes interaction and the inseparability of self from activity, thus giving us some understanding of how we come to contemplate objects in our environment and construct our identity.

This exploration of the concept of self, self development, and self maintenance guides the focus to identity development and identity complexity. Bruner defines identity as a "personal meaning system that is created over the course of the individual's experience with the world and is organized primarily in narrative form" (quoted in Saari, 1996, p. 144). Saari (1996) explains identity as the content of the autobiographical stories told to self and others and states that "identity may also be seen as an individual's personal theory about himself or herself, about the world, and about his or her relationship with the world and vice-versa. It is through this personal theory that the individual organizes past experiences and plans future actions" (p. 144). Identity does not fundamentally exist inside the isolated individual waiting to be uncovered through an archeological exploration of the layers of an unconscious, but is a meaning system created through dialogue with others (Saari, 1996).

Further elaborating on the idea of self and others, internal and external, Patrick Casement (1991) writes: "For each person, there are always two realities: external and internal. External reality is experienced in terms of the individual's internal reality, which in turn is shaped by past experience and a continuing tendency to see the present in terms of that past" (p. 3). People have to create an understanding of their environment before they can create a sense of who they are in that environment. This understanding is a core element of identity and therefore necessary for the development of identity complexity. In addition, it is likely that personal identity does not form in an early developmental stage and then endure reasonably intact throughout life. If this were the case there would be no need to understand identity complexity since it would not exist. Identity is constantly modified, created, and recreated in negotiations with inter-

active partners throughout a person's life (Saari, 1996).

To help consider the application of these ideas, the following case study will be discussed from the framework of Winnicottian object relations theory. The identifying information has been changed to protect the confidentiality of the client and her family.

The Case of Monica

Monica, a 34-year-old black female born and raised in the West Indies, came to treatment because she was having difficulty dealing with her 14-year-old daughter, Mercedes. Monica, a divorced woman with a strong Catholic background, became enraged after finding a love letter in Mercedes's book bag written by a female classmate. Mercedes admitted to Monica that she had long been attracted to girls but that this was her first experience with a same-sex romantic relationship. Monica, unable to deal with the possibility of Mercedes being gay, sent her to live with her paternal grandmother. Their relationship became strained and the distance between them increased when Mercedes decided to make her living situation with the grandmother permanent. Monica decided to seek treatment when she realized that she was unable to deal with this situation alone.

During our initial session, Monica revealed to me that her difficulties had begun long before she and Mercedes starting having problems. Born in Trinidad to an unmarried, poor, uneducated mother and an idealistic, uninvolved father who was married to another woman at the time that Monica was conceived, Monica felt unloved and unaccepted by family members and peers. At age ten, she was sexually assaulted by her mother's boyfriend and kept this information a secret for more than a year. When she finally told her mother what happened, her mother accused her of lying and sent her to live with her grandmother in Chicago. Due to some problems with school transcripts and transfer of credits, Monica was placed in the fourth grade in a Chicago public school. Monica's West Indian accent, fully developed body and tall stature made her stand out as an eleven-year-old in a classroom of nine-year-olds. She was ridiculed and shunned the entire year. Monica's grandmother was sympathetic to Monica's experience and the following year enrolled her in a private school in an upper-middle class, mostly white community. If Monica thought the year at the public school had been bad, she was not ready for the treatment she received from the students and teachers at the private school. For the first time in her life, she was called

"nigger," and she soon came to understand that while she didn't fit well in the public school, she didn't fit at all in the private school. Despite the hardships, Monica maintained a high grade point average and graduated with honors. She was accepted to a prestigious private high school with a full scholarship where she graduated at the top of her class despite having no friends and feeling very much estranged from the high school community.

Shortly after graduating (at age 19) Monica met James, a 21-year-old, African-American man whom she described as "street smart, smooth, and right out of the hood." James appealed to Monica because he seemed to fit into what she understood to be the Black community. Monica and James started dating immediately, and soon after she became pregnant with Mercedes. Though the pregnancy thwarted Monica's plans to attend college, she was excited by the prospect of becoming a wife and mother. Monica and James married when Mercedes was a year old, and they both tried to settle into their role as parents. Monica and James spent a great deal of time sharing experiences about their respective pasts and trying to comfort and support each other. However, Monica found it difficult to relate to some of the things that James revealed to her. One such revelation was that James had been sexually assaulted as a child by his father. Monica wondered if that meant that James was gay. She tried to compare it with her own experience of being sexually assaulted, but decided that his experience was far beyond her comprehension because it involved two people of the same sex. These thoughts haunted Monica and she no longer felt that she and James were soul mates. They were separated shortly thereafter and divorced when Monica was 25 and James was 27.

James and Mercedes remained close following the divorce, and Monica was very critical of their relationship. She wondered if James was the reason that Mercedes was gay. After the divorce, Monica began working as a secretary in a prestigious law firm downtown. She stated that she found the climate at the law firm quite "alien" and felt as if she didn't fit in because she was the only African-American in the office. However, she admitted that she probably wouldn't have fit in even if there had been other African-Americans, as she had not had any good relationships with people of her race in the past. After working at the law firm for four years, she enrolled in college and majored in psychology, a major she chose in hopes of understanding herself better. We began our work together during her senior year.

During our initial session, Monica became preoccupied with my braided hairstyle and wondered aloud if she too should consider wearing braids. She then wondered if the hairstyle would be considered appropriate at her workplace. She questioned me about how I was accepted as a Black person working in a "White organization." She was intrigued by my answers and wondered if she should consider becoming a social worker. This discussion seemed important to Monica, so I participated to the extent that I felt comfortable. I too was intrigued to be working with one of the very few African-American clients served by the agency. I was accustomed at this point to being perceived as an enigma, or a "pink poodle" of sorts, even by other African-Americans. Monica and I had similar experiences in this respect. However, while I felt sufficiently rooted in my African-American heritage, Monica felt excluded from hers. As we sat face to face, we were alike in our "differentness" and different in our alikeness.

I felt the full force of Monica's disconnectedness from the various parts of herself and the resulting difficulties from this disconnection. She assumed that one must take on the characteristics of the host environment, not bringing any parts of her own self with her. Further, she did not conceptualize a self to bring. Monica often operated like a chameleon, taking on the shape and color of her environment while maintaining none of her own characteristics, unaware of her characteristics formed in previous environments. While able to perform socially in her multiple environments, Monica sensed her disconnection and was not sure where she belonged.

In my work with Monica, I found that despite her strengths and abilities, she lacked a basic sense of self and exhibited little empathy. This confounded and intrigued me all at once. While she spoke eloquently about feeling different and excluded from her environment(s), she harshly judged her daughter for being gay and her ex-husband for being sexually assaulted by his father. One might assume that someone who experienced exclusion and alienation would understand another's experiences with these issues. This was not the case for Monica. Her identity was not complex enough to integrate and understand her own experiences, much less understand the experiences of others. Monica's preoccupation with my hair, or what may have been perceived as a blatant exhibition of my Blackness, was puzzling and foreign to her. It had not occurred to her that people not only exist in their environments, but help determine them. She also seemed to confuse my role as a social worker,

with my identity as Black woman who happens to be a social worker. The notion that identity and role can be integrated seemed to be a foreign concept.

Dorothy Jones (1990) says the self is both product and potential transformer of society and that self is socially and historically constituted. In addition, the social context of experience has a powerful impact on an individual's internal reality shaping both its conscious and unconscious content thus allowing a person the experience of a self-in-the-world. Monica clearly had many selves (or part selves), but they were not continuous across contexts, and she seemed unable to articulate, differentiate, or integrate them. Her early experiences with caregivers and important others did very little to help her develop a sense of self. She was an outsider from the very beginning, and this continued into adulthood. That she saw herself as an outsider is a very important consideration in that she somehow understood self as separate from environment, yet her self was not formed so that it might be articulated. Monica had very little capacity for self-reflection, and she was unable to identify ways in which she was distinct from others even though she understood herself to be different from others.

Saint Augustine introduced the idea of a private self capable of self-reflection and believed that acceptance and understanding of this private self intimated a love of the self (Modell, 1990). He envisioned the very contemporary idea that self-knowledge leads to self-acceptance, a healthy form of self-love. According to Saari (1991), psychological health can be defined as a "highly developed capacity to create meaning with the result of that capacity being identity complexity" (p. 23). Further, "the more possibilities the individual can envision in any given situation, the more alternatives that person can consider in the selection of behavior. Thus, the possibility of adaptive behavior would be increased by a multifaceted comprehension of the world" (p. 23). In this light, adaptation can be understood as integration of socially acquired symbols that make socially acceptable responses not only possible, but likely. Monica's early caregiving and later experiences precluded the development of her ability to contemplate the objects in her world (they had not been affectively attuned), as well as select behaviors that would contribute to the healthy development of a sense of self and identity complexity.

Monica attended only three sessions, missing several subsequent sessions before finally discontinuing treatment after two months. Despite my intentions and hopes of providing for Monica a holding environment, in which interpsychic exploration could occur, I believe that like all of her other environments, the therapeutic space was perceived as hostile and inhospitable. I was similar to her in ways that she could not quite understand, and different from her in ways that felt all too familiar, thus reinforcing her belief that there was not a goodness of fit. Monica had a foot in at least two worlds but found grounding in neither of them. Her semblance of identity stood on shaky ground that could neither hold her nor be influenced by her.

Conclusion

If Mead's (1934) beliefs are accurate that the self is created primarily by society, that one first experiences oneself as an object of others, and that selfhood is not created but bestowed upon the individual from without, then one must wonder what processes occur when, for individuals like Monica, the environment or community is limiting, impinging, exclusive, and/or incongruent with the person's sense of self. Further questions to explore are: What might the development and maintenance of identity complexity look like in a hostile environment for a person who has not adapted to it, or for a person who has not been able to integrate and create meaning within this environment? How do we understand how people develop and maintain identity complexity when participating in multiple environments that are dissimilar in nature and difficult to bridge? If belonging to a community is indeed important and the demands of the community or communities become too difficult to tolerate, how will identity complexity be impacted? As social workers seek to understand and provide services to clients who are struggling through the matrix of identity complexity, these questions should be considered and explored utilizing existing theories and case studies.

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Jacqueline R. Anderson completed her second year in the doctoral program. She is the Director of Programs at Deborah's Place, a not-for-profit agency that serves women who are healing from the experience of homelessness.

The Policy That Never Was: The Equal Rights Amendment

by Scott Smith

Abstract

This article chronicles the history of the Equal Rights Amendment, and evaluates the need for the ratification of the amendment. The ERA was first introduced into Congress in 1923 by suffragist Alice Paul. The amendment was designed to insure that women, who had just been granted the right to vote, would be treated equally to men. Opponents of the ERA have argued that the amendment is redundant because of the 14th Amendment, and that a precedent would be established that would not consider women's biological differences. The author argues that the amendment is necessary because women, who constitute the majority of the population of this country, continue to be at high risk for poverty and are victims of discriminatory practices and other forms of oppression.

Introduction

Ever since King George received the letter declaring that the thirteen colonies in the New World would no longer be denied certain basic rights, a premise of human equality has been inserted into the fabric of our nation's existence. Our national history, however, speaks a different tale. Equality in our nation only applies to those who are male and of European descent. One group consistently experiencing discrimination and prejudice on a large scale is women. And since the female gender can include various races, the term "women" is essentially an inclusive term for inequality.

Until 1920, women did not possess the right to vote, and to this day, many of the rights extended to citizens as a whole are abridged on the basis of gender. Alice Paul, a leader in women's suffrage, saw this future. Shortly after the 19th Amendment (women's suffrage) was enacted, she proposed another amendment, the Equal Rights Amendment (ERA). The amendment has three articles:

> Section 1. Equality of rights under the law shall not be denied or abridged by the United States or by any state on account of sex.
> Section 2. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article.
> Section 3. This amendment shall take effect two years after the date of ratification (Equal Rights Amendment, 2000).

The language of this policy certainly does not seem extreme, militant, or threatening to any population's essential liberty. However, since the ERA was first introduced in 1923, it has been consistently overturned as a policy. This article will examine the arguments and social conditions working against the passage of an amendment that guarantees equality for women, and will make a case for its ratification.

Women: The Minor Majority

According to the U.S. Census Bureau (2000), women constitute 50.9% of the population. In a country born on the ideologies of liberty and democracy, there is a tragic irony in the fact that the majority of this country is abridged of the same basic freedoms cited as the reasons for our country's formation. Historically, women have been treated as less than equals. The root of this inequality originates in a philosophy called "natural order," a Social-Darwinistic attempt to claim that, since men and women are different (and men are typically physiologically stronger), women are secondary in function and value (Baker, 1999; Denning, 2000). While this concept of women as the "weaker sex" seems absurd to an educated 21st century mind, one needs to consider the environment in which the Constitution was originally framed to understand why there were not guarantees of equality for women[1].

In an agrarian society, the social context of our country until the mid-1800's, women's roles were clearly defined and their value understood – they prepared the meals, worked in the fields, made clothes, and kept the home clean. Women were viewed as essential, and while this perception constituted a form of sexism, its ramifications were less pronounced and less severe than the sexism women began to face in an increasingly industrial society. Indeed, as the evolu-

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[1] This author wishes to clarify at this point that women were among many outgroups that did not receive constitutional protection. This paper is not designed in any way to minimize the hardships that were faced and still are faced, by many other groups. Rather, this paper seeks to focus attention on one group in the hope of social change.

tion to an industrial society occurred, women were deemed unfit for the work conditions of factories and relegated to household duties – duties perceived to be easier by modernization. It seems that this shift in roles fundamentally created the perception that men did the "real" work, while women just took care of the home and children (Karger & Stoez, 2002).

Social perceptions are problematic, however, social perceptions can and do change. The more vexing issue was that women were not legal equals under the Constitution. In the United States, where rights are offered and guaranteed via written laws, the absence of such a law is the absence of rights. Moreover, laws that sought to protect women, such as those developed during the industrial revolution to protect women from the harsh environments in factories, created a legal precedent for the notion that women are weaker than men (Karger & Stoez, 2002).

Progressive women were not content to accept this label, and voraciously fought to be considered equal. They had a victory in the 19th Amendment, and were ready to go one step beyond, a step to another amendment guaranteeing that they would be equal under the law to men. But the fight for equal rights under the law, which began in 1923, continues today.

History of the ERA

To understand the complexity of the ERA, it is essential to understand its history – a history girded in close calls and vigilant fights (National Organization for Women, 2002). In 1923, Senator Curtis and Representative Anthony (nephew of suffragist Susan B. Anthony), both Republicans, introduced the ERA. Alice Paul, who led the suffrage campaign and was head of the National Women's Party, authored the original bill which received very little attention at the time.

Through Paul's persistence, however, the amendment was reintroduced into each session of Congress from 1923 until 1946, when it had its first close call and missed passage in the Senate by only three votes. In 1950, the Senate actually approved the amendment, but a rider nullified every equal protection aspect of the bill, essentially making it void. Very little movement occurred until 1967 when the National Organization for Women (NOW), a newly founded feminist group, vowed to fight assiduously for the ratification of the ERA. Three years later, NOW's actions, as well as the actions of other women's groups, would finally start to be noticed.

In February of 1970, twenty NOW leaders disrupted hearings of the Senate Subcommittee on Constitutional Amendments and demanded that the ERA be heard by the full Congress. Three months later, the Subcommittee began hearings on the ERA under the direction of Senator Birch Bayh (D–IN). The next month, the ERA finally left the House Judiciary Committee due to a discharge petition filed by Representative Martha Griffiths (D-MI). In 1971, it looked like the ERA would finally have its day when the House, by a 354-24 margin, approved the bill without amendments. The bill also received the support of the National Educational Association (NEA) and the United Auto Workers (UAW), both of whom voted at their annual conventions to endorse the ERA (National Organization for Women, 2002).

On March 22, 1972, the full Senate approved the Equal Rights Amendment without changes in an 84-8 vote. Senator Sam Ervin (D-NC) and Representative Emanuel Celler (D-NY) succeeded in setting the customary time limit of seven years for ratification. More organizations blossomed and offered their support for the ERA, including the National Conference for Puerto Rican Women and the League of Women Voters (a group that previously resisted the ERA). The ERA, now possessing the necessary two-thirds vote from Congress, and in accordance with the Constitution's amendment procedure, was sent to state legislatures, where three-fourths (38) of them would have to ratify it before it became law (National Organization for Women, 2002).

The initial prognosis for the ERA was good: of the thirty-two state legislatures in session in 1972, over twenty ratified the amendment. The proximity of victory sparked the beginning of a campaign by Phyllis Schlafly, perhaps the most visible and vocal opponent of the ERA, to exterminate the bill. The Illinois Republican lawyer, columnist, and author waged a ten-year battle to defeat the ERA (D'Agostino, 2001). In 1973, this nemesis to the ERA came up against a formidable protagonist in the AFL-CIO, which brought with it the Democratic Party's support base. This gave momentum to the ERA movement at the state level. Pressure from right wing, anti-ERA groups began to surface in state legislatures, but by the 1979 deadline, thirty-five of the requisite thirty-eight states had ratified the bill (Denning, 2000).

Only three states short of ratification, ERA proponents convinced Congress to extend the deadline for ratification to 1982 (with the argument that the Constitution imposes no time limit for ratification of amendments). By then, however, even ardent supporters were exhausted. ERA opponents, on the other hand, were just warming up to the fight. To make matters worse for supporters, five states rescinded

their earlier ratifications. Subsequently, ERA opponents launched all-out attacks, attempting to pass rescission bills in at least a dozen states. Before the validity of those rescissions could be hashed out in the courts, the new deadline passed and ERA's opponents declared victory. Meanwhile, ERA proponents were left to advance women's rights using the Equal Protection Clause and the Civil Rights Act's prohibition of sex discrimination (Denning, 2000).

The ERA received yet another blow in 1980 when the Republican Party reversed its 40-year history of support for ERA. Presidential candidate Ronald Reagan and newly elected right-wing party officials actively opposed the amendment, while the Democratic Party reaffirmed its support for the ERA. The election in November revealed, for the first time ever recorded, that men and women vote quite differently in elections (National Organization for Women, 2002). Women who voted against Reagan cited his opposition to the ERA as their reason, but even without their support, Reagan won the election and became the first President to oppose the ERA.

By mid-1981, women's groups were rallying again to extend the ERA deadline, set for June 1982. This move was almost extinguished at the end of 1981 when Judge Callister[2] ruled the ERA extension illegal and rescission of the amendment legal. This opinion marked the first time in this country's history that a federal court declared an Act of Congress relating to the amending process as unconstitutional (National Organization for Women, 2002). Although the Supreme Court subsequently overturned Callister's ruling, the victory was short-lived; on June 30th, 1982, the bill was stopped three states short of ratification. The blame for failure this time was spread evenly between Republican desertion of the ERA and weak Democratic support derived from the racial and gender imbalance in Congress (National Organization for Women, 2002).

For a bill so troubled by close calls, it is difficult to imagine any particular junction would be more angst-ridden than another, but 1983 was just such a time. The vote in the House that year failed six votes shy of the two-thirds majority needed for ratification. The most troubling aspect of this vote was that fourteen co-sponsors voted it down, and three co-sponsors did not vote at all (National Organization for Women, 2002).

Why the ERA Lost

Although the Equal Rights Amendment has never received the support necessary for passage, a 1995 Harris poll commissioned by the Feminist Majority Foundation found that 86% of adults favor the ERA (Baker, 1999). So why did the ERA lose? One opposing argument in this nearly century-old debate is that women simply do not need an amendment guaranteeing equality. Indeed, opponents of the ERA suggest that women possess a greater degree of equality now than when Alice Paul wrote the ERA, making the need for such a bill a moot point. Significant social fears have been also been cited as reasons for the failure to enact the ERA. Opponents argue that the equality afforded by the ERA would result in including issues such as women in military combat positions, abortion, and homosexual marriage (D'Agostino, 2001). Schlafly and other opponents convinced women that the ERA would actually detract from their quality of life. She argued, "The Equal Rights Amendment would force us to pretend there are no differences between men and women at any time, anywhere…[so] the first thing that would happen would be registration for the draft" (D'Agostino, 2001, p. 12). Schlafly's statement reflects the underlying issue that fuels the ERA debate - the question of how women's roles are defined in our society (Scott, 1985).

Surprisingly, there were opponents who favored the sentiment of Constitutional protection of equality, but disliked the amendment. Arguing that the bill would not possess judicial authority, these feminists proposed there were other options to secure women's rights and did not join the fight (National Organization for Women, 2002). While conservatives like Schlafly, as well as other opponents, can easily be blamed for the defeat of the ERA, NOW and other groups point to the financial agendas of corporate America as a major deterrent, proposing that because of their "[concern…about underwriting costs], a silent lobby of insurance and big business interests… used their influence to kill the ERA…" (Baker, 1999, p. 56).

14th Amendment Woes

Those who oppose the ERA frequently appeal to the 14th Amendment as the basis for equal treatment of all people in this country. They argue that the 14th Amendment provides ample protection for everyone, and that failures of the 14th Amendment to provide

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[2] At the time the litigation began, Judge Callister held the high office of Regional Representative in the hierarchy of the Church of Jesus Christ of Latter-day Saints (Mormon Church), an institution that officially opposed the ERA.

equality would only be weakened with the addition of an amendment specifically protecting women. Ironically, the very same opponents who make the argument that the 14th Amendment is sufficient to protect women's rights are often the dissenting voices for interpretations of the 14th Amendment that actually guard the rights of women. For example, in a discussion about the Supreme Court's decision to admit women into the Virginia Military Academy based on the 14th Amendment, Steve Forbes asserted:

> The High Court's rigid, one-size-fits-all approach to public education misreads the 14th Amendment's equal protection clause. That principle doesn't mean that every school has to be the same. It means that students must have equal access to a publicly financed education from kindergarten through high school, as well as equal opportunity to receive advanced education from a state-supported college or university (Forbes, 1986, p. 26).

Another argument against the ERA in light of the 14th Amendment is that there is no assurance that justices who adhere to sexual stereotypes will apply the ERA more thoroughly than they apply the 14th Amendment. Author Wendy Kaminer argues: "[Justices] can always find that some discriminatory laws merely reflect the natural order, which [the] law is presumably powerless to challenge. [For example,] the Supreme Court once held that prohibitions on female lawyers were only natural" (Kaminer, 2001). The question her point raises is whether the 14th Amendment is specific enough to protect women against shifts in public morality. In a legal system where rulings get overturned and justices leave their positions, without more specificity in the Constitution, the rights a woman enjoys today may be removed tomorrow.

In considering the issue of the 14th Amendment versus the ERA, it is important to emphasize that social and economic conditions are more favorable for women today than at any other point in American history. Thus, the question arises, "Is the ERA obsolete?"

Is the ERA Obsolete?

In 1977, when it looked like the ERA was going to pass, opponents warned that certain laws, such as divorce, child custody and child support, would be impacted (Myricks, 1977). For example, Myricks proposed that in divorce proceedings, customary maintenance payments to women would be deemed unconstitutional because either sex would have the right to

maintenance. He also predicted that child support would be the equal responsibility of both husband and wife, and that child custody would be open to both parents. Additionally, he asserted that property ownership would be affected because women's non-monetary contributions to the home would bear more weight, and property division would be based on all marriage acquisitions fully belonging to both parties. Women would also gain rights of consortium, he argued, and could sue for the loss of the love/affection on a civil level as men had already been allowed. In instances of divorce where desertion is declared because the woman no longer chooses to live in the same domicile as her husband, Myricks said that the ERA would invalidate the desertion argument because a woman is not bound to her husband. Moreover, he suggested that states with more archaic laws that genderfied roles and responsibilities would lose power to enforce their laws (Myricks, 1977).

The point to be argued here is that the laws identified as vulnerable to alteration with the passage of the amendment, have changed even without the passage of the ERA. Additionally, women today are serving in the armed forces in more specialized and combat roles, as well as holding more public offices and high-ranking positions in corporate America (Myricks, 1977). Furthermore, Congress has acted on behalf of women without the ERA, as evidenced in 1964 when Title VII of the Civil Rights Act barred private job bias by race and sex. Indeed, the Supreme Court has been interpreting the Constitution in favor of women for several decades now without the ERA. In 1971, the Court first cited the 14th Amendment to overturn sex-biased law. Additionally, the 1973 Roe vs. Wade decision legalizing abortion has been maintained, workplace sexual harassment was declared illegal in 1986, and the Virginia Military Academy was ordered to admit a woman for the first time in 1996 (Baker, 1999). These cases lend credibility to claims that the Supreme Court has enacted a de facto ERA and convince some people that we do not need the ERA (Baker, 1999).

Why We Need the ERA

There is a façade of equality in our society today that leads individuals to believe that gains in pay equity and employment opportunities for women means there is no need for the ERA. The myth is, essentially, that women are just fine now. The reality is starkly different. In fact, women are the victims of severe inequality in three specific areas – economic disparity, discriminatory practices, and personal liberty.

Economic Disparity

According to the Institute for Women's Policy Research (2001), women earn $.76 for every dollar a man earns, resulting in an average loss of $4,205 per year for married women and their families, not to mention the increased hardships for single mothers. Five myths are used to justify women earning less than men:

> Myth 1 – A working mother's wages are not necessary for her family's survival.
> Myth 2 – A working mother is unreliable.
> Myth 3 – Large numbers of working women leave the workforce to return home
> to raise their children.
> Myth 4 – The cost to business of providing benefits to working mothers is prohibitive.
> Myth 5 – Women are doing better economically (Karger & Stoesz, 2002).

It was startling to discover that in our own field of social work, a profession committed to equality, males still earn substantially more than their female counterparts (Gibelman, 1995). This unfortunate reality reinforces the fact that pay equity is a widespread problem with far-reaching financial consequences for women. Poverty among women is compounded by the lack of economic parity. The U.S. Census Bureau (1998) claims that 22.6% of women live in poverty, and the number increases to 29.9% in female-headed single-parent homes. Lower earnings over a lifetime both prohibit the acquisition of wealth during working years and lower women's retirement income because it is based on past earnings. The statistics speak loud and clear: Nearly one in every seven women aged 75 and older is poor, and the overall poverty rate in our country is nearly twice as high for women as men (U.S. Census Bureau, 1998).

Discriminatory Practices

Ruth Ginsburg, while a Columbia law professor, made a case for the ERA by arguing that there is no incentive to overhaul laws that discriminate on the basis of sex without it (Baker, 1999). This applies to more than just job discrimination; a study on housing discrimination showed that of the approximately 12,000 cases filed annually, the majority were women and single mothers (Smith, 2000).

Within the broader category of discrimination is the practice of "window dressing," where women are appointed or positioned into roles of equality to hide broader discrimination (Karger & Stoez, 2002). This factor has to be considered when interpreting statistics that show an improvement in women's occupations, but does not detract from the appropriateness of the women who hold such positions.

Personal Liberty

The women's movement has always been associated with a demarcation from social norms, and as such, has been controversial. What we know from history is that times change. We would no longer dare justify slavery, though there were moments in our past where emancipation was considered to be a ridiculous notion.

Freedoms offered to women via legal cases such as Roe vs. Wade do not necessarily indicate women will always be afforded these liberties. Supreme Court cases can be reviewed and overturned, and the rights a woman has today may not be rights tomorrow. A constitutional amendment would help ensure that this instability of rights would not happen. In this sense, the ERA is not only a determiner of future rights, but also the guarantor of existing rights.

The Next Step

Presently, the ERA is introduced every session to Congress and finds itself buried in committee. The bill, although technically expired as of 1982, can still be implemented based on the precedent set by the court's acceptance of the re-introduction of another amendment, the 27th Amendment for congressional pay raises. Many proponents of the ERA are calling for changes in the language of the bill that would reflect the current state of affairs. For example, NOW did not push to include abortion and gay rights in the bill originally, but would like to see these issues included in future revisions. They argue that expanding the issues included in the amendment will lend itself to acquiring a broader base of supporters (Baker, 1999). Others argue that to enhance the chances of the ERA passing, its best to maintain the language of the original legislation, and that the addition of issues such as abortion and gay rights will only complicate the matter and insure that it will not pass (Baker, 1999).

Conclusion

The ERA is a policy that seeks to protect the majority of this country from economic disparity, discriminatory practices, and threats to their personal liberty. The amendment would help insure the exercise of individual freedom, and for this reason it is essential that social workers become a part of the fight. The principles underlying the ERA, self-determination and

the innate worth of the individual, are bedrock values of social work, further requiring us to respond. To be silent on this issue is to be complicit in the unequal treatment of the majority of this country, and to betray the essence of who we are professionally.

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Scott Smith completed his first year in the MSW program. His second-year field placement will be at John Hersey High School.

Going to the Movies With the Theorists:
An Analysis of Love Relationships in Film

by Keeley Cultra and Mandy Harris

Abstract

The love relationships depicted in three contemporary movies are analyzed using the theories of Sigmund Freud, Margaret Mahler, Erik Erikson, and John Bowlby. The application of these theories to romantic relationships in film provide a more thorough understanding of both the movie relationships and the developmental theories of these prominent theorists. The authors utilize personal observation and published literature to apply the theories to each relationship within the three movies.

Welcome to the Movies

The vicissitudes of love are often the focal story in film, and in this edition of *Going to the Movies with the Theorists,* we have invited four renowned psychoanalytic theorists to analyze love relationships in film from the perspective of their theories. The movies we have chosen for their critical review are *The Bridges of Madison County, Leaving Las Vegas,* and *Carrington.* So sit back, get comfortable, and savor this most stimulating conversation about the many meanings of love from some of the top relationship experts in modern history.

The Critics: A Brief Introduction

Sigmund Freud is the forerunner for the theories of our other movie reviewers and made significant contributions to the fields of psychology and social work with the development of the psychosexual stages of development. He utilizes the psychosexual stages of development to describe the various phases of life and the influences of the aggressive and libidinal drives on all individuals. In particular, Freud is known for his concept of the Oedipal stage in which a young child falls in love with the opposite-sex parent and then must reconcile those urges as a normal stage in development. Freud described the difficulties that individuals may have in different stages of their lives, which may cause them to become fixated at a particular stage and struggle to continue their psychological development (Berzoff, Flanagan, and Hertz, 1996). It is with these concepts that Freud will shed light on the relationships depicted in our three movies.

Erik Erikson is a very well-known theorist within the fields of psychology and social work. He also considers himself to be a lifelong lover of the movies. In Erikson's viewing and analysis of the three movies in question, he used the psychosocial stages of development he devised in conjunction with Freud's psychosexual stages of development. Erikson identified specific developmental events, key conflicts, and strengths that arise in each stage of life (Berzoff et al., 1996). His theory allows for a more complete understanding of the journey that we all must take throughout our lifetimes, as well as the strengths that we gain as we navigate each stage of life. Erikson will discuss the misfortune of the characters in the movies who, at times, become lost or stranded within the earlier stages of their development, leaving them unable to move forward.

Margaret Mahler is an object relations theorist who primarily postulated how individuals make attachments to others, internalize these attachments, and develop into autonomous persons through the processes of separation and individuation. These processes, although distinct from one another, together lead to the psychological birth of an infant. Mahler equates independence and autonomy with health and maturity. She defines separation as a process by which a young child moves away from the mother and learns to experience him or herself as a separate and unique entity. Through the process of individuation, a child comes to realize him or herself as an individual possessing unique qualities. In addition, Mahler described a series of phases within the separation-individuation process that coincide with specific periods in the child's life and relate to the psychological maturation of the child (Berzoff et al., 1996).

John Bowlby, the last of our fine movie reviewers, is well known for his theory of attachment. This theory outlines the primary importance of the attachment relationship between an infant and the primary caregiver, who is typically the mother. As an ideal, Bowlby suggests that within this relationship the child is provided with a safe and loving foundation in life, as well as the opportunity to discover and develop skills for the other relationships within the child's lifetime. Unfortunately, and as depicted by the characters

within our three movies, these attachment relationships may be dysfunctional or become strained, providing the easily influenced child with a negative perspective on relationships. Therefore, in the end, the attachment relationship may yield individuals with secure, anxious/ambivalent, or avoidant tendencies within their relationships (Berzoff et al., 1996).

The Movies

The Bridges of Madison County

The Bridges of Madison County is based on the novel by Robert James Waller, and was filmed in small town Iowa. The story is based on the simple life of a farmwife, Francesca, who has lived her life as expected. She has a fine husband who supports the family and two children. However, one summer she finds herself alone for a long weekend as her husband and children travel to the Iowa State Fair. It is during this brief period of time that Francesca's life is turned upside-down when she meets a traveling photographer by the name of Robert Kincaid. In him she finds her soul mate and must make a decision about her future that threatens to tear apart the very foundation of her life.

Margaret Mahler, Object"ive" Movie Critic

The Bridges of Madison County takes place on a dusty farm in the middle of rural Iowa. It is the story of the brief, albeit heated, affair between Robert Kincaid, a National Geographic photographer, and Francesca, a housewife who, although surrounded by a loving husband and two children, secretly yearns for "something more" in her life. Something more knocks on her door one summer day in the form of Robert, who is in the area taking photos for a series on the unique covered bridges of Madison County.

Although a reasonably healthy chap, and a member of what is certainly the healthiest of the dyads in the films under review, it appears at the onset of the film that Robert has not yet achieved object constancy, an extremely important capacity typically attained between ages two and three. Such a competence would render him capable of providing himself with self-soothing in the absence of Francesca, the love of his life. During their brief relationship, Francesca bestows upon him a pendant given to her by her grandmother in Italy. The pendant serves as a transitional object for Robert and he wears it for the rest of his life, as evidenced in the National Geographic photograph Francesca's children discover

after her death. Viewers may remember that young children in the pursuit of object constancy often use transitional objects to help them retain the warm, positive memories of their mothers in her absence.

It seems as though Robert and Francesca have both reached object permanence, which is a similar capacity, but a purely cognitive one originally discussed by Jean Piaget. This is substantiated by the manner in which the pair is able to discuss, with vividness, a small café located in Francesca's hometown in Italy that Robert once visited on assignment. As the movie progresses, however, the thought occurred to this author that perhaps they both successfully manipulated the entire separation-individuation process, including the achievement of object constancy, as they are able to retain their love for one another for the remainder of their lives, even though they never again correspond with each other. They are each able to develop a healthy self-object of the other that sustains them.

John Bowlby, "Attached" to the Movies

Viewers, be prepared for the powerful message portrayed by the relationship between Robert and Francesca. These two dynamic characters illustrate a relationship that is the result of a secure attachment and avoidant attachment, and it packs quite the emotional punch (Santrock, 1998).

Francesca is a farmwife in rural Iowa whose life is primarily focused on the care of her husband and children. Francesca enjoys a friendly and trusting love with her husband and, although the relationship does not provide much excitement, she accepts and supports her husband fully. It appears that Francesca has had the pleasure of participating in secure attachment relationships both in her adulthood and her childhood, in her tendency to express both her passionate and selfless love without self-consciousness (Santrock, 1998).

Robert, the visiting *National Geographic* photographer, on the other hand, illustrates an avoidant attachment style. He describes his tendency to avoid lasting relationships with all people, as he tends to move around frequently for his job. He expresses no regret for the loss of connection with people, and explains that he has never felt the need for emotional relationships in his life. In fact, he appears to harbor a desire to avoid the vulnerability and risk that is part of the true emotional connection between people. However, he soon finds the desire and need for them in his growing attachment to Francesca.

Robert and Francesca engage in a heated love affair

in which they experience the true depths of intimacy, passion, and commitment as part of their secure attachment to each other. In the end, after their few days of freedom to be together, it becomes necessary to end their relationship as Francesca chooses to stay with her family in Iowa rather than leaving with Robert. Although it is difficult, both Robert and Francesca are able to say good-bye knowing that they will forever be in each other's hearts and minds. It is their secure attachment to each other that defines the rest of their days, although they do not find it necessary to be together to hold that love in their hearts (Santrock, 1998). The viewer may be saddened by Robert and Francesca's separation in life, but may find solace in the joy that their secure attachment bestowed upon them in their brief time together.

Erik Erikson, Lifelong Lover of the Movies

Robert and Francesca are clearly the healthiest pairing of these three films, but even they have their fair share of obstacles to overcome in their relationship. Robert appears to be experiencing a fixation at the stage of young adulthood when "intimacy vs. isolation" is the normative crisis. Robert very clearly defines his life in terms of his isolation from others, and even goes so far as to explain that he prefers to maintain his isolation as opposed to creating emotional connections with others. Robert seems to have gone the route of exclusivity in which he believes he is the only person he needs in order to survive as a social being (Bendicsen, 2002).

Now Francesca is a woman after my own heart. She does not appear to be fixated at any stage of the psycho-social model, and seems to be addressing her current stage of middle adulthood and its normative crisis of "generativity vs. stagnation" with determination and commitment. Francesca understands that her family needs her but also that she needs them as she finds meaning in her life as a mother and wife. I feel quite certain that despite her longing for Robert's continued involvement in her life, she will find satisfaction and contentment in the crises she has overcome and the virtues she has attained (Bendicsen, 2002).

"Bridges" is a worthwhile film to see in its clever depiction of an illicit affair with the clear message that there are basic expectations of individuals at each stage of their lives. In fact, what could be a better mental image of the connections between the various stages of life and the journey that these stages take us on than the beautiful covered bridges and roads of rural Iowa (Bendicsen, 2002).

Sigmund "sex, stages, and videotapes" Freud

The Bridges of Madison County is a passionate display of love in its most primal form. The characters experience a neurotic type of love. Robert's love for Francesca fits the necessary compulsive preconditions I suggested in *A Special Type of Object Choice Made by Men.* His love object "belongs" to another man (her husband), she has a poor sexual disposition (she sleeps with Robert, who is, in effect, a total stranger), and he feels a twinge of jealousy at the idea that she will be sharing her life, love, and body with her husband for the remainder of her life. He, therefore, wants to rescue her from her existence without him and take her to all of the world's exotic places (Bendicsen, 2002). According to my drive theory, such neurotic anxiety is experienced as guilt due to the repression of sexual or aggressive wishes, memories or fantasies that are kept out of consciousness. He therefore developed this neurosis due to a conflict between the id and the superego that the ego was ill equipped to mediate (Berzoff et al., 1996).

Leaving Las Vegas

The movie *Leaving Las Vegas* depicts the tortured lives of Sera, a prostitute, and Ben, a suicidal alcoholic. It is in their very darkest moments that they find each other and become involved in a relationship that is originally based on their own selfish needs for superficial human contact. However, with time, Sera finds herself becoming genuinely attached to Ben and commits herself to him despite his continued efforts to end his life. Sera's decision alters her life forever, and poses the ultimate question of whether she is willing to risk it all for love regardless of whether that love is then returned.

Margaret Mahler, Object"ive" Movie Critic

Leaving Las Vegas is the tragic tale of Sera, a professional prostitute, who meets Ben, who is recently unemployed and alcoholic. Viewers will find the characters to be interesting case studies in the process of separation- individuation. I surmise that Sera is too individuated at the beginning of the movie. Viewers will notice the way in which she is able to remove herself from the men she sleeps with. She allows herself to be present with them in a very physically intimate manner, yet totally compartmentalizes her emotions in a separate and safe place so that she can perform without damaging her inner being. After meeting Ben, however, she is able to work through her separation-individuation fixation and indeed, develops a

strong attachment to Ben, even though he is unable to reciprocate. This experience with Ben forever changes Sera. He unconsciously helps her to work through her inability to cohere and as a result she gains the capacity to invest emotionally in her relationships.

Her partner Ben, on the other hand, has not developed the ability to successfully exist alone. He is not able to distinguish between being alone and being lonely (Berzoff et al., 1996). Viewers are left wondering if his family left due to his drinking habit, or if he has resorted to drinking because his family has left. He decides to go to Las Vegas to drink himself to death, believing he has nothing left to live for. And even then, he cannot exist on his own. He hires Sera, a prostitute, to keep him company, to talk with him, and simply to be near him to ease his pain. Viewers may anticipate Ben falling in love with Sera and learning to co-exist with her due to the neediness he exhibits at the onset of the film, but I am afraid they will be sorely disappointed. This movie does not have a happy ending, folks. Ben has established firm boundaries on the level of intimacy with which he is able to involve himself. Just when Sera lets down her guard and begins to love him unconditionally, he pulls away. He makes it apparent that he is not capable of providing her with the emotional nourishment she craves. As a result, Sera is forever changed. She is now able to invest emotionally with other people and, in all probability, will have to change her way of life.

John Bowlby, "Attached" to the Movies

This movie is an excellent example of dysfunctional attachment styles, and the ways in which an attachment style can impact the relationships throughout an individual's lifetime. The main character, Ben, provides an example of an ambivalent attachment in that he seeks out a relationship with the prostitute, Sera, and does appear to desire a secure relationship. However, he sabotages this desire by pursuing other superficial relationships, which create an environment in which his original ambivalent attachment relationship is repeated. In other words, Ben's relationship with Sera is centered on the physical and tends to avoid the establishment of true commitment and intimacy in favor of maintaining the trivial nature of the relationship.

Sera, on the other hand, illustrates an avoidant attachment in that she strives to maintain distance between herself and the individuals who come into her life. Her relationship with Ben, in which she willingly cares for him and sacrifices to support him, appears to be a first in her life. She describes her abil-

ity to both maintain distance and control the other men she encounters and interacts with, but she experiences an immediate connection with Ben and that leads her to take the risk of allowing herself to be more intimate and committed than she has been in any other relationship.

In the end, Ben is unable to offer anything more in the relationship than his ambivalent attachment and exits both his life and the relationship with the same ambivalence that appears to characterize his entire life. Sera is left behind to pick up the pieces of her life with the realization that she has both participated in the first real relationship of her life and that it is not possible for her to return to her previous lifestyle of detachment after having been involved in her first true emotional exchange. This movie is effective in its illustration of the sadness and joy that is part of many loving relationships, but will surely leave the viewer with a saddened heart.

Erik Erikson, Lifelong Lover of the Movies

The two main characters in this film have very clearly become fixated in different stages of development, and illustrate the desperate results of people who follow a damaging path. Sera is fixated in the genital stage, which is based on the normative crisis of "identity vs. identity diffusion or role confusion." Sera is clearly unsure of her identity and how her role is related to others in her life, and has simply complied with the paths that have been laid before her. She became a prostitute because she was capable of doing the job with little emotional attachment, and simply did not have a preference as to the paths or identities that she took on (Bendicsen, 2002).

Ben, on the other hand, is fixated in the latency stage, which is focused on the normative crisis of "industry vs. inferiority." Ben illustrates the experience of inertia in which an individual experiences a lack of action or thought that hinders productivity. Ben avoids the process of completing tasks or addressing his duties in favor of drinking himself to death. He truly demonstrates the futility of life that can result when an individual doubts him or herself, and simply does nothing at all to avoid the experience of failure (Bendicsen, 2002).

The one bright spot in this film can be found in the realization that Sera has perhaps gained a sense of identity in the course of her relationship with Ben, but the tragedy is paired with this realization in that her role of caretaker is no longer necessary. Ben has completed his one task of killing himself, and leaves her unfulfilled yet again. This is truly a dark film that

will leave the viewer with a feeling of incompleteness (Bendicsen, 2002).

Sigmund "sex, stages, and videotapes" Freud

Leaving Las Vegas is the heartbreaking tale of Ben, a former Hollywood executive, who, after losing everything significant to him, travels to Las Vegas to spend his remaining days with alcohol, the only thing that has remained faithful to him. He intends to spend his time in solitude, but discovers that his id impulses to drink and otherwise satisfy his libidinal and aggressive drives are powerfully restrained by his ego and he consequently experiences a need for companionship. In his quest for camaraderie, he meets Sera, and hires her to simply keep him company rather than engaging in the sexual acts which she is typically hired to perform.

Ben's motivation for employing Sera is an interesting display of narcissistic love (Bendicsen, 2002). Ben seeks in Sera a person similar to himself, who, beneath all of her self-destructive habits, harbors a great deal of sadness as a result of significant losses in her life. Furthermore, he sees in her characteristics that he would himself like to possess. Sera is able to separate her emotions from her daily acts and does not allow herself to be dependent on other people, because experience has proven to her that such reliance on others always results in hurt and betrayal.

Carrington

The movie *Carrington* offers viewers a glimpse into the complicated relationship between artist Dora Carrington and writer Lytton Strachey. Dora Carrington is a headstrong woman who is known for her single-mindedness in attaining her desires, which becomes heightened when she makes an acquaintance with Lytton Strachey. The two creative individuals are instantly attracted, although their desires for intimacy within their relationship are clearly conflicting. Similar to the issues raised in *Leaving Las Vegas*, the two characters are forced to address the question of whether they are able to commit selflessly or otherwise to a relationship, regardless of the return on that commitment and love.

Margaret Mahler, Object"ive" Movie Critic

Carrington is a movie depicting the unconventional relationship between the early 20th century painter Dora Carrington and the gay writer Lytton Strachey. Ms. Carrington was a gifted artist who, seemingly, devoted her life to Strachey. It is evident that Carrington had a traumatic early childhood. She is unable to

exhibit either appropriate object constancy or self-constancy, as indicated by her inability to physically separate herself from Strachey. Self-constancy, a complement to object constancy, enables an individual to think of him- or herself as a separate being and to develop a core identity. Carrington did not have the capacity to imagine herself as an individual separate from that of her dear Strachey. Throughout her life, she was unable to find a man who satisfied her intellectually and emotionally as much as he did, although she had numerous (albeit usually brief) sexual relationships with men. She felt her greatest role in life was as Strachey's partner. She coddled him in extreme ways; she bathed him, covered her walls with paintings of him, refused to live separately from him; she ultimately found life without him to be too overwhelmingly painful and took her own life.

Strachey, by comparison, appears relatively healthy with regard to his separation-individuation. During most of the movie, he is extremely separated and individuated. Although viewers may admire the manner in which he is able to individuate himself, they will notice that for most of his life, he is too separated from the people with whom he interacts. He exists rather in his own world and is his own unique personage who doesn't seemingly rely on anyone. The truth of the matter is that he is extremely dependent on the undivided love and attention he receives from Carrington, and actually manipulates her into pampering him as she does. He perpetuates her tendency to idolize him throughout their years together. At the end of his life, Lytton becomes much less separated and much healthier. It appears that he regrets many of the decisions he has made, including taking advantage of Carrington's admiration of him and not expressing his love for her. His deathbed confession and the loving letter he sends her provide evidence of this.

John Bowlby, "Attached" to the Movies

The relationships that comprise this dramatic film are an example of attachment styles at their most emotional. The main character, Dora Carrington, is a female artist who is known to avoid intimacy and passion in her relationships in an effort to maintain the protective distance that offers her a degree of emotional security, and thus depicts an anxious/ambivalent attachment. She attempts to engage in several committed relationships with men, but finds herself in a position of conflict as a result of her unwillingness to incorporate physical intimacy and passion into these relationships. It is not until her relationship with Lytton Strachey, a renowned writer of the times,

that she iss willing to consider a relationship of more than an intellectual nature. However, she, very much like Ben of *Leaving Las Vegas*, insures that she will continue her pattern of anxious attachment in that Strachey was a homosexual man and not desirous of her affection. Carrington maintained her attachment to Strachey throughout both of their lives. As a result, she was always unsure of her emotional security because Strachey continued to pursue other relationships and attachments.

Lytton Strachey was another example of anxious/ambivalent attachment in the constant anxiety he expressed over the consistent presence of his love interests in his life. At those times in which it became possible that his love interest was going to cease to be a consistent presence, he would take any course of action necessary to preserve his relationships. He could be quite manipulative in his efforts to maintain the relationships he held most dear, but was also known to sabotage himself in his relationships with his distancing behaviors and quick temper.

The pairing of two individuals who primarily relate to others with an anxious attachment style made for a volatile relationship. Both Carrington and Strachey gained a great deal of support and love from each other, but it was never a relationship in which either individual felt secure or stable (Santrock, 1998). It is a relationship best described as having missed the boat in the fulfillment of basic attachment needs. However, if you're looking for a movie with drama and the true human experience, then look no further!

Erik Erikson, Lifelong Lover of the Movies

Dora Carrington and Lytton Strachey provide quite an interesting study of the psycho-social model in their numerous idiosyncrasies and the roles they assume throughout their lifetime. Dora Carrington seems to be fixated at the Oedipal stage with a normative crisis of "initiative vs. guilt," which plays out in her various interactions and relationships with men. Carrington is quite unsure of the roles she should assume around or with people, and as a result tends to simply act or do as others wish. She may have gained the inhibition that can result from an inadequate completion of this stage, which is "the experience of guilt that leads to a psychological restraint of thought, expression, and activity" (Bendicsen, 2002). In her relationship with Lytton Strachey, Carrington struggles with the conflict between the roles he wishes her to assume and the roles he expects her to decide upon for herself. Essentially, Carrington insures that the patterns of relationships and roles that she has experienced throughout her childhood and young adulthood continue into her later life.

Carrington's love interest, Lytton Strachey, is an example of a fixation at the anal stage with a normative crisis of "autonomy vs. shame and doubt." Strachey has clearly gone to the extreme of legalism in which he is quite self-righteous and has a tendency to exploit others for his own gain. For example, Strachey informs Carrington that she must marry his love interest, who is threatening to leave them both, or he will leave as well. Strachey is aware that Carrington will do as he pleases, but he simply views it as necessary to attain his own desires. In fact, Strachey has truly found the ideal situation in that he can manipulate the environment to suit him without an argument from Carrington (Bendicsen, 2002).

This movie is quite dramatic in its portrayal of such fixations and the lasting results of such behaviors, but we must all remember the seriousness of working through each stage of life. Just let Carrington and Strachey be a reminder to you of this very important lesson (Bendicsen, 2002).

Sigmund "sex, stages, and videotapes" Freud

The movie *Carrington* depicts the lives and loves of Dora Carrington, an early 20th century painter, and the primary object of her desire, Lytton Strachey, an eccentric writer and critic. It exemplifies perfectly my theory of the psychosexual stages of development. Doris Carrington had a tumultuous relationship with her mother and a very close relationship with her father. She is obviously fixated in the Oedipal stage because she was unable to resolve her Electra complex at the appropriate time in her development (Austrian, 2002). Carrington devalued her mother and harbored a great deal of animosity towards her for not providing her with a penis. She felt a profound sense of loss at not being able to experience the privilege associated with being male and was cognizant of the low value placed on the intellectual, cultural, and artistic contributions of women compared to those of men. As a result of this overwhelming sense of castration, Carrington never forgave her mother, nor was she ever able to identify with her mother and unleash her penis envy. Therefore, she did not develop many traditionally feminine traits, as is quite apparent by the masculine manner in which she dresses and fashions her hair. Because it is at the Oedipal stage of development that a child's moral conscience emerges, Carrington clearly has not developed a proper conscience that could provide her with an internalized set of moral principals.

Furthermore, Carrington suffers form poor ego control, as is witnessed in the scene in which she engages in sexual relations with her husband's best friend with her husband only yards away fishing. She is unable to understand why her suitor is disturbed by her husband's proximity and the possibility of being discovered. Apparently, her ego has not developed sufficiently in order that her id impulses are moderated, and her sexual, id-driven urges are thereby permitted to assume control.

The true object of Carrington's affection is Lytton Strachey. Although he adores Carrington, he is unable to provide her with a relationship on the level that she seeks. Contrary to the popular belief of our time, I believe that he was born bisexual as all humans are. His homosexuality developed during early childhood as a result of a strong mother and a weak or absent father. He developed the exclusively male type of homosexuality as a result of an unresolved pre-oedipal conflict, that is, the unsuccessful negotiation of the separation-individuation phase of early childhood. This, of course, is counter to the "partial homosexuality" that develops as a result of a fixation in the later part of the Oedipal phase (Current theories of the genesis of homosexuality, para 3; and Environment does not cause homosexuality, para 6).

Conclusion

As evidenced by these movies reviews, not everything ends so happily ever after. But it sure gives us plenty to analyze. Thanks for joining us at the movies.

~ The End ~

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Keeley Cultra has completed her first year in the MSW program. She interned last year at St. Mary's of Nazareth Outpatient Behavioral Health Center. Her second-level field placement will be at Taft High School. She has worked in the field of child welfare in Chicago for the past seven years.

Mandy Harris has completed her first year in the MSW program. Her first-year field placement was at the Juvenile Protective Association and her second field placement will be at The University of Chicago Hospital in adult oncology.

Dissertation Abstracts

Congratulations and best wishes to Joann Beathea on this significant accomplishment! The dissertation topics continue to represent the diversity of interests and the commitment of clinical practice of our Ph.D. students. Dissertations are available in the faculty lounge at the School of Social Work and at the periodical desk on the 8th floor of Loyola's Lewis Library, 25 E. Pearson.

Now Think About That!:
Understanding Aggression of African American Women on Probation and Parole

Carol Joann Grady Beathea, Ph.D.

Few studies exist which offer understanding about aggressive acts of African American women probationers/parolees from the women's perspectives. This is a qualitative study using oral history and ethnographic methodology to explore the motives and subjective meanings leading to criminal activity of 13 African American women on probation/parole.From a focus group retreat and 13 individual interviews, the women in this study have broken their silence to share their life experiences, which have affected their decisions to engage in criminal behaviors toward others and themselves.Some women experienced the motives to engage in criminal activity as means to cope with poverty. Others experienced the motives to engage in the criminal acts as produced by an alien self-experience outside of their self regulatory control. The comprehensive psychology and philosophy of mind Intrapsychic Humanism was used as the guiding theory.

In general, the results indicate serious and unrelenting trauma throughout childhood, and a notable lack of any relationship with a responsible adult who valued and stably nurtured them. In their attempt to adapt to the devastating inner pain produced by child abuse plus neglect in the context of deprived, violent, and corrupting environments, the women in this study developed both conscious and unconscious motives for pathological pleasure and motives for painful experiences. The results also disclosed that the overriding conscious desires of the participants were to fit in with others, provide for themselves and their children, to be cooperative with a significant partner, to be loved by their caregivers and to be cared for, protected and defended by family and society. The findings suggest that helping professionals who work with minority clients may need to understand that any change for the betterment of society begins by tapping the inner resources in individuals through a caregiving relationship with them.