TECHNIQUES AND GUIDELINES FOR SOCIAL WORK PRACTICE, 7/E

The colors in this document are not
an accurate representation
of the final textbook colors.

c h a p t e r   5

The pages of this Sample Chapter may have
slight variations in final published form.

Part V Specialized Techniques and Guidelines for Social Work Practice

Most of the techniques and guidelines described in prior sections of this book could be used by almost any social worker, in almost any social work position, in almost any human services agency. In addition to the generic tools of the social worker's trade, specialized knowledge and skills are required for some social work practice activities. Part V concludes the book with two chapters on these specialized aspects of social work.

Some client groups require special sensitivity by the social worker. For example, unique insight and understanding is required to help a client deal with the devastating impact of poverty, to serve a client who has been battered by a spouse, or to carefully assist a client who is at risk of committing suicide. Clients from different age groups call for special sensitivity, too. Working with a child or adolescent requires knowledge of developmental factors and communication skills that are unique to young people, and at the other end of the age spectrum, older people also have unique needs that a social worker should recognize. These and other client conditions (e.g., cognitive delay, brain injury, physical disability, chemical dependence, serious mental illness, eating disorders) are often encountered in social work practice. Chapter 15 identifies guidelines for working with clients experiencing these circumstances and conditions.

Another set of specialized guidelines can help the social worker obtain employment and have a satisfying and productive experience as a social worker. Chapter 16 presents guidelines that will assist the worker in dealing with the demands of a social work job. Items about managing stress, preventing worker burnout, working within and coping with life in a bureaucracy, and giving and using supervision can improve a worker's effectiveness and efficiency. In addition, there are guidelines for performing the challenging tasks of testifying in court and dealing with managed care. And given the times in which we live, items on dealing with sexual misconduct and avoiding malpractice suits have been included, as well. Finally, to support the social worker in carrying out his or her professional obligations, this chapter provides guidelines for consuming and contributing to social work knowledge, improving the social work image, and becoming a leader in the human services.

15 Guidelines for Working with Vulnerable Client Groups

INTRODUCTION

Social workers practice within a wide variety of settings, and consequently, they encounter a wide variety of clients with a wide variety of concerns, problems, and requests. Although it is not uncommon to find that many of the clients served by a particular agency or program have the same presenting problem, each client is an individual and will react to his or her situation and to the social worker in a unique way. Thus, social workers must always adapt their approaches and techniques to the special needs, characteristics, and circumstances of the clients they serve.

For this chapter, items were selected to illustrate how a social worker might adapt his or her approach to the client by providing information on several different client groups and offering guidelines for addressing the special needs, characteristics, and challenges presented by each group. By comparing the approaches recommended for these diverse client groups, the reader will come to a deeper appreciation of why direct-service practitioners, as well as those who design and administer programs, must always consider the uniqueness of the clients they serve. In addition, the reader will understand more clearly why an approach that works well for one group may not be appropriate for another.

15.1 The Client Who Is Poor

PURPOSE: To adapt direct-service approaches to the concerns of persons living in poverty.

DISCUSSION: As a profession, social work has always focused attention on poverty and the difficulties faced by persons who do not have enough resources to obtain the basics of life, such as food, shelter, and medical and dental care. Poverty has devastating effects on individuals, families, and communities. It is a contributing factor to many other problems, such as the breakup of families, violence, crime, substance abuse, suicide, and a multitude of health problems. Poverty is especially injurious to children because they are most vulnerable to the effects of poor nutrition, disease, family insecurity, and social instability.

The causes of poverty are always complex and will vary somewhat, depending on whether one is examining poverty in a first-world, modern country or in a third-

world, developing country. Among the economic forces that contribute to poverty in a developed country such as the United States are recession, downturns in regional economies, widespread job layoffs, shifts in the types of skills needed to secure a job, and rapid increases in the costs of essential goods and services (e.g., housing, electricity, health care). Racism and job discrimination can also restrict the economic opportunities available to whole segments of a population. And in some instances, poverty results from the social dislocation and economic disruption caused by war or political turmoil. Natural disasters, such as floods and earthquakes, can have similar social and economic effects.

Even in good economic times, some individuals and groups are at risk of being poor, including those with inadequate education and few job skills and those who have significant intellectual limitations, a serious mental illness, an addiction, or a debilitating health problem. Moreover, individuals and families who are economically independent can quickly slide into poverty after a tragedy such as a house fire, a serious injury or illness, or the death of the family's breadwinner. People who are elderly and live on a fixed income are also at risk of slipping into poverty whenever there are significant increases in the cost of living.

In the United States, many of those who are poor are the so-called ***working poor.*** They are holding down two or three part-time jobs but not earning an adequate income or receiving important benefits such as health insurance. Many of those living in poverty are mothers and their children. Families headed by young mothers are at particular risk of being poor because many of these women lack needed job skills. Mothers who are raising their children after a divorce are often at risk, as well, because many fathers do not or cannot pay adequate child support. As a group, women with limited education face special challenges; many of the jobs available to them (e.g., waitress, maid) pay low wages, and often the time of work for these jobs is at night or on weekends, when child care is especially expensive and transportation is harder to arrange.

Poverty is fundamentally an issue of social and economic justice. It is always related to the fairness of the distribution of resources and how a society addresses the needs of all its people, especially those who are vulnerable and least able to compete in the marketplace. No matter what the cause—whether primarily individual factors or large-scale economic forces—no person should have to live in poverty. No one should have to go without minimum levels of food, safe housing, medical care, and protection from preventable disease and injury. Social workers, regardless of their practice settings and job titles, have the responsibility to collaborate with others to develop social and economic policies that will reduce the incidence of poverty and directly assist those who are poor.

Social workers who directly serve individuals and families who are poor will find this additional information and guidance useful:

1. When designing or selecting an approach to working with clients who are poor, recognize that once an individual becomes poor, he or she encounters a multitude of forces and barriers that keep him or her poor. For example, in order to get a job, an individual must have appropriate clothing, transportation, recent job experiences, and a permanent address—things that many poor people do not have. A mother who wants to work may discover that the cost of child care will consume

much of the pay she will receive from a minimum-wage job. Working one's way out of poverty requires not only the motivation and the capacity but also the opportunity to do so. It is a slow process that requires planning and methodically executing a multitude of small steps. Changing one's life circumstances is difficult for anyone, but doing so when one is poor is especially difficult given the demoralizing and exhausting effects of poverty. In order to escape poverty, most people need various financial subsidies and the assistance of empowering programs.

2. If you frequently encounter clients living in poverty, you must have a working knowledge of the government programs and private agencies in their communities that may be of assistance. Because the causes of an individual's or a family's poverty are usually multifaceted, the most effective programs are those designed to address an array of personal and family problems and issues. All such programs must be able to address the financial emergencies that are so common among people living in poverty. In addition to providing services for job training, job finding, job retention, and the like, programs must also address common barriers to employment, such as the lack of child care and transportation. Providing access to higher education and technical training is one of the most cost-effective approaches to addressing the problem of poverty among people who are healthy and of working age.

While conventional programs that provide education and job training are needed by and helpful to many who are poor, these programs are usually not sufficient for those people who are also suffering the psychological effects of severe child abuse and neglect, domestic violence, and other traumatic life events. Counseling and therapy must be an essential element of any successful program intended to assist these individuals.

Economic self-sufficiency is certainly a desirable goal and a realistic one for many poor persons. Nonetheless, it is important to recognize that for some individuals of working age, this goal is not realistic because their capacity for work has been severely limited by serious and chronic conditions such as mental illness, mental retardation, brain injury, and substance abuse.

3. Be alert to the fact that existing welfare policies, program rules, and eligibility criteria can be very real barriers or obstacles to people who are in need of assistance and services. *Client advocacy* by the worker is often needed to help an individual secure needed services. *Class advocacy* is also necessary, but the process of changing welfare policies and bureaucratic structures is definitely slow and difficult (see Items 13.22 and 13.33).

4. Understand that a client's views about being poor are important because his or her response to current circumstances, sense of hope about the future, and level of distress about being poor are shaped by his or her prior life experiences and by the people with whom he or she frequently interacts. Among people who are poor, you will find a variety of beliefs, attitudes, and feelings about being poor. For example, an individual who has always been poor will view living in poverty somewhat differently than an individual who had an adequate income for many years before becoming poor. Moreover, a person who lives in a community made up of mostly poor people will view poverty differently than the person who lives in a community where very few people are poor. Some people who are poor, as officially measured by government standards or other objective criteria, may not define themselves as poor.

Unless you understand the client and his or her situation, you will be unable to make informed decisions concerning what options are possible and what might be the best course of action for him or her. To better understand the client's situation, keep the following questions in mind:

- What is the client's specific concern, problem, or request? Is it related to a lack of money or to some nonmonetary concern?
- What are the client's goals, and what needs to happen in order for him or her to achieve these goals?
- What strengths has the client developed in order to survive and cope with his or her very difficult circumstances?
- What personal and family characteristics, situational factors, and economic forces are contributing to the poverty experienced by this individual?
- Was there a time when the client was self-sufficient and making an adequate living? If yes, what happened to change the situation?
- Did the client grow up in a family living in poverty or in a family with adequate economic resources? Has he or she always expected to be poor, or is being poor an unexpected development in life?
- Did the client grow up in a community where many others were poor? If yes, what meaning did he or she assign to being poor, and was that similar to or different from most others in the community?
- Does the individual have family and close relatives who are poor, or is he or she economically different from family and relatives?
- Has the client been abandoned or rejected by family and relatives who are better off economically? If yes, did a problem such as mental illness, substance abuse, or criminal activity contribute to this ostracism?
- Who are the client's sources of social support and everyday assistance? Are these persons also poor?
- What strengths or resiliency factors has the client relied upon to survive and cope with the challenges and stressfulness of living in poverty?

5. Strive to understand the emotional and mental state of the person who is poor. Living in poverty is extraordinarily stressful because so many aspects of a poor person's life are uncertain, unpredictable, and beyond his or her control. This stress gives rise to anxiety, fear, and frustration. Consequently, some people who are poor are quick to anger and resentful toward anyone who somehow makes their life even more difficult. Still others feel hopeless and respond to their circumstances and to service providers with passivity and emotional dependency.

Because the dominant American culture values work, money, material possessions, independence, and outward appearance, persons who are poor are prone to developing feelings of inferiority and shame. They often feel rejected and treated as social outcasts. They may feel guilty about being poor, especially if they are the parents of young children and see that their children are being harmed by their life circumstances. Some poor individuals may cope with these painful feelings by withdrawing from ordinary social relationships. Some may express their embarrassment and resentment by criticizing and tearing down the work and efforts of other people, including those working in programs that attempt to address the problems faced by the poor.

Some of the people who live on the streets or in shelters for the homeless are especially challenging clients. Their economic situation is often interrelated with problems of substance abuse, personality disorders and mental illness, brain injury, inadequate nutrition, and other disabling health problems. Some of these individuals are so immersed in a life-style of day-to-day survival that they approach every relationship in a calculating and manipulative manner in order to meet their daily basic needs. Some become belligerent and aggressive.

Those who are poor must be approached in ways that recognize their uniqueness along with their worth and dignity. It is also important to recognize that a client's sense of frustration and hopelessness, unpredictable life-style, and preoccupation with immediate needs can become barriers to his or her effective use of professionals and human service programs that expect cooperation, adherence to schedules, and follow through on plans.

6. The use of empowerment strategies and the strengths perspective are critically important ingredients in professional efforts and programs designed to help persons who are poor (see Items 11.5, 11.6, 13.9, and 13.23). Those who struggle with the effects of poverty need to tell their stories and come to understand that their circumstances are similar to those of many others. Doing so helps them feel less isolated and more connected to other people. People who are poor need to build or rebuild their self-respect and self-esteem and learn to take control of their lives. This is most likely to occur when they join with others to bring about positive change in their life situations and communities and to advocate for needed legislation, public policies, and programs. As these individuals participate in social and political action, many will learn the leadership and organizational skills and gain the self-confidence that are important to achieving economic self-sufficiency.

7. Identify and arrange opportunities for clients to share their knowledge and skills for dealing with poverty. For example, many who are poor have learned how to be frugal and thrifty in shopping and otherwise stretching their limited resources. Many have located and learned to use various programs and community resources that are overlooked by others. Many are very creative in cooperating with others and working out arrangements that permit several individuals or families to share what they have and to help each other cope. Still others have arrived at profound insights into the human condition and developed a truly inspiring spirituality. These are all important strengths that need to be recognized and, if the client is willing, shared with others who struggle with many of the same issues.

8. Strive to reduce the social distance and power differential between yourself and the client. Do this by looking for opportunities to talk with clients about the very ordinary aspects of life, such as family and friends, interests and hobbies, special times in their lives, and today's experiences. Meet with clients at times that are most convenient for them, possibly in their homes or at their worksites. When it is appropriate to the practice setting, share meals with clients. Also invite them to share their music, art, and other creative skills if you believe it will be a positive and welcome experience for them.

9. Offer people opportunities to shape the programs they utilize and to learn leadership skills by serving on agency boards and advisory committees. People often have a need to express appreciation for help they have received and perhaps even to

reciprocate. If you believe this is important to a particular client, arrange opportunities for him or her to make some contribution to the appropriate program or agency. For example, a client might be eager to do some cleaning at a shelter for homeless persons or otherwise assist other clients. Unfortunately, issues of facility insurance and legal liability may be barriers to arranging reciprocity.

10. Appreciate the fact that the person living in poverty often leads a life of desperation. Frustration can push this person into making impulsive decisions. For example, a mother may buy her child a pair of expensive shoes or splurge on a restaurant meal. Fear and worry over a lack of money can also draw a person into activities that are illegal and that violate their conscience. For example, in an effort to secure money, someone may sell drugs, steal, or engage in prostitution. You will feel frustrated when these choices make matters even more difficult for clients. And while you cannot condone illegal behavior, you must understand why clients make these choices and avoid becoming judgmental or moralistic. Doing so would create a barrier to additional work with the client.

11. Many professionals (e.g., social workers, physicians, nurses, psychologists) admit to feeling somewhat uncomfortable when working directly with persons who live in truly desperate economic circumstances. This discomfort stems, in part, from the obvious fact that the client has so little and that, by comparison, the professional has so much—more than he or she really needs. In addition, the professional realizes that he or she does, in fact, have the ability (i.e., the money) to alleviate this client's immediate financial distress, at least for a few hours or a few days. It is this awareness that tugs on the professional's conscience and sense of fundamental justice. In working with clients who have other types of problems, the professional knows that he or she does not have the ability to bring about such an immediate change. In work with the economically poor, the professional must struggle with the question If I have the ability, do I have the responsibility?

SUGGESTED BIBLIOGRAPHY

Anderson, Linda, Paul Sundet, and Irma Harrington. *The Social Welfare System in the United States: A Social Worker's Guide to Public Benefit Programs.* Boston: Allyn & Bacon, 2000.

Levitan, Sar, Garth Mangum, and Stephen Mangum. *Programs in Aid of the Poor*, 8th ed. Baltimore: Johns Hopkins University, 2003.

Shlomo, Sharlin, and Michal Shamai. *Therapeutic Intervention with Poor, Unorganized Families.* New York: Haworth, 1999.

15.2 The Client Who Is a Child

PURPOSE: To adapt basic social work techniques and approaches to the special needs of children under age 12.

DISCUSSION: Children are not miniature adults. Thus, the techniques and approaches that are effective with adult clients may not work with children. Social workers whose clients are children must add some new skills to their repertoire, such as the use of play. The sections that follow provide guidelines for a range of tasks that are involved in working with a child.

Planning the Interview

1. Anticipate how the child's level of development will affect his or her capacity to understand situations and to use language. How and what children think and feel are closely tied to their developmental stages. Realize, however, that there is much variation among the children in a particular age group.

2. Be clear about why you are meeting with the child and what you hope to accomplish. Plan several alternative methods to accomplish your goal. Anticipate what might go wrong (e.g., child will not talk, child cries, child will not leave parent, etc.) and consider how you might handle such situations.

3. Play is a child's natural means of communication and interacting with others. Consider using some form of play or related activity to help put the child at ease and facilitate communication. Prior to the interview, assemble play materials that may be needed. For young children, provide art materials (e.g., finger paints, clay, building blocks) as well as objects that can be used to portray family members and situations (e.g., dolls, puppets, doll house, toy animals). For older children, consider simple card or board games, toy telephones, puzzles, and electronic games.

4. Conduct the interview in a room that is familiar and comfortable to the child. If that is not possible, consider an open space that affords some privacy (e.g., a public park or school playground).

Introducing Yourself and Getting Started

5. When first meeting a child, explain who you are and how you want to be addressed (e.g., "My name is Ron Hoffman. Please call me Ron. My job is to help children who are having problems at home"). Place yourself at the child's level physically; sit or squat so you do not tower over the child. Initiate some friendly interaction by showing an interest in items the child is wearing or carrying or ask about the child's school or favorite games or TV shows.

6. Do not disguise the interview as recreation; this may confuse the child about who you are and what your role is. Also be cognizant that little or no confidentiality can be provided to a child. Do not promise to keep secrets. If the child appears reluctant to talk for fear of retaliation by others, you may need to describe what you can do to keep him or her safe.

7. If the child is at least 6 or 7 years of age, ask what he or she knows about the purpose of the interview. This will reveal what the child is expecting. Then explain why you want to speak with the child. Ask if he or she has talked to anyone else about the meeting and what others have said about the meeting or perhaps what instructions the child was given about what to say and do.

8. If the child is frightened by the prospect of being interviewed, attempt to normalize the situation by saying something such as "When I was your age, I was afraid to talk to new people." It may be necessary to ally the child's fear that being interviewed means he or she is in trouble or that the interview is some kind of punishment.

9. If the child refuses to interact, try engaging him or her in a parallel activity and then gradually initiate conversation about the activity. For example, if the child does

not talk but begins to play with a doll, pick up another doll and engage in similar play. This will often lead to some interaction and an opportunity for verbal exchange. Young children who are frightened and withdrawn will sometimes relax and let down their guard in response to you clowning around with them; however, they must be certain that you are trying to be silly and somewhat outrageous. If you put on a clown mask or clown nose, the child will not likely misunderstand your intention. If the child seems unwilling to talk, try doing something unexpected (e.g., "Brian, we are going to be doing a lot of talking and we may get thirsty. Should we get some juice now or should we wait until later?").

Gathering Information from Children

10. Because young children have limited verbal ability, much of the information you gather about a young child will need to be based on your observation of his or her nonverbal behavior in play and interactions with you and others. However, in order to draw valid inferences, it is important to observe the child in several different situations. Do not base conclusions on a single observation or interaction with the child.

11. Children often "act out" their concerns and project their thoughts and feelings onto dolls or pictures. Thus, consider using these items to set up a make-believe situation relevant to the topics you wish to explore and then ask the child to complete the story or describe what the dolls or characters in the picture are doing, thinking, and feeling. You may need to initiate the storytelling about the dolls or pictures, but once the child is attentive, you can ask the child to continue the story. Always be cautious about interpreting the meaning of a child's play. Indeed, young children incorporate their thoughts, feelings, and recent experiences into their play. However, children also incorporate into their play various themes drawn from TV programs and books, from incidents described by their friends, and from events they have observed outside the home. Thus, it may be difficult to pinpoint the exact source of the themes that appear in a child's play.

12. When observing a child, remember that themes of violence are quite common in normal children's play and in the stories they tell. Thus, violence-related talk and play, especially by boys, is not by itself an indicator that a child has been physically abused or exposed to violence in the home.

13. In their interactions with adults, children between the ages of 3 and 6 are eager to please, suggestible, and easily influenced when asked leading questions. Children this age are also sensitive and reactive to an adult's verbal and nonverbal communication, and they may modify their story or what they have to say in order to make it fit what they believe the adult wants to hear. If the child concludes that you disapprove of what he or she is saying, the child may stop talking. Conveying warmth and acceptance is especially important in interviews with children.

14. Children who are older than about 6 years will be better able to use words to communicate their thoughts and feelings and to answer questions, if the questions are simple and age appropriate. However, children of this age will need encouragement and assistance to fully describe a situation or event. For example, you may

need to ask What happened next? Then what did you do? Where did this happen? Who was with you? As a general rule, avoid asking *why* questions because children find it difficult to accurately describe the reasons behind their behavior.

15. By age 9 or 10, most children are able to observe and describe patterns of behavior and to make general observations related to people's personalities, traits, and attitudes. Because children at this age can now think conceptually, they pay more attention to the words of a message. Also, they are able to detect phony or insincere messages and they become suspicious when they observe incongruency between a person's words and behavior.

16. Story completions, dolls, and drawing may still be necessary interviewing techniques for children between about ages 7 and 9, but many children older than 9 years will respond thoughtfully to an interviewer's questions if the interviewer is nonthreatening and unhurried. Children of this age group find it easier to talk about personal matters if they can do so while playing a simple card game or a board game like checkers that does not require a great deal of concentration. Puppet-to-puppet interaction can facilitate communication and talking on play telephones usually works well. Sentence completions are also useful (e.g., When at home, I am afraid that . . .). Many 7- to 10-year-olds respond well to humor, if it is not subtle

17. Many children, especially young children, are easily distracted, such that they move quickly from one topic or focus to another. Consequently, they may describe what they think or feel about an important topic only once or with just a few words. Asking a child to stay focused on a topic is seldom successful; however, you may initiate a return to this important topic at a later time. If pressured to remain focused on a painful or sensitive topic, the child may become noncommittal or silent (e.g., not answer or shrug off communication).

18. To make a discussion or exploration more specific, the game of Hot or Cold may prove useful. For example, if the child is having difficulty articulating a concern, you might say something like the following:

> "Jimmy, I am going to make some guesses about what is bothering you. If my guesses are getting closer to what is troubling you, tell me that I am getting warm. If my guesses are wrong, tell me that I am getting cold."

Understanding How Children Think

19. Children between the ages of about 3 to 6 are subjective, concrete, and egocentric in their thinking. For example, they believe an event or activity that makes them happy will have the same effect on all people. Their thinking is characterized by an all-or-nothing pattern. That is, things are either good or bad; the child is unable to understand mixed feelings or ambivalence. The child may describe a person as mean and then just minutes later describe the same person as nice or fun. Such thinking in extremes and absolutes leads them to categorize both themselves and others as, for example, either good or bad, smart or dumb, and so on. Children of this age describe themselves and others in terms of external characteristics (e.g., age, hair color, grade in school, etc.); they do not mention personality traits except in global terms such as "She is happy" or "He is a bad person."

20. Beginning at about age 6, the child's thinking becomes more objective and logical. Gradually, the child acquires the ability to imagine himself or herself in the place of another and to understand that people differ in how they think and feel. However, even a 7-year-old may still believe that he or she is the total cause for how others, especially parents, feel and behave. It is not until about age 9 or 10 that children truly understand that they do not cause all of the behaviors and emotions they observe in others.

21. By about age 10, the child no longer thinks in absolutes and views himself or herself as an individual who is separate from others and a mixture of characteristics and abilities (e.g., someone who is skilled at some things but not others or good sometimes and bad other times). At this age, he or she realizes it is possible to have conflicting thoughts and to feel opposing emotions simultaneously (e.g., to be angry at someone you love). Also, the child now has the ability to reflect on his or her own thoughts and actions and can figure out how others will probably react in a particular situation or react to certain information. Thus, the child can now manipulate words and information in order to influence how others will behave.

Assessing the Truthfulness of Children's Statements

22. If you investigate reports of abuse and neglect or conduct child custody evaluations, you will often make judgments about whether a child is telling the truth. As a general rule, the younger the child, the less able and the less likely he or she is to fabricate a falsehood. However, it is important to remember that children, like adults, can and do misunderstand and misinterpret their experiences and will at times lie.

23. Children from about 4 to 6 years old can and will tell a simple lie in order to avoid punishment (e.g., "I didn't break the cup"), but they do not have the cognitive abilities necessary to fabricate a complex story having several interrelated elements, actions, or actors. In trying to describe something that happened, they can often recall central actors or central events but not the connecting details, such as what happened before and after and how one action lead to another. They have what some call a *script memory,* which means they can remember events (e.g., a birthday party) and rituals (e.g., going to bed, mealtime, etc.) but not accurately remember events that are not part of their usual routines. Children this age frequently exaggerate events or boast when describing their abilities and experiences; however, when asked, "Is that pretend or real?" or "Is that an 'I wish' story or is it true?" they generally can articulate the difference between what was true and what was an exaggeration.

24. Children between the ages of about 7 and 11 usually place a high value on honesty and fairness in relationships. They may, however, lie in order to avoid punishment or to get what they want. At this stage, they possess the cognitive abilities necessary to deliberately mislead others by selectively withholding information and using other forms of deception. They often embellish the truth in order to tell an exciting story. Children in the age range of about 9 to 11 are usually eager to please adults and inclined to say what they believe adults want to hear. They have good memories of central actors and events and good free recall (i.e., able to recall and describe without the aid of detailed questioning by an interviewer).

25. The social worker should not assume that a young child can accurately describe when an event happened. Young children do not use clocks or calendars to measure time. In fact, preschool children do not grasp the concept of time; young grade school–age children typically use events such as nap time, lunch time, Christmas, start of school, and other events as markers of time. Such markers, rather than clock times and dates, should be used to establish timeframes.

26. Sometimes, a parent or another adult will pressure a child to lie to a social worker in order to avoid the disclosure of some problem or criminal activity or perhaps as a way of hurting another person, such as an ex-spouse. If an adult has coached a child on what to tell a social worker, the child will often speak in adultlike language, use few gestures and facial expressions, and not display genuine and appropriate emotions. Moreover, the child will be either inconsistent regarding the major element of the story or extremely consistent regarding the major element but unable to describe supporting or connecting details.

27. Assessing the truth of a child's statement is a special challenge in the case of alleged child sexual abuse. As a general rule, sexually abused children are reluctant to report the abuse and do not want to talk about it. When children do self-report sexual abuse, they seldom lie about such matters. Deliberate false reports (i.e., actual lying by the child) are extremely rare among children below age 12 and infrequent among teenagers. Nonetheless, the child's lying about, misunderstanding, or misinterpreting the situation, along with the child's having named and accused the wrong person, are all possibilities that the interviewer must keep in mind. The likelihood of deception and making a deliberate false report becomes higher when the child is the focus of a custody or visitation dispute and is instructed or encouraged by one parent to accuse the other parent of some wrongdoing.

Indicators of a possible deception by a child and/or by his or her parent include the following:

- Disclosing of and talking about the incident seems too easy for the child (i.e., is not afraid or reluctant to tell others what happened).
- The child does not show expected or authentic emotion when describing what happened (e.g., does not cry or display distress, embarrassment, fear, anger, etc.).
- The child uses adultlike words to describe sexual activity (as if coached or rehearsed by an adult).
- The child describes the sexual activity using only visual images and not information drawn from the other senses (i.e., smell, taste, touch, sound).
- The child does not seem to be afraid of the alleged offender; for example, the child does not seem hesitant to meet with or confront the alleged offender when the possibility of doing so is mentioned.
- The child is not hesitant to talk about the sexual abuse in the presence of a nonoffending parent. (Most children try to shield the parent from the details and thus the pain of what happened.)
- The child talks about having been sexually abused but does not display any of the other behavioral signs and symptoms associated with child sexual abuse. (See Item 11.21, Assessing a Child's Need for Protection.)

■ When a parent is encouraging the child to report the sexual abuse, the parent does not display the emotions that are normal in such a situation. For example, the parent does not seem genuinely shocked, sad, depressed, anxious, worried, alarmed, and/or fearful. The parent may also express anger at the alleged offender and seek revenge yet not display genuine alarm or distress over what has supposedly happened to the child.

Additional Suggestions

28. Realize that during an interview, you get only a sample of the child's behavior. The child may behave differently in other situations and with other people. The farther removed the child is from his or her usual social and family context, the more cautious you must be in drawing conclusions about the child's behavior. For example, the child who appears anxious or withdrawn during an office interview may simply be fearful of an unfamiliar environment. In-home interviews are important to an accurate assessment of a child's functioning.

29. Allow the child to set the pace of the interview. Permit him or her to move around and explore the room. Children—especially young children—have a short attention span. Excessive squirming and a lack of attention probably indicates that the child is tired and the interview should end.

30. The vocabulary and manner of speaking you use in an interview should be appropriate to the age of the child. For example, with a 12-year-old, you can use words and expressions very similar to those used with an adult, but with a 5-year-old, your speech must be simple and concrete.

31. Because young children are responsive to nonverbal communication, you will likely find it helpful to make frequent use of facial expressions, touch, changes in voice tone, and gestures. However, do not hug or caress a child, for this makes many children feel uncomfortable. In addition, this could be misinterpreted as inappropriate sexual contact. Touch can be especially confusing and even threatening to a child who has been physically or sexually abused.

32. Answer a child's question honestly and directly (e.g., "I believe you will be in foster care until the school term ends"). Do not use euphemisms; do not beat around the bush. Avoid giving elaborate explanations. When giving important information to a child, try to present it in phases and small doses.

33. When behavior-control rules are necessary during an interview, explain the rules, along with any consequences for breaking them (e.g., "You are not permitted to hit me; if you do hit me, I will put away the toys").

34. During an interview, give the child as much choice and control as possible. But be sure to offer choices among alternatives that you can accept. This point is illustrated in the following statements:

Misleading: "Well, Ellen, what would you like to do? We can do whatever you like."

Correct: "Ellen, today you can use the finger paints or the crayons. Which one do you want to use?"

35. Outings, treats, or gifts should be used judiciously. Although they are an extension of normal adult-child interaction and may be helpful in building a relationship, they are easily misinterpreted. Also, be careful that your gift of even a small toy is not viewed as competition with the child's parents.

36. Children are protective of their parents. A child will usually defend his or her parents, even abusive parents. Be objective and concrete in talking about the parent-child relationship and the parents' behavior (e.g., "Your dad does has a problem with alcohol. He gets drunk about once a week. He cannot stop drinking. That is why your parents are getting a divorce"). Do not criticize the parents.

37. A series of interviews should usually have structure and a routine, depending on each child's needs. For example, some children like interviews that have definite beginning and ending rituals. Others, however, may want relief from structure and need freedom to do more of what they feel like doing.

Children in Out-of-Home Placement

38. Many of the children known professionally to social workers are in out-of-home placement (i.e., foster family care, group homes, institutional care, etc.). Realize that placement is always disruptive and emotionally traumatic to a child. Many children blame themselves for the family problems that led up to the placement and view placement as a punishment for some real or imagined wrongdoing. Once separated from their natural families and in placement, many children worry intensely about the well-being of their parents and any siblings still at home.

39. Be sensitive to the pain of their separation and loss experiences. Relationship losses, especially a series of losses, have long-lasting, negative effects on a child. Thus, it is critically important to minimize the number of separations experienced by a child. If a child must be separated from someone to which he or she is emotionally attached, the move should be as gradual as possible, thus giving the child an opportunity to prepare and time to adjust. A ritual such as a going-away party helps the child make this transition by symbolically ending one relationship and beginning another. Without such a ritual, the child might feel as if he or she was given away or rejected; a transition ritual gives the child permission to let go of one relationship and begin a new one. After the physical separation, it is important that the child be able to return to his or her former home for occasional visits.

40. Some children make a fairly good adjustment to placement, but most experience a good deal of inner turmoil and insecurity. They are often uncertain about why they are in placement. Thus, you should assume that the child in an out-of-home placement has many questions about his or her past, current situation, and future. Make it as easy as possible for him or her to ask these questions, and be as factual and honest as possible in answering them.

41. A child's biological parents and family are central to his or her identity. Do everything possible to maintain frequent contacts and visits between the child in placement and his or her parents, siblings, and other close relatives. If a child has little or no contact with one or both parents, he or she will usually create an elaborate

fantasy that explains the situation. In the long run, frequent visitation is helpful to the child, even if the visits are at times upsetting to him or her. It is better for the child to struggle with and adjust to an unpleasant reality than to perpetuate a pleasant fantasy.

42. Because foster children experience so much change and because their lives are so unpredictable, you must be prepared to become a predictable figure in their lives. The foster child is especially sensitive to any hint of rejection. Contacts should occur on a regular basis. If you must miss an appointment, explain the reason directly to the child. If you may not be able to keep a promise, do not make it!

43. Children often feel shame and embarrassment about being in foster care, and consequently they fabricate a story to explain their situation. When the fabrication is discovered, the child acquires a reputation for being a spinner of tall tales or a liar. Thus, it is important to help these children develop an understandable and acceptable explanation of why they are in an out-of-home placement so they can more comfortably describe their living situation to teachers, friends, and others.

44. When speaking with foster parents, adoptive parents, or group care staff, be truthful about the child's behavior, situation, and history. Efforts to conceal the child's life experience in an attempt to protect the child or because you fear others will not understand almost always backfire.

SELECTED BIBLIOGRAPHY

Poole, Debra, and Michael Lamb. *Investigative Interviews of Children.* Washington, DC: American Psychological Association, 1998.
Taffel, Ron. *Getting through to Difficult Kids and Parents.* New York: Guilford, 2001.
Timberlake, Elizabeth, and Marika Cutler. *Developmental Play Therapy in Clinical Social Work.* Boston: Allyn & Bacon, 2001.
Wilson, Claire, and Martine Powell, eds. *A Guide to Interviewing Children.* New York: Brunner-Routledge, 2001.

15.3   **The Client Who Is an Adolescent**

PURPOSE: To adapt basic social work techniques and approaches to the needs of adolescents.

DISCUSSION: The developmental period known as *adolescence*—between about ages 12 and 18—is often a stormy one. For the adolescent, it is a time of rapid physical and psychological change, awakening sexual desire, and figuring out who he or she is and how he or she fits into society. It is often a time of conflict and tension between adolescents and their parents, frequently regarding issues of authority and control. Parents typically worry that their adolescent children will become involved with drugs, have irresponsible sexual experiences, or be injured by recklessness. A small percentage of parents become so frustrated with their adolescent children that they kick them out of the home.

The problems most likely to bring adolescents to the attention of a social worker include family conflict, alcohol and drug use, running away, behavior problems in school, violence, delinquency, pregnancy, threat of suicide, and the need for foster care or residential treatment. The following background information and guidelines are useful when working with adolescents:

1. Adolescents are typically idealistic, painfully self-conscious, struggling with authority issues, fiercely attached to peers, preoccupied with bodily changes and their sexuality, seeking popularity and conformity within their peer group, and desperately trying to develop an identity apart from their family.

2. Adolescents have an intense need to be heard. Yet because they experience strong emotions and are often uncertain about what they really believe, they usually find it difficult to talk openly with adults. With this in mind, you should listen nonjudgmentally and look for the underlying meanings of adolescents' words and feelings. Encourage them to talk about life from their perspective and as they experience it. Try to engage them to talk about their needs, hopes, and dreams, but do not push them to do so; that will be perceived as an effort to control and will likely invite further resistance.

3. Adolescents are sensitive to any hint of artificiality in others, even though they themselves may pretend to be someone they are not. Thus, it is important to be genuine. Do not try to talk and act like their peers. It is nearly impossible to keep up with the latest adolescent fads, music, and slang. Imitating adolescent talk is likely to make you appear phoney.

4. Most adolescents are preoccupied with the here and now. Many have tunnel vision and seem unable to think beyond today or tomorrow. Gently encourage adolescents to examine their current decisions and actions in light of their hopes and dreams, opportunities, and goals. When their thinking is clearly unrealistic or dangerous, it is usually best to tell them so in a respectful but firm manner.

5. Many adolescents in the United States and Europe report having a pervasive sense of hopelessness concerning their future. They complain that life is pointless and that violence and pollution are making life unbearable. Many feel as if their elders have robbed them of a future, and consequently, they feel cheated and angry. Since they feel hopeless and bitter, they have little motivation and few interests, other than getting through the day with as little discomfort as possible.

6. Many of the adolescents you will see are involuntary clients, who have been brought to or sent to a social worker or a social agency by parents, school officials, a juvenile court judge, or a probation officer. This is an uncomfortable and awkward situation for the adolescent because of the authority struggles common to this developmental period. The adolescent may respond to you with silence as a means of resisting adult intrusion, or he or she may challenge you and any other adult authority by being noncooperative and rude and by using abusive language. When working with an adolescent, be aware that your own unresolved parent-child and authority issues may surface in the professional relationship.

Despite the challenges they present, adolescents are resilient and have a great capacity to grow and change. Because these clients are often lively, inquisitive, and questioning, your work with adolescents can be stimulating, fun, and truly rewarding. Effective social work intervention during this developmental period can prevent serious problems and have lifelong, positive effects.

7. Adolescents need an environment that is predictable and provides structure and limits. In many practice settings, such as group homes and treatment centers, social workers have the responsibility for creating this environment and deciding what rules are necessary. Adolescents will typically test the rules and limits put in place by adults. Thus, before you create a new rule, make sure it is really necessary, can be enforced, and is worth fighting over. Then, once you have decided that a particular rule is necessary, inform the adolescent of the rule and the consequences for violating it. When enforcing rules and imposing consequences with adolescents, it is critically important to be fair and consistent.

8. Because the peer group is so important during adolescence, group approaches (e.g., group discussion, psychodrama, and group counseling) can be useful. Most adolescents are more accepting of a group-related intervention than a one-to-one interview. Adolescents in need of out-of-home placement usually do better in a group home setting than in foster family care. Behavioral contracting works fairly well with adolescents (see Item 13.6).

9. Because of adolescents' high energy level, interactions with them should be planned around movement and physical activity. If possible, avoid office interviews; rather, try talking with adolescent clients while walking, shooting baskets, working out in a gym, or riding in a car. Movement seems to make it easier for adolescents to talk and express feelings.

10. Strive to promote mutual understanding and improved communication between the adolescent and his or her parents. By helping parents recall and talk about their own behaviors, thoughts, and feelings during their adolescent years, you can often increase their understanding and acceptance of their teenager. Keep the parents informed and involved when working with their adolescent child. At the same time, provide the adolescent with as much confidentiality as is legally permissible.

11. During adolescence, some individuals are drawn into gang activity. Youth join gangs for a variety of reasons, but it is often because the gang meets their needs for peer recognition, a sense of identity and belonging, self-esteem and pride, and excitement and camaraderie. For many, the tribal culture of the gang serves as a substitute family. In some instances, youth join a gang because it offers some safety and protection from other gangs in their neighborhood.

Youth gangs or street gangs have existed in major U.S. cities since the late nineteenth century. In the past, their illegal activity was mostly theft. In recent years, many youth gangs have adults as leaders, have grown more violent, and are often involved in serious criminal activity such as drug dealing and murder. Economic gain from drug dealing has become a driving force behind the expansion of gang activity. Consequently, it is increasingly difficult to distinguish between some youth gangs and organized crime.

SELECTED BIBLIOGRAPHY

Carrell, Susan. *Group Exercises for Adolescents: A Manual for Therapists,* 2nd ed. Newbury Park, CA: Sage, 2000.

McWhirter, J. Jeffries, Benedict McWhirter, Anna McWhirter, and Ellen McWhirter. *At-Risk Youth: A Comprehensive Response,* 2nd ed. Pacific Grove, CA: Brooks/Cole, 2000.

Rose, Steven R., and Marian Fatout. *Social Work Practice with Children and Adolescents.* Boston: Allyn & Bacon, 2003.

Sommers-Flannagan, John, and Rita Sommers-Flannagan. *Tough Kids, Cool Counseling.* Alexandria, VA: American Counseling Association, 1997.

15.4   The Client Who Is Elderly

PURPOSE: To adapt social work techniques and approaches to the special needs of the elderly.

DISCUSSION: In most developed countries, a growing percentage of the people are in the older age range. For example, in the United States by the year 2030, about 20 percent of the population will be 65 and older. Given this trend, social workers must give increasing attention to the needs and concerns of older people, especially those in their seventies, eighties, and nineties. The following background information and guidelines will help the worker serving the elderly client:

1. As people grow older, they experience many losses (e.g., deaths of loved ones, loss of health, restricted mobility, etc.) and usually feel less independent and more vulnerable. They begin to worry about their ability to take care of themselves and about becoming a burden to their children or other family members. In response, many elderly persons hold on tightly to whatever freedom and independence they still possess. Some become staunchly independent and resist any service or professional they perceive as somehow limiting their freedom. When working with elderly clients, you should allow them to retain control, make choices, and maintain independence to the greatest extent possible.

2. Most elderly clients prefer a friendly social worker to one who is more formal. However, they expect to be treated with dignity and respect, and many will react negatively to someone who is too informal and familiar or who takes the relationship for granted. When addressing the elderly client, use the title *Mr., Mrs.,* or *Miss* until you have asked and received permission to use his or her first name. Also consider the nature of your appearance. Elderly clients may be especially bothered by what they perceive as unusual clothing, hairstyles, or jewelry worn by a social worker or other professional.

3. For both physical and psychological reasons, it is usually more comfortable for the elderly client to be interviewed at home than in an office. A good way to break the ice and get your relationship with an older person off to a good start is to show interest in the furnishings in his or her room or home, such as family pictures, unique pieces of furniture, homemade items, and the like.

4. When first forming a relationship, focus on the elderly client's most obvious and concrete needs, which are the ones he or she can most easily discuss. Like most other clients, the elderly person understands and can easily talk about needs like transportation, housing, medical care, and home maintenance but will find it more difficult to talk about personal matters and express feelings in the presence of someone he or she does not know very well.

5. If the elderly client is much older than you, the two of you probably have different mores, values, and attitudes. For example, "taking charity" is difficult for many older people, and they usually find it harder than younger persons to accept counseling and psychotherapy. Many are concerned about the cost of services. Early in your contact, clarify any financial implications. Some older clients will simply reject services rather than inquire about the cost or reveal their inability to pay.

6. Most elderly people have some degree of vision and hearing loss. Thus, it is important to speak clearly and repeat yourself as often as necessary. Your nonverbal communication is important as a means of compensating for the client's auditory deficit. Also, the pace of an interview will usually be slower with an elderly person, and the client's lack of energy may limit the length of the interview.

7. During their later years, older people become increasingly aware of their unique relationships with their children and grandchildren. It may be of great importance for them to stay in contact with offspring or to reactivate relationships that have deteriorated. Some may want to reach out to estranged offspring and patch up differences or make amends for harm they caused. Do everything possible to facilitate intergenerational family communication.

8. As people grow older, they often think more about the meaning and purpose of life and the achievements and disappointments of their own lives. For many, religious beliefs and spirituality take on added importance. Look for opportunities that allow the elderly to share their thoughts and what they have learned about life.

9. Allow and even encourage the client to reminisce. Thinking and talking about the past is a normal activity for the elderly—it is not a sign of deteriorating mental abilities. Listen carefully to the reminiscence; it will reveal much about the client's values, feelings, and current concerns.

10. Given the impact of racism, discrimination, and prejudice on people, be especially sensitive when interacting with elderly people who are members of racial or ethnic minorities. As a general rule, they will be more suspicious and distrustful of agencies and more sensitive to anything that might appear demeaning and disrespectful. The values common to a particular ethnic group may make life more or less difficult for the aging person. For example, in certain ethnic groups (e.g., Chinese American, Native American), the elderly occupy a position of respect and influence within families. On the other hand, the importance of hard work as a value within some ethnic groups (e.g., Slavic American) may make the nonworking elderly person feel particularly unworthy and unimportant.

11. Be alert to indicators of elder abuse and neglect (especially self-neglect), such as bruises, cuts, burns, or untreated injuries that are explained in a vague or defensive

manner; improper clothing for the weather; wandering outside at odd hours or into dangerous areas; mail, newspapers, or other deliveries that are not picked up; unusual activity or no signs of movement from their home; unpleasant odors associated with hygiene or housekeeping; the person does not recognize you or does not know where he or she is or the day or time; the person has means to meet basic needs but is facing an eviction, utility shutoff, or has many unpaid bills; or the person is dependent on a stressed, chemically dependent or mentally ill caregiver and basic needs are not being met.

SELECTED BIBLIOGRAPHY

Dreher, Barbara. *Communication Skills for Working with Elders,* 2nd ed. New York: Springer, 2001.

Greene, Roberta. *Social Work with the Aged and Their Families.* Hawthorne, NY: Aldine de Gruyter, 2000.

15.5 The Client Who Is in Crisis

PURPOSE: To assist the client in coping with a personal crisis.

DISCUSSION: The social worker will encounter many clients who are in a state of crisis. Although the word *crisis* is widely used, it has a specific meaning within the field of mental health. Essentially, a crisis consists of a perception and the reaction to that perception. When an individual is in ***crisis,*** he or she perceives a particular situation to be an intolerable and overwhelming difficulty and one with which he or she is unable to cope. The individual reacts with anxiety, panic, despair, and disorganization. A crisis is a sudden but temporary breakdown in a person's ordinary and usual capacity to cope with and manage one's life. Among the events that can precipitate a crisis are the death of a loved one, loss of a job, divorce, birth of a child with a severe disability, serious illness or accident, house fire, rape or mugging, or other traumatic event.

A personal crisis is a time of both danger and opportunity. It is dangerous because if the crisis is not resolved constructively, it can set in motion a downward spiral that leads to a level of functioning lower than that which existed prior to the crisis. On the other hand, a crisis can be an opportunity to learn new coping skills and actually elevate one's usual level of functioning. A crisis is *time limited;* within a matter of 4 to 6 weeks, the person will come to some level of adjustment and equilibrium. And as suggested, that adjustment may be either positive or negative, depending in part on how others respond to the person during the crisis.

It is important to distinguish between a genuine personal crisis (i.e., a short period of distress and readjustment) and a life-style that is characterized by one emergency after another, year after year, but in which nothing is done to face or change the circumstances that give rise to these emergencies. For individuals immersed in this crisis-ridden mode, life is like a roller-coaster ride, and the emergencies they experience are energizing and addicting, rather than deeply distressful.

The concept of crisis overlaps, to a degree, with two mental disorders: Acute Stress Disorder and Posttraumatic Stress Disorder (PTSD). The essential feature of

an *Acute Distress Disorder* is the appearance of certain symptoms within 1 month after exposure to an extremely traumatic event. Symptoms include anxiety, "numbing" (or an absence of emotional responsiveness), reduced awareness of one's surroundings, a feeling that life is unreal, a feeling of being detached from one's body, an inability to concentrate, and an inability to remember the important details of the traumatic event. If this condition goes untreated and/or if the person experiences additional traumatic events, the second condition, PTSD, may develop.

Posttraumatic Stress Disorder is characterized by the occurrence of the above-mentioned symptoms plus flashbacks, recurring frightening dreams about the event, and extreme distress reactions when reminded of the event. PTSD may arise 3 or more months after exposure to an intensely emotional and/or life-threatening experience, such as rape, war-related combat, kidnapping, torture, an automobile accident, and witnessing the traumatic death of another person.

If an individual is not making progress in working his or her way through the expected 4- to 6-week crisis period and if symptoms of an Acute Stress Disorder or PTSD become evident, he or she should be referred for appropriate psychiatric treatment.

The following guidelines will be useful when dealing with a person in crisis:

   1. Listen actively and offer emotional support. A person in crisis is in a heightened state of either anxiety or depression and also feels a sense of failure because he or she is unable to cope. The client is probably preoccupied with the precipitating event and will have difficulty focusing attention on anything else. Before the client can consider alternatives, make decisions, or plan ways for resolving problems, he or she will need much emotional support from the worker and significant others. This support may range from simply acknowledging the existence of the upsetting experience to offering strong reassurance (e.g., "You did the right thing in leaving that violent situation and coming to our shelter").

   2. Involve others in the helping process. People in crisis are often most receptive to assistance provided by those whom they already know and trust (e.g., family, friends, employer, minister, neighbors, etc.). Encourage the client to reach out to others, or, with his or her permission, contact these significant others and enlist their help on behalf of the client.

   3. Allow the client to express emotion, whether crying or expressing feelings of fear or anger, while you continue to provide emotional support and acceptance. The client's strong emotions and intense feelings will diminish with time.

   4. Communicate hope. A hopeful attitude is an essential element in responding to a person in crisis. If you communicate a belief in the client's ability to cope, he or she will be less fearful and will gradually regain self-confidence.

   5. People in crisis are preoccupied with their pain and problems. They have tunnel vision and can think of little else. Consequently, they are not able to step back and objectively analyze their situation. Ask questions and actively examine the details of their situation as a way of helping them think more clearly.

   6. Use partialization. The person in crisis feels as if he or she is facing a giant and completely unmanageable problem. By breaking the problem down into several smaller ones, to be addressed one at a time, the client will feel more hopeful about regaining control.

7. Provide factual information. Often, a crisis arises because the person has misconceptions about his or her situation or because intense feelings have distorted his or her perception of reality (e.g., "I just know that I'm going to lose my job" or "This goes to prove that no company is going to hire someone in a wheelchair like me"). Provide factual information related to the person's concern (e.g., "No, I don't think it is because you are in a wheelchair that you weren't hired; there are laws against discrimination of that kind"). When appropriate, give honest feedback needed to correct misunderstandings (e.g., "Mr. Jones told me that you weren't hired because you were belligerent and sarcastic during the interview").

8. A person in crisis has difficulty making decisions and anticipating the consequences of his or her actions. Thus, you may need to provide highly specific directions as to what the person needs to do or what will probably happen if he or she takes a certain course of action. It is especially important to help the client anticipate the consequences of destructive behaviors (e.g., "If you lose control and again injure your child, she will be placed in a foster home").

9. Reinforce adaptive behavior. Help the individual identify what worked in the past; encourage the client to take similar actions to address his or her current problem. An important part of crisis intervention is to encourage clients to take action so they begin to regain a faith and trust in their own capabilities.

10. Consider using a behavioral contract (see Item 13.6) as a means of providing the client with structure and direction. This helps the client mobilize inner resources, and it also sends the message that you have confidence in his or her ability to take the steps needed to get through the crisis.

SELECTED BIBLIOGRAPHY

James, Richard, and Burl Gilliland. *Crisis Intervention Strategies,* 4th ed. Pacific Grove, CA: Brooks/Cole, 2001.

Myer, Rick. *Assessment for Crisis Intervention.* Pacific Grove, CA: Brooks/Cole, 2001.

Roberts, Albert, ed. *Crisis Intervention Handbook,* 2nd ed. New York: Oxford University Press, 2000.

15.6 The Client Who Is a Battered Woman

PURPOSE: To understand domestic abuse and respond appropriately to a battered woman.

DISCUSSION: As used here, the term *battered woman* refers to an adult female who has been physically, sexually, and/or emotionally abused by a spouse or intimate partner. Unfortunately, this type of abuse is common and results in many serious injuries and deaths. In the United States, a woman is more likely to be assaulted, injured, raped, or killed by a her male partner than by a stranger or any other type of assailant. The vast majority of the abusers are men and the abuse occurs most often within a heterosexual relationship. However, it may also occur within gay and lesbian relationships. (For ease of discussion, the authors will refer to the offender or abuser as the male and to the victim as the female.)

The abuse can take several forms, but all are intended to control the woman—for example:

- *Physical injury or threats of injury* (e.g., pushing, choking, punching, beating, hitting with objects, forcing sex, threatening to hurt her or the children)
- *Emotional abuse* (e.g., humiliating her, making her the object of demeaning jokes, blaming her, undermining her confidence, saying she is crazy, insisting that she deserves to be punished, denying her opportunity to make decisions)
- *Isolation* (e.g., controlling what she does, who she talks to, and where she goes, closely monitoring her activities)
- *Economic manipulation* (e.g., controlling her access to money, giving her an allowance, preventing her from getting or keeping a job, threatening to take all possessions and leave her with nothing)
- *Intimidation* (e.g., displaying weapons, abusing pets, destroying her property, threatening to commit suicide if she does not do what he wants)
- *Using the children* (e.g., threatening to take the children, threatening to report the woman for child abuse).

Typically, there is a cycle of abuse with three major phases: (1) tension building, (2) the explosion, and (3) the "honeymoon." In some cases, the cycle may be quite short, such as a matter of days; in other cases, it may take several months to cycle through these phases:

- *Phase 1—Tension building.* Tensions between the two people begin to rise. Some outbursts may occur but these are minimized and rationalized away by both parties. The woman typically tries to protect herself and maintain some control over the situation by being compliant and not showing anger.
- *Phase 2—Explosion.* The abuser finally explodes. Anger is expressed in extreme verbal abuse, physical violence, and/or rape.
- *Phase 3—Repairing the damage (Honeymoon).* The abuser expresses sorrow for what he has done. He fears that she will leave, and to keep her from leaving, he becomes very attentive, loving, and thoughtful. Since this loving behavior does not fit with his prior behavior, she becomes confused and may doubt her own perceptions and sanity. She probably wants to believe that the episode of abuse was atypical and out of character. She may conclude that she is the one responsible for the abuse and think: "If only I would have done things right, he would not have gotten angry." This period of good behavior by the abuser eventually runs its course and the cycle begins again.

Those who believe they must hurt others in order to solve a problem are, in fact, the problem. Men who abuse women have several of the following characteristics:

- Extreme and irrational jealousy and possessiveness toward the woman, often coupled with an unjustifiable belief that she is interested in other men
- Desire to control the woman and isolate her from friends and family by saying such things as "All we need is each other—no one else"

- Quick to anger and have an explosive temper
- Moods and behavior may fluctuate from being kind and gentle to being violent and oppressive
- Refuses to take responsibility for his own behavior; blames others, especially the woman, for whatever goes wrong in his life
- Often a history of having been abused as a child or a witness to frequent family violence
- Often a history of legal violations related to violence
- Either denies or rationalizes his outbursts and abusive behavior
- Usually feels remorse after a violent episode, promises that it will never happen again, and, for a time, becomes a very devoted and loving partner; however, this does not last and eventually he repeats the abusing and violent behavior

There are a number of reasons battered women are often reluctant to leave an abusive relationship or return to it after only a brief separation:

- Fear of retribution and even more serious violence
- Lack of money and no suitable place to live
- Fear of losing her children, home, possessions, and economic security
- Feelings of self-doubt, low self-esteem, shame, or a distrust of other people
- Fear of not being believed or of being blamed for causing the abuse
- Religious beliefs and morals that emphasize maintaining a marriage
- Desire to preserve the family for benefit of the children
- Wanting to believe that the abuse will stop or a tendency to deny or minimize the seriousness of the abuse
- A tendency to equate love with dependency

An abusive situation should be considered especially dangerous if there is a pattern of frequent and/or severe violence, the abuser and/or the abused woman use drugs or alcohol, the woman or her children have been threatened with death, the abuser has access to deadly weapons, either the abuser or victim has a psychiatric impairment, the abuser has a history of criminal activity, the abuse has taken the form of forced sexual acts, the abuser has threatened suicide, the abuser has tortured or killed animals as a display of his willingness to take extreme action, and the woman has made suicide threats or attempts.

Social workers and programs offering services to battered women must strive toward the following goals:

- Ensure that the woman and her children are safe and protected.
- Help the woman understand the nature and cycle of abuse and that she has options that can keep her and her children safe.
- Help her make decisions, formulate plans, and obtain the services she will need in order to ensure safety in the future.
- Help her and her children heal from the psychological effects of abuse and reestablish a sense of personal boundaries.

Those working directly with abused women should keep the following guidelines in mind:

1. Give immediate attention to helping the woman with her basic needs such as the need for safety, food, shelter, transportation, assistance in caring for the children, legal counsel, and so on. Do not immediately assume that the battered woman is in a heterosexual relationship; refer to the abuser as "partner" until you learn the gender of the offender.

2. Because a woman caught up in a abusive relationship is prone to intense self-doubt and self-blame, be sure to establish a warm, caring, and nonjudgmental relationship; listen attentively and respectfully to her story, her fears and confusion, and her reasons for wanting to maintain the relationship. She may want to remain in the relationship because she and\or her children truly love him and believe that he will change.

3. Focus on the woman's strengths, such as the decisions and behaviors that have kept her alive or that protected her children; help her to identify and name her survival skills as a way of counteracting her feelings of self-doubt and helplessness.

4. If she decides to remain with the abuser, assist the woman in developing an escape plan (safety plan) that she can immediately implement if she is again threatened. The plan should include her packing and then hiding from the abuser a bag that contains money, clothing, personal items, and copies of legal documents that she (and her children) would need to live apart from the abuser.

5. Anticipate that the woman's emotions and moods will fluctuate widely and that she will experience great ambivalence about ending the relationship; discourage her from speaking with the abuser when she is feeling especially insecure and confused. At such times she is vulnerable to his influence and is likely to return to him without really considering the danger.

6. If the woman's children have witnessed the abuse of their mother, anticipate that they, too, are feeling frightened and confused and are in need of counseling.

7. Do not assume that the woman has some underlying emotional need or problem that causes her to remain in an abusive relationship. However, as a response to ongoing abuse, the woman may indeed develop problems such as alcohol or drug abuse, depression, anxiety and posttraumatic stress disorder.

8. Understand that the woman may have to leave and return to the abuser several times before she is finally convinced that the abuse will not end unless the abuser is motivated to make use of a program of therapy and training. Couples counseling (i.e., both partners attend at the same time) is not an appropriate mode of intervention because the abused woman will be afraid to speak honestly in the presence of the abuser and the abuser will typically deny or minimize the abuse.

9. After leaving an abusive relationship, it may take from two to four years before the battered woman recovers emotionally and becomes significantly less fearful, anxious, and depressed. The same can be said for the children who have experienced the terror of seeing their mother beaten and threatened.

SELECTED BIBLIOGRAPHY

Berry, Dawn. *The Domestic Violence Source Book,* 3rd ed. Los Angeles: Lowell House, 2000.

Renzetti, Claire, Jeffrey Edleson, and Raquel Bergen, eds. *Sourcebook on Violence against Women.* Thousand Oaks, CA: Sage, 2000.

Roberts, Albert, ed. *Handbook of Intervention Strategies with Domestic Violence: Policies, Programs and Legal Remedies.* New York: Oxford University Press, 2002.

15.7 The Client Who Is at Risk of Suicide

PURPOSE: To assess risk of suicide and take preventive action.

DISCUSSION: Given the high rate of suicide among teenagers, young adults, and the elderly, the social worker will encounter clients who are at risk of taking their own lives. The warning signs of *suicide* include depression, preoccupation with death and pain, giving away prized possessions, unexplained changes in behavioral patterns, sudden increase in the use of drugs and alcohol, and impulsive or reckless behavior. Clinical data indicate that most suicide victims have consulted with a physician within six months of their suicide. Although not all people who end their lives are clinically depressed, studies reveal that depression is often present.

The symptoms of *depression* include pervasive sadness, feelings of hopelessness, lack of interest in activities once enjoyed, inability to concentrate, thoughts of suicide, unexplained aches and pains, fatigue and restlessness, changes in appetite and sleep habits, withdrawal from others, early waking from sleep or erratic sleep patterns, irritability, and unexplained crying. Whereas depression in adults usually results in a retardation of activity, depression in children and youth is often expressed in agitation.

Legally and ethically, the social worker must make every reasonable effort to prevent a client's suicide. This includes providing counseling, staying with the person during times of high risk, and, if necessary, calling the police and arranging involuntary hospitalization. State laws dictate when police can detain a suicidal person and when involuntary hospitalization is permitted. An individual who acknowledges thinking about suicide is at high risk for suicide if he or she exhibits these traits:

- Has a history of prior attempts
- Is in a troublesome or painful situation that is growing worse, more complex, and more painful
- Has a clear plan for suicide and access to the chosen means of suicide (e.g., has a gun or a supply of sleeping pills)
- Has changed rather quickly from being distressed and talking a lot about suicide to being apparently at ease and content
- No longer has access to a person who was an important source of support and encouragement

The following guidelines will help the social worker in assessing a client's suicide potential and responding to the client who is at risk of suicide:

1. Take every message about suicide seriously. It is very significant that the person is talking about harm to self rather than expressing his or her frustration in other ways. It is a myth that people who talk about suicide will not kill themselves. Unfortunately, the message may be subtle and, in some cases, it is not until after the death that its meaning becomes clear. In 10 to 20 percent of suicides, there are no noticeable warnings prior to the death.

2. If you believe that a client is at risk of suicide, consult with other professionals on how best to proceed. Do not allow yourself to be "hooked" by the suicidal client into a promise of complete confidentiality. Ordinary rules of confidentiality must be broken in order to prevent a death.

3. Listen for indirect statements of suicidal intent, such as "I won't be around much longer," "There is nothing worth living for anymore," and "I just can't stand the pain any longer." Be especially concerned about such statements if the person has recently experienced the loss of an important relationship, a loss of status among peers, an episode of family violence, or is in the throes of adjusting to chronic pain, a life-threatening illness, or a serious physical limitation.

4. Keep in mind that the person thinking about suicide is experiencing intense feelings of ambivalence—the desire to live and, at the same time, the desire to escape pain, even if by death. The person does not really want to die but wants desperately to get away from his or her pain. Thus, assume that the person talking about suicide is ambivalent and hoping for your assistance. Reach out and support that part of the person holding to life.

5. Ask simple and direct questions when communicating with the suicidal person. Do not be afraid to ask if he or she is thinking about suicide. Speaking openly will not increase the likelihood of suicide. Direct questioning tells the suicidal person that you are concerned and not afraid to talk straight. Also, questioning is a way of eliciting the information needed to be of help. Examples of questions include Are you thinking of killing yourself? Can you tell me why suicide seems like the answer? and Who else knows you are thinking about suicide?

6. Seek to understand why life seems so painful and futile to the individual. Suicide is seen by the person as a solution to a problem. Thus, it is of critical importance to identify the problem as it is perceived by the individual. Do not argue or become judgmental—the suicidal person already feels helpless and hopeless. Do nothing that would add to his or her feelings of inadequacy of shame.

7. Determine whether the person has worked out a specific suicide plan. Suicide is seldom an impulsive action. Ask questions such as Do you have a plan for killing yourself? How do you plan to get the gun you intend to use? Where do you plan to kill yourself? and What time of day or night do you plan to kill yourself? The more detailed and specific the person's plan, the higher the risk of suicide. Many suicidal people have thought much about their suicide plans, but most have not thought about an alternative or a "plan B." Thus, if you can interfere with a key element of their plan, you can often thwart their suicide.

8. Determine whether the person has chosen a specific method (shooting, hanging, pills, etc.) and if he or she has access to the method. The person who has selected a method and has access to it is at high risk.

9. Determine the lethality of the method. Highly lethal methods include shooting, jumping, hanging, drowning, carbon monoxide poisoning, car crash, or taking high doses of barbiturates, sleeping pills, or aspirin. Less lethal methods include wrist cutting, gas stove, or tranquilizers and nonprescription drugs (excluding aspirin and Tylenol). The more lethal the method, the higher the risk and the greater the chance that a suicidal gesture will result in death.

10. Determine whether the person has attempted suicide in the past. Ask questions such as Have you attempted suicide in the past? How did you try to kill yourself at that time? Did you seek professional counseling? and Was it helpful? A history of prior attempts elevates the risk.

11. Determine what has happened recently that causes the person to think more and more of suicide. For example, ask What has happened over the past days or weeks that has increased your sense of hopelessness? Determine what this event means to the person: Is his or her perception realistic? Is the person too upset to understand the situation clearly? Will the event or situation continue to trouble the individual or will things change in time? Ask Why do you believe your situation will not improve? and How might your situation be different six months from now?

12. Most suicidal people have "tunnel vision"—they can think only about their pain and helplessness. It is important to help them identify and consider alternative methods for dealing with the situation. How has the individual managed stressful situations in the past? Will any of these methods work in the present situation?

13. Determine whether the suicidal person has anyone to rely on during a time of crisis. Many of the people who commit suicide feel ignored or cut off from the people around them. The risk of suicide increases when a person is widowed, divorced, or separated. It is important to help significant others come to the support of the suicidal person.

14. Help the person see that suicide is a permanent solution to a temporary problem. Identify other possible solutions to dealing with the pain the individual is experiencing but do not lie or offer false hope. Ask the client to immediately enter counseling as an alternative to suicide. If necessary, ask him or her to agree not to commit suicide for a specific period (e.g., two weeks) or to promise not to commit suicide before talking to you one more time. If a referral for counseling is made, you or someone else should accompany the client to the initial interview. Follow-up is necessary to ensure that the client is making use of the service.

15. In extreme situations and when nothing else seems to be working, attempt to engage the person in a discussion of what will happen after he or she is found dead. Sometimes this will jar the person into thinking more clearly about the consequences of a suicide—for example, What kind of a funeral service do you want? Who should be notified of your death? Should the people to be notified of your death be approached or talked to in a certain way? Can we make a list of all the people who

should be contacted and invited to your funeral? Who do you want to have your favorite possessions? What do you want your obituary to say?

16. When dealing with persons who are actively suicidal, it is important to remember that they may have no hesitation about also killing you or someone else in the process of taking their own life. For example, a suicidal person with a gun may shoot you if you attempt to take away the gun.

17. Realize that it may not be possible to prevent the suicide of a person who is genuinely committed to taking his or her own life. Counseling, close monitoring, and hospitalization may delay a suicide but such efforts will not always prevent a suicide.

SELECTED BIBLIOGRAPHY

Jacobs, Douglas, ed. *Suicide Assessment and Intervention.* San Francisco: Jossey-Bass, 1998.
Schneidman, Edwin. *Comprehending Suicide.* Washington, DC: American Psychological Association, 2001.

15.8 The Client with Cognitive Delay

PURPOSE: To adapt usual social work methods to the special needs of an adult with cognitive delay (mental retardation).

DISCUSSION: The two key features of *mental retardation* are significantly subaverage general intelligence and significant limitations in adaptive behaviors such as communication, self-care, and academic skills. There are many forms of mental retardation and dozens of causes, such as inborn errors in metabolism, chromosomal aberrations, ingestion of toxic chemicals, malnutrition, viral infections, and head trauma.

Roughly 3 percent of the population has some degree of mental retardation. Of those, about 80 percent have delays in the mild to moderate range and 20 percent in the ranges termed severe and profound. Signs of cognitive delay are usually apparent early in childhood. Early diagnosis and early medical and educational intervention are of critical importance to minimize the effects of the condition (see Items 11.17 and 11.19).

Because of the stigma attached to the word *retardation,* the term *cognitive delay* is increasingly used by educators and parents as a substitute, especially when speaking about children. However, *mental retardation* is a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders* (see Item 11.20) and a term frequently used by physicians and health care professionals. The term *developmental disability* is a legal and programmatic category of mental disability. Although definitions may vary slightly from state to state, a ***developmental disability*** is often defined as a severe disability caused by physical or mental impairment that limits a person's development, appears before the age 18 (or 22), is likely to be lifelong, and affects the person's functioning in self-care, learning, self-direction, language, independent living, mobility, and/or economic self-sufficiency. The developmental disabilities are

mental retardation, cerebral palsy, autism, severe dyslexia, and epilepsy. Of these, mental retardation is the one most frequently diagnosed.

Most adults with mental retardation hold jobs (albeit low-paying ones), and many marry and have children. Although society shows concern and empathy for children with cognitive delays, it tends to reject or stigmatize adults with this condition. Because persons with significant cognitive delay or mental retardation often experience frustration and social rejection, they are at risk of developing emotional problems and patterns of unusual behavior.

The following guidelines will aid the social worker serving an adult client with cognitive delay:

1. Individualize the client. Focus mostly on the client's abilities. Discard any stereotypes you may have concerning people with this condition. They have the same physical, emotional, social, sexual, and spiritual needs as everyone else.

2. Adapt your approach to the client's abilities (e.g., his or her intellectual level, language skills, etc.). To the extent possible, clients should participate in making decisions that affect their own lives. This may be limited in the case of one who has a very severe disability, but other clients may be excellent sources of information about their own preferences, abilities, and limitations.

3. People with cognitive delay have limited verbal skills and difficulty with abstract thinking. Thus, be prepared to utilize alternatives to verbal communication and the ordinary helping skills. Behavioral techniques, special teaching methodologies, nonverbal group work techniques, role-playing, modeling, and the creative arts are examples. (This is not to say that verbal techniques cannot be effective with some clients.)

4. Because the client's attention span may be short, the length of interviews will need to be adjusted accordingly; and because the client's memory may be limited, each contact and communication should be planned as a discrete event rather than as a continuation of previous conversations. When you give explanations, you may need to repeat them and use several concrete examples and illustrations. Your language must be clear, straightforward, and simple but never patronizing.

5. Because the client's life situation is so heavily influenced by the people in his or her immediate environment (e.g., family members, group home manager, neighbors, employers, etc.), the social worker must be prepared to formulate interventions designed to change these people's level of understanding and the expectations they place on the client. The social work practice roles of client advocate, case manager, broker, and mediator are especially important in work with this client group.

6. In your interactions with your client, do nothing that might reinforce inappropriate behaviors. For example, hugging is not a conventional greeting among adults who do not know each other very well. Thus, initiate a handshake rather than allow yourself to be hugged by the client.

7. Address adults with cognitive delay as you would any other adult. For example, always use *Mr.* or *Miss,* unless you know each other so well that you are on a first-name basis. Avoid demeaning language, such as referring to an adult as a "kid."

8. Certain behavioral patterns and medical disorders are associated with some forms of mental retardation. This area of knowledge is of critical importance in assessment and case planning and in working as part of a team with other disciplines, such as psychology, physical therapy, occupational therapy, medicine, speech therapy, special education, and vocational rehabilitation.

9. The principles of normalization should guide the delivery of social services and the formulation of client habilitation plans. *Normalization* refers to the utilization of approaches and services that are as culturally normative as possible. The phrase *culturally normative* means typical or conventional. Normalization does not refer to being "normal" but rather to attempts to decrease deviance (i.e., differences that are socially created). Moreover, normalization does not imply that the person with a disability should be placed in situations that generate unusual frustration or impossible competition just because those situations are typical for the average person. However, it does call for actions that remove forms of overprotection and recognizes that learning and living one's life involves a degree of risk taking and possible failure.

10. It is in relation to clients with severe disabilities that a social worker is likely to encounter the legal procedures known as guardianship and conservatorship. In a **guardianship** arrangement, a court finds a person to be legally incompetent because of young age or mental or physical incapacity and therefore invests another person (the guardian) with the power to manage the incapacitated person's money and property and to make certain other decisions such as those related to health care. In a **conservatorship,** the court appoints another (the conservator) for the more limited purpose of managing the legally incompetent person's estate. Neither of these two procedures should be confused with **power of attorney,** which does not involve a court finding of legal incompetence but simply involves the use of a notarized document in which one legally competent person voluntarily gives to another the legal power to take certain actions such as selling a property, depositing or withdrawing funds from a bank, or paying bills.

SELECTED BIBLIOGRAPHY

Dosen, Anton, and Kenneth Day. *Treating Mental Illness and Behavior Disorders in Children and Adults with Mental Retardation.* New York: Springer, 2001.

Hilton, Alan, and Ravic Ringlaben, eds. *Best and Promising Practices in Developmental Disabilities.* Austin, TX: Pro-Ed, 1997.

Luckasson, Ruth. *Mental Retardation.* Washington, DC: American Association on Mental Retardation, 2002.

15.9 The Client with Brain Injury

PURPOSE: To consider the aftereffects of brain injury in assessment and case planning.

DISCUSSION: Recent advances in emergency medical treatment have made it possible to save the lives of many people who have a stroke or a traumatic head injury. Prior to these advances, a high percentage of the individuals with these conditions died.

Consequently, a growing number of individuals in U.S. society have survived a life-threatening event but struggle with the aftereffects of brain injury. Brain injury results in significant but often subtle alterations in memory, judgment, impulse control, perception, emotionality, speech control, and motor control. Such changes can have a profound effect on the person's capacity for social functioning, employability, and family relationships.

The most common causes of brain injury are blows to the head and strokes. The actual effects of an injury depend primarily on what parts of the brain are damaged and the type of damage. For example, the effects of stroke (*cerebral vascular accident,* or *CVA*) can be quite circumscribed because a blocked blood vessel will cause damage to a very specific area of the brain. For this reason, once the location of stroke-caused damage is known, the aftereffects can be predicted with some accuracy. By contrast, the aftereffects of a traumatic brain injury, such as one acquired in an auto accident or a beating to the head, can be defuse and unpredictable because the tearing and shearing of tissue occurs in several areas of the brain.

Individuals with significant brain injury, especially if caused by trauma, will often develop a pattern of rigid thinking. Because they have difficulty detecting subtle differences among ideas and nuances in meaning and are frustrated by complexity and ambiguity, they tend to hold tightly to their understandings and interpretations. They are inclined to view an issue or position as either entirely right or entirely wrong and have difficulty accepting a middle ground and considering both the advantages and disadvantages of a proposal. This black-or-white type of thinking makes it difficult for them to make workable decisions and causes others to perceive them as rigid, abrasive, opinionated, and narrow minded.

Stroke

Typically, the most visible sign of a stroke is a paralysis on one side of the body. Damage to the left side of the brain results in right-sided paralysis and problems with speech and language (termed *aphasia*). In addition, the person tends to be slow, hesitant, and disorganized when faced with an unfamiliar situation.

CVA damage to the right brain results in left side paralysis and causes difficulties in perception. The person tends to be impulsive, have poor judgment, and overlook his or her limitations. This individual can often describe and explain tasks that need to be done but is not able to do them. He or she has trouble both expressing emotions and perceiving the emotional signals of others.

Many of those who have had a stroke have what is termed *one-sided neglect*, meaning that they may have lost sections of their visual field or have lost sensory signals to parts of their bodies. For example, a man with a paralyzed arm may be unaware that his arm is dangling near a hot stove. Another illustrative example is the woman who looks at her own leg and then becomes upset because she concludes someone is laying in bed beside her. Persons with such perceptual problems can easily become confused while traveling or moving about.

Other problems commonly associated with a stroke include (1) the person becomes careless and neglectful of personal grooming and appearance; (2) loss of memory retention span (i.e., a decrease in the number of things that can be retained and attended to at one time); (3) decreased capacity for short-term memory, which

makes new learning difficult; (4) difficulty in generalization (i.e., applying what was learned in one situation to another); (5) emotional lability (i.e., laughing or crying for no apparent reason); (6) sensory deprivation (i.e., loss in the ability to taste, hear, see, perceive touch, etc.); and (7) fatigue.

Traumatic Brain Injury

As indicated earlier, brain injury caused by a blow to the head tends to affect more areas of the brain than an injury caused by stroke. Trauma to the brain may result in paralysis or other physical symptoms such as seizures and a decrease in strength and coordination; however, it is common for the person to appear physically normal but experience a number of cognitive, behavioral, and emotional problems. Difficulties in memory, judgment, attention, perception, and impulse control can result in major problems in social interaction and job performance and can be especially troublesome if others assume these problems are caused by laziness or intellectual deficit rather than impaired brain functioning.

For the social work practitioner who may encounter a client who has had a stroke or a traumatic brain injury, several guidelines are important:

1. Be alert to the possibility of brain injury effects whenever presenting problems involve personality changes, impulsiveness, poor memory, and poor judgment. Inquire as to a history of a concussion, coma, stroke, skull fracture, or other injuries to the head caused by, for example, car accidents, sports injuries, or violence.

2. If there is reason to suspect the existence of a brain injury, consult with a rehabilitation specialist, neurologist, or neuropsychologist concerning the symptoms and determine if a referral for an in-depth evaluation is indicated. A medical doctor who specializes in physical rehabilitation and in treating the aftereffects of stroke and head injury is called a *physiatrist.* This medical specialty is known as *physiatry* (not to be confused with *psychiatry*).

3. Rehabilitation programs can be successful in teaching patients how to compensate for some of the deficits caused by brain injury. They are most beneficial when started as soon as possible after the brain damage has occurred.

4. The family of a person who has had a stroke or acquired a head injury will need information, guidance, and support in learning to cope with the many changes they face in relating to a loved one who may seem like a different person. Support groups exist in most communities.

5. Individuals with brain injury may fabricate an explanation or make up a story in order to cope with or hide their problems of poor memory and learning difficulties. They may hold tightly to false beliefs because the beliefs help them make sense out of the unorganized bits of information they possess and the confusion they experience. The family may be distressed and angry when the person with brain injury insists that an obviously false belief is true. Organizations such as the National Head Injury Foundation and the National Stroke Association provide information as well as support to the survivors of head injury and stroke and their families.

6. The family should be encouraged to review relevant legal documents, contracts, wills, financial agreements, and the like and to develop legal protection against impulsive decisions and poor judgments made by a family member who experiences the effects of a head injury.

7. State departments of vocational rehabilitation may have special employment programs for persons with serious cognitive deficits caused by head injury. Such services may include job coaching and extended or supported employment programs. Cognitive deficits that preclude competitive employment may qualify a person for Social Security Disability Income benefits.

SELECTED BIBLIOGRAPHY

Acorn, Sonia, and Penny Offer, eds. *Living with Brain Injury: A Guide for Families and Caregivers.* Toronto, Canada: Toronto Press, 1998.

Miller, Laurence. *Psychotherapy of the Brain-Injured Patient.* New York: W. W. Norton, 1993.

Senelick, Richard, Peter Rossi, and Karla Dougherty. *Living with Stroke: A Guide for Families.* Chicago: Contemporary Books, 2000.

15.10   The Client with a Serious Physical Disability

PURPOSE: To adapt social work techniques and approaches to the special needs of a client with a serious physical disability.

DISCUSSION: Nearly 20 percent of the people in the United States experience some sort of physical or mental impairment that limits their functioning. For 8 percent, that impairment affects their ability to find and secure employment, thus further limiting their ability to fully participate in society. For social workers in many settings, but especially those employed in hospitals and rehabilitation centers, understanding the impact of a disabling condition is critical to effective practice.

A variety of conditions are typically included among the serious physical disabilities that people experience. Persons who have a physical deformity or orthopedic impairment, are blind or deaf, or have a speech disorder are most visible in this population group. Many other individuals, however, may be limited in their physical activity by less apparent chronic physical conditions such as arthritis, heart disease, high blood pressure, diabetes, and asthma. In most cases, these conditions will not be completely cured or corrected by medical intervention. Social workers will then assist these people (and their families) to use their strengths and abilities to lead lives as full and rich as possible.

A grasp of certain terminology is important to any discussion of disability. The term ***impairment*** refers to a long-term or permanent bodily, sensory, or cognitive limitation caused by a disease or injury or by advanced age. If the impairment significantly hampers a person's capacity to perform his or her major social roles and other normal and usual activities (e.g., self-care, moving about, and communicating with others), it is termed a ***disability.***

To a considerable extent, the degree to which an impairment becomes a disability depends on the physical and social barriers the person encounters in his or her environment or situation. An example of a *physical barrier* for a person using a wheelchair is a set of stairs. An example of a s*ocial barrier* for the same person is the prejudice or discrimination that keeps him or her from securing a job for which he or she is qualified and for which the ability to walk is not required. Thus, a *disability* is the outcome of an interaction or interplay between the person's impairment and existing physical, social, and attitudinal barriers. The terms ***handicap*** and ***handicapping condition*** often are used to describe an impairment or a disability that imposes a very serious limitation on a person's capacity to function physically, socially, or economically in a normal or usual environment.

From this discussion, we can see that eliminating physical and social barriers and using adaptive technology and equipment can go a long way in keeping an impairment from actually becoming a significant disability or handicapping condition. In recent decades, federal laws such as the 1973 Rehabilitation Act, the 1975 Education for All Handicapped Children Act, and the 1990 ***Americans with Disabilities Act*** (***ADA***) have greatly benefited persons with disabling conditions. The ADA, which has been described as the "emancipation proclamation for the disabled," provides a national mandate and the legal mechanisms to remove barriers for and eliminate discrimination against persons with disabilities, especially in the areas of employment, access to public services and public transportation, access to goods and services offered by businesses, and access to telecommunications. The ADA is a solid basis for social work advocacy with and in behalf of persons with disabilities.

It is important for the social worker to be familiar with the various programs and services a client with a physical disability might need. The two most significant federal programs are worker's compensation, which provides financial assistance to a person recovering from a work-related injury, and programs under the Social Security Act, including Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). In addition, a number of local programs that focus on specific disabling conditions (e.g., cerebral palsy, arthritis, multiple sclerosis, blindness) can be found in most communities.

The social worker should remember these useful points when working with persons who are physically disabled:

- Work first with the person and then the disability.
- Use a strengths perspective and look for abilities to offset disabilities.
- Maximize client self-determination.
- Seek to normalize as much of the client's life as possible.
- Empower the client by asking how you might help, rather than assuming he or she needs assistance.
- Be prepared for advocacy.
- Engage the client's family and friends in providing services.
- Above all, treat the client with dignity.

SELECTED BIBLIOGRAPHY

May, Gary, Martha Raske, and Cynthia Baker. *Ending Disability Discrimination: Strategies for Social Workers*. Boston: Allyn & Bacon, 2005.

Rothman, Juliet. *Social Work Practice across Disability*. Boston: Allyn & Bacon, 2003.

15.11 The Client Who Is Chemically Dependent

PURPOSE: To engage the chemically dependent client in ways that increase the chance he or she will seek treatment and deal effectively with his or her addiction.

DISCUSSION: Many of the individuals and families receiving services from social agencies are affected directly or indirectly by alcohol and/or drug dependency. The abuse of chemicals is a contributing factor in many other problems, such as marital discord, parent-child conflict, spouse abuse, child abuse and neglect, suicide, homicide, financial problems, crime, and auto accidents. Substance abuse also contributes to the spread of AIDS due to intravenous injections and indiscriminate sexual behavior related to the disinhibiting effects of drugs and alcohol. The use of alcohol and drugs by a pregnant woman can damage the fetus and result in various birth defects and neurological and developmental problems.

Individuals who are alcohol dependent and/or drug dependent are usually difficult and challenging clients because of the pathological denial, rationalization, and self-delusion that are part of the addiction process. These individuals typically reject offers of professional help and will see an addictions counselor only after being court ordered or coerced into treatment by family or friends. The social worker's response to these clients must be based on an understanding of how alcohol and drugs affect the mind and body and on the realization that it is seldom possible to break an addiction without great and persistent effort and specialized treatment.

Some professionals find it useful to distinguish between dependency and abuse. *Chemical abuse* or *substance abuse* refers to occasional use that causes problems in only one or two areas of functioning. In contrast, *chemical dependency* refers to a pattern of frequent use that is affecting several areas of personal and social functioning.

A **chemical dependency** can be defined as a pathological relationship with a mood-altering substance. The dynamics of this relationship resemble those of a neurotic love affair, but in this case, the love object is a chemical. Each time the chemical is used, its mood-altering effects reinforce usage, and over time, this learning process results in *psychological addiction.* In addition, many chemicals alter the body's neurochemistry, which can lead to a physiological or physical dependence characterized by *tolerance* (i.e., an ever-increasing amount of the chemical is required to bring on the desired mood-altering effect) and by symptoms of *withdrawal* (i.e., the individual becomes physically ill in the absence of the chemical). An individual may go to extremes (e.g., stealing, violence) to avoid the onset of the distress and discomfort that characterize this type of illness. Making efforts to avoid or delay symptoms of withdrawal is referred to as the *withdrawal avoidance syndrome.*

Generally speaking, the chemicals most sought after are those with a rapid onset of action. Onset of effect is related to chemical properties, dose, method of intake, and characteristics of the user. The effect of a chemical is also influenced by the psychosocial setting of its use.

There are local and regional differences in the popularity of certain chemicals, terminology, and preferred methods of intake. There are continual changes in the

street lingo applied to illegal substances and new chemical combinations appear frequently. Provided here are brief descriptions of the legal and illegal substances most often abused and that serve as the basic ingredients for new combinations.

Nicotine

The nicotine found in tobacco is highly addictive. Because this stimulant is so widely used and is a contributing cause in cancer and heart and lung disease, nicotine may cause more illness and death than all of the illegal street drugs combined. Tobacco is usually smoked but is also chewed or placed next to the gums in the form of "snuff."

The cessation of smoking brings on a physical withdrawal syndrome and a craving that is particularly uncomfortable and drawn out. These effects can be alleviated almost immediately, however, by a return to the use of nicotine. This makes quitting exceedingly difficult.

Alcohol

If one considers the number of individuals and families affected, the number of injuries and deaths caused by drunken driving, and the number of health problems either caused or exacerbated by drinking, the abuse of alcohol (a legal drug) is the number one drug problem in the United States. Because alcohol depresses the central nervous system (CNS), it can be very dangerous when used with other drugs or medications that also depress the CNS.

The American Medical Association, the National Council on Alcoholism, and the American Society of Addiction Medicine all view alcohol dependence as a chronic disease that is often progressive and fatal. Genetic, psychosocial, and cultural factors influence the development and manifestations of this disease. The individual who will eventually develop a dependency can often consume a great deal of alcohol without showing the effects; this phenomenon may be genetic in origin.

There is no cure for this disease; at best, it can be controlled through complete abstinence from alcohol. Treatment experts generally agree that once addicted, the individual can never again become only a casual user of alcohol (i.e., a social drinker). If the alcohol-dependent person tries to drink in moderation, he or she will soon resume a pattern of uncontrolled problem drinking. There is some research to support a so-called harm reduction model of treatment, but the vast majority of experts continue to endorse abstinence as the only sure way to maintain control over alcohol addiction.

In its early stage, alcohol dependence is difficult to recognize because the symptoms are subtle. Moreover, the dependent person's drinking pattern may be almost indistinguishable from that of a person who drinks too much only occasionally. However, one may observe that the dependent person drinks a greater amount and more often than others and that drinking plays a part in most of his or her activities. Yet during this early stage, the consumption of alcohol may not significantly interfere with job or family functioning.

In the middle stage, the alcohol-dependent person becomes physically addicted. When his or her blood-alcohol level is lowered, he or she will experience withdrawal symptoms, including anxiety, agitation, tremors, and sweating as well as

fluctuations in blood pressure and blood-sugar levels. Increasingly, the individual will have trouble remembering what occurred while drinking, a phenomenon called a *blackout.* He or she will drink more, more often, and for longer periods than intended, and as a result, he or she will be late for or miss work-related appointments and family events. Family and job functioning also will be adversely affected at this point, and family and friends will commonly ask the individual to cut back. The individual may quit drinking for a few weeks at a time but will eventually start again. Experiencing these short periods of abstinence will convince the dependent person that it is possible to quit whenever he or she really wants to and that drinking is not a problem. Concerned family members may reach out for professional help, but typically, the alcohol-dependent person will deny there is a problem.

In the late stage, the seriousness of the problem is apparent to everyone but the alcoholic, for paradoxically, the more serious the addiction becomes, the less he or she will be aware of what is happening. By this point in the addiction process, the individual may have lost his or her family and job and may have alcohol-related health problems. However, the denial and self-delusion will continue, and only experiencing a major personal or health crisis will temporarily shake him or her into reality.

The progression of alcohol dependency may be somewhat different for different individuals. For example, an adolescent who engages in heavy drinking may develop a dependency after only 6 or 18 months of drinking. Other individuals may drink for 15 or 20 years before the onset of dependency.

Amphetamines

There are several forms of amphetamines. All are CNS stimulants. Some (e.g., Dexedrine and Benzedrine) are manufactured by pharmaceutical companies and prescribed in the treatment of narcolepsy, brain dysfunction, and obesity. When these prescription drugs are sold illegally on the street, they are often called "uppers," "dexies," "bennies," and so on. As new laws placed tight controls on the prescription use of these drugs, related forms (i.e., the methamphetamines) were produced illegally and are now widely used because of their strength, low cost, and the ease with which they can be manufactured in simple laboratories. Among the ingredients used in making methamphetamine are Sudafed and related cold remedies that may contain Ephedrine, sodium hydroxide, sodium sulfate, ether, iodine, acetone, rubbing alcohol, brake cleaner, engine starter, drain cleaner, rock salt, farm fertilizer, lye, red phosphorus from matches or road flares, and nail polish remover.

Among the forms of methamphetamine are methamphetamine sulfate (i.e., "crank"), methamphetamine hydrochloride (i.e., "crystal meth"), and dextromethamphetamine (i.e., "ice"). These chemicals produce an intense and long-lasting euphoria and have been called the "poor man's cocaine." Depending on their form, they may be snorted, swallowed, smoked, or injected.

The abuse of these stimulants is indicated by hyperactivity, nervousness and anxiety, dilated pupils, irritability, and going for long periods without sleep or food. Some users experience a dry mouth, sweating, headache, blurred vision, dizziness, and sleeplessness. High doses can cause dangerously rapid or irregular heartbeat, tremors, loss of coordination, and physical collapse. Long-time and heavy use can lead to malnutrition, skin disorders, ulcers, weight loss, kidney damage, depression,

and speech and thought disturbances. A methamphetamine injection causes a sudden increase in blood pressure that can precipitate a stroke or heart failure.

Heavy use can result in a psychosis involving hallucinations (seeing hearing, and feeling things that do not exist), delusions (having irrational thoughts or beliefs), and paranoia (feeling as though people are out to harm him or her). In such a state, the person may exhibit bizarre and sometimes violent behavior. Methamphetamine use is a major factor in some cases of child abuse, domestic abuse, and other forms of violence. Withdrawal from this drug (often referred to as "crashing") is uncomfortable and often characterized by fatigue, nightmares, insomnia, depression, and a wildly fluctuating appetite.

Cocaine

Cocaine, like the amphetamines, is a CNS stimulant. Derived from the coca plant native to the high mountain regions of South America, cocaine is smuggled into a country as a fine, white, crystalline powder (cocaine hydrochloride). This powder is then diluted, or "cut," to increase its bulk and stretch the supply for sale.

The most common method of administration is intranasal, or "snorting" the diluted powder. When snorted, the euphoric effects begin within a few minutes, peak within 15 to 20 minutes, and disappear within about 45 minutes. During this brief period, the user often feels confident, energetic, talkative, and omnipotent.

Chemical procedures can be used to separate or free the pure cocaine from the other usual additives in powdered cocaine. This results in "freebase" that can be smoked—a more direct and rapid way to transmit the chemical to the brain. Smokeable "crack" or "rock cocaine" is particularly potent and highly addictive.

The smoking of "crack" produces a short but very intense "high." Whereas the users of powdered cocaine may develop their addiction over many months or even years, "crack" smokers can become addicted in a matter of days.

Since freebase cocaine is water soluble, it can also be injected. This is the most dangerous method of administration. Because it produces an immediate and intense euphoria, intravenous use is highly addictive.

Regular users of cocaine often report feelings of restlessness, irritability, anxiety, and sleeplessness. Cocaine causes physical and mental damage similar to that caused by the amphetamines. High doses over a long period may precipitate a "cocaine psychosis" with hallucinations of touch, sight, taste, or smell. Because cocaine stimulates the body and its nervous system, it is not uncommon to experience a physical "crash" and a mental depression following a period of use. These depressions and mood swings can be debilitating and last from a few hours to several weeks. The uncomfortable psychological and physiological effects of withdrawal are a constant source of anxiety for cocaine abusers.

Marijuana

Marijuana is the common name for a tobacco-like dried leafy substance made from the plant *cannabis sativa*. The main psychoactive ingredient in marijuana is THC (delta-9-tetrahydrocannabinol). The amount of THC in the marijuana determines how strong its effects will be on the user. Hashish, or hash, is made by taking the resin from the leaves and flowers of the plant and pressing it into cakes; it contains

more THC than crude marijuana. Marijuana and hash are usually smoked but sometimes taken orally.

Research and the clinical experience of drug treatment programs identify several adverse effects. Some individuals become psychologically addicted, and heavy users may develop *amotivational syndrome,* such that they generally lose interest in life's major activities and feel increasingly passive and sluggish. Marijuana addicts do not experience the physiological withdrawal syndrome that commonly follows use of so-called hard drugs, but it is not uncommon for these individuals to report a psychological withdrawal that includes intense feelings of craving.

An individual "high" on marijuana or hashish will feel euphoric and may speak rapidly and loudly and have dilated pupils. Some individuals experience sensory distortions. The drug can impair short-term memory, alter sense of time, and reduce the ability to do things that require concentration and quick reactions such as in driving a car. A possible response to marijuana is an acute panic reaction.

Because many people view marijuana as relatively harmless, it is the most politically controversial of all illegal substances. Because it holds promise as a treatment for glaucoma and for the side effects of chemotherapy, some advocate for the legalized use of marijuana as a regulated medicine.

PCP

PCP (phencyclidine) was developed as an anesthetic but later taken off the market for human use because it sometimes caused hallucinations. It continues to have use in veterinary medicine. PCP is easily manufactured and is available in a number of forms (i.e., white crystal-like powder, tablet, or capsule). It can be swallowed, smoked, sniffed, or injected. PCP powder, sometimes referred to as "angel dust" or "dust," is sprinkled on marijuana and smoked.

The sought-after effect is euphoria. For some users, small amounts act as a stimulant. For many, PCP changes how they perceive their own bodies and things around them; movements and time are slowed. The effects of PCP are unpredictable, and for this reason many "experimenters" abandon its use. Others, unfortunately, become dependent. Negative effects include increased heart rate and blood pressure, flushing, sweating, dizziness, and numbness. When large doses are taken, effects include drowsiness, convulsions, coma, and sometimes death. PCP can produce violent or bizarre behavior. Regular use affects memory, perception, concentration, and judgment. Users may show signs of paranoia, fearfulness, and anxiety. When under the drug's influence, some become aggressive; others withdraw and have difficulty communicating. A PCP-induced psychosis may last for days or weeks.

Hallucinogens

Hallucinogens, or psychedelics, are drugs that affect a person's perceptions, sensations, thinking, self-awareness, and emotions. This category includes such drugs as LSD, mescaline, and psilocybin. *LSD* is manufactured from lysergic acid, which is found in a fungus that grows on grains. LSD is sold on the street in tablets, capsules, or occasionally in liquid form. It is usually taken by mouth. *Mescaline* comes from the peyote cactus and, although it is not as strong as LSD, its effects are similar. Mescaline is usually smoked or swallowed in the form of capsules or tablets. *Psilocy-*

bin comes from certain mushrooms. It is sold in tablet or capsule form or the mushrooms themselves may be eaten.

The effects of psychedelics are unpredictable and depend on dosage as well as the user's personality, mood, expectations, and the surroundings. The person's sense of time and self change. Several different emotions may be felt at once or swing rapidly from one to another. Sensations become mixed and seem to "cross over," giving the user the feeling of hearing colors and seeing sounds. For some, these strange sensations are frightening and cause a "bad trip" that may last a few minutes or several hours and involve confusion, suspiciousness, anxiety, feelings of helplessness, and loss of control. Physical effects include dilated pupils, higher body temperature, increased heart rate and blood pressure, and often sweating, irregular breathing, and tremors. Some users sit in a stupor, whereas others become agitated.

In recent years, a manufactured hallucinogenic known as *MDMA,* or "Ecstasy," has become popular in the United States and Europe. It is usually taken by capsule or tablet. Its use brings on mild distortions of perceptions, has a calming effect, and, for many, creates a feeling of empathy with others. It does not cause the visual illusions often associated with the psychedelics. Physical dependency is not a major problem, but psychological dependence does develop in many users. Growing evidence indicates that frequent and heavy use of MDMA causes damage to the brain.

The use of hallucinogens can unmask underlying mental or emotional problems. Also, some users experience *flashbacks,* which are intense and intrusive memories and emotions that can occur days and even weeks after having taken the drug. Heavy users sometimes develop impaired memory, loss of attention span, confusion, and difficulty with abstract thinking.

Sedative Hypnotics

Sedative hypnotics are prescription drugs often referred to as sleeping pills, sedatives, and tranquilizers (antianxiety medications). Two major categories are the barbiturates and the benzodiazepines, which include Xanex, Valium, Librium, Ambien, and Ativan. These manufactured pharmaceutical drugs are usually obtained with a prescription from a physician, but prescriptions are commonly altered or forged by addicts. These pills are sometimes stolen and sold on the street, as well. Because they depress the central nervous system, they have a calming effect and promote sleep. An individual who has taken a higher than prescribed dosage may give the appearance of being drunk (e.g., staggering, slurred speech, sleepiness, etc.) but not smell of alcohol. When taken with alcohol (also a depressant), these drugs can cause unconsciousness and death.

The sedative-hypnotic drugs can cause both physical and psychological dependence. When regular users suddenly stop, they may develop withdrawal symptoms, ranging from restlessness, insomnia, and anxiety to convulsions and death. Barbiturate overdose is a factor in many drug-related deaths; these include suicides and accidental poisonings.

Inhalants

Inhalants are chemicals that produce semitoxic vapors. The vapors are concentrated and then inhaled in a practice sometimes called *huffing.* The inhalants are grouped into four classes: (1) volatile solvents (e.g., certain glues, gasoline, paint thinner, nail

polish remover, lighter fluid); (2) aerosols (e.g., spray paints); (3) anesthetics (e.g., ether, chloroform, nitrous oxide); and (4) amyl and butyl nitrates. Nearly all of the abused inhalants act to depress the body's functions. At low doses, users may feel slightly stimulated and some, like butyl nitrite, produce a "rush" or "high" lasting for a few seconds or a couple of minutes. Young people are likely to abuse inhalants, in part because these chemicals are readily available and inexpensive.

Possible negative effects include nausea, sneezing, coughing, nosebleeds, fatigue, bad breath, lack of coordination, and a loss of appetite. Solvents and aerosols decrease the heart and breathing rates and affect judgment. Deep breathing of the vapors may result in a loss of self-control, violent behavior, and unconsciousness. Inhalants can cause death from suffocation by displacing oxygen in the lungs and by depressing the central nervous system to a point that breathing stops. Moderate to long-term use can damage the brain, liver, kidneys, blood, and bone marrow.

Opiates

Opiates (narcotics) are a group of drugs used medically to relieve pain, but they also have a high potential for abuse. Some opiates (opium, morphine, heroin, and codeine) come from the Asian poppy. Others, such as meperidine (Demerol), are manufactured. Heroin accounts for most of the opiate abuse in the United States.

Opiates are ingested, snorted, smoked, or injected intravenously. After causing an initial rush, they tend to relax the user. Indicators of opiate abuse include needle scars on the arms and the backs of hands, drowsiness, frequent scratching, red and watering eyes, sniffles, and a loss of appetite overall but an attraction to sugar and candies. In contrast to the effects of most other abused drugs that dilate the eye's pupils, the opiates constrict the pupils. When an opiate-dependent person stops taking the drug, withdrawal symptoms begin within 4 to 6 hours; symptoms include anxiety, diarrhea, abdominal cramps, chills, sweating, nausea, and runny nose and eyes. The intensity of these symptoms depends on how much was taken, how often, and for how long. Withdrawal symptoms for most opiates are stronger approximately 24 to 72 hours after they begin but subside within 7 to 10 days.

Most of the physical dangers of opiate abuse are caused by overdose, the use of unsterile needles, contamination of the drug by other chemicals, or combining the drug with other substances. Over time, opiate users may develop infections of the heart, skin abscesses, and congested lungs.

Pain Medication

Addiction to prescription pain medication is perhaps the fastest-growing addiction problem in the United States. These addictive compounds include Darvon, Darocette, Percodan, Percocette, Demerol, Vicodin, Hydrocodone, and Oxycodone. Many individuals get caught up in dependency and illegal use after first taking one of these drugs as a prescribed and legitimate medical treatment. Once dependent, the individual goes through withdrawal symptoms that are similar to those associated with withdrawal from an opiate. Being addicted to pain medication may give rise to reckless and criminal behavior, as the individual desperately attempts to secure the drug. Prescription forgeries and pharmacy and hospital robberies are both associated with the abuse of these addictive pain medications.

Guidelines for Dealing with a Chemically Dependent Client

Social workers should consider numerous guidelines throughout their relationship with a chemically dependent individual and his or her family:

1. Because the abuse of and dependence on alcohol and other drugs is such a pervasive problem in U.S. society, the social worker should assume that it will be a contributing factor to many of the individual, family, and community problems encountered in practice. In fact, the existence of a substance abuse problem must be considered even when neither the client nor the client's family has mentioned it. An individual who is chemically dependent is seldom capable of accurately reporting the frequency with which he or she uses chemicals or the quantity that he or she uses.

2. Drugs and alcohol are used initially because they make people feel better, even if but for a short time. Curiosity and peer pressure also play a role. The powerful reinforcement provided by the chemical's mood-altering effects often leads to dependence. No one starts using a drug with the intention of becoming dependent or addicted; in fact, beginners usually believe they are invulnerable to addiction. There is a steady supply of both legal drugs (e.g., alcohol) and illegal drugs because so much money can be made in this market.

3. Never underestimate the psychological power of alcohol and drugs. The addictive process can turn an otherwise kind and honest person into a self-centered individual who is compelled to lie, cheat, and even injure loved ones in order to protect and maintain his or her love relationship with a chemical. Typically, the user is adamant in denying any dependence on a substance and denies any connection between his or her problems in life and his or her use of alcohol or a drug.

4. Be alert to *signs of chemical dependency.* An individual with an alcohol and/or drug problem will probably exhibit several of the following behaviors and patterns:

- Displays increased tolerance (i.e., over time, the individual will need more and more of the chemical to experience its effects)
- Experiences symptoms of physiological withdrawal; often uses the chemical to relieve those symptoms
- Continues to use the chemical even though use is causing serious personal, family, and work-related problems
- Continues to use the chemical despite having been warned by a doctor that use is causing a serious health problem
- Uses more of the chemical, uses it more often, and uses it over longer periods than intended or planned and as a result is late for or misses work-related appointments and family events
- Voices a desire to cut back on use but is unsuccessful in efforts to control drinking and/or drug use
- Abandons activities and relationships that were previously important in favor of drinking and/or drug use
- Neglects appearance, grooming, and hygiene
- Experiences a decrease in physical and intellectual capacities, such as physical stamina and ability to concentrate, pay attention, and think logically

- Participates in illegal and/or reckless activities (e.g., stealing, prostitution) in order to obtain the chemical, when there has been no prior history of such activities
- Constantly uses sunglasses to protect dilated eyes from light (i.e., indicates drug use)

5. If your client comes to an interview intoxicated, there is no point in trying to gather psychosocial data or to engage the client in a counseling process. Explain in a polite but firm manner that you need accurate information to do your job and must therefore postpone the interview, rescheduling it for a time when the client is sober. Expect the client to become angry but remain calm and firm.

6. If an intoxicated individual appears at your agency, secure basic identifying information (name, age, address, etc.) and then attend to the individual's physical condition. Be alert to the life-threatening dangers of delirium tremens or drug overdose and the need for detoxification under medical supervision. If you know that the client intends to drive away from the agency under the influence, you have a duty to notify law enforcement.

7. Do not become part of an enabling system. That is, do not lend the client money and do not write letters or make phone calls that "cover" for the client and protect him or her from the real-life consequences of chemical abuse.

8. Because alcohol and drugs alter mood, individuals with underlying mood disorders (e.g., depression, anxiety, and bipolar disorder) are particularly vulnerable to the abuse of these chemicals because using them may help these individuals feel better, at least for a short time. Individuals with low self-esteem, feelings of powerlessness or loneliness, and emotional pain are also attracted to the numbing effects of certain chemicals. However, these underlying problems and issues cannot be properly assessed and treated until after the individual has stopped the misuse of chemicals.

9. Learn the basic principles and techniques of *motivational interviewing,* an approach being used increasingly with substance-abusing clients. It has the effect of decreasing these clients' resistance and increasing their motivation to change (i.e., to enter treatment and continue efforts toward recovery). This approach rests on the observation that clients tend to be more committed to a plan (e.g., treatment, sobriety) when they perceive it to be one of their own choosing and one that will addresses their personal concerns. Also, clients tend to become even more resistant when a professional insists that they have a "problem" and that they must accept the label of being an "alcoholic" or "drug addict." The underlying strategy of motivational interviewing is to engage the client in a discussion of his or her current situation in a way that will create a dissonance or a perceived discrepancy between his or her drinking or drug use and what he or she considers to be important (e.g., self-esteem, health, success on the job, being a good parent, etc.). This approach strives to help clients verbalize what they really want and then conclude for themselves that their drinking or drug use is a barrier to reaching their own important goals.

10. Learn about the behavioral pattern of *codependency* that develops as a result of living for many years with someone who is chemically dependent. Typically, the codependent assumes responsibility for the behavior of others (e.g., the alcoholic) while neglecting his or her own needs. Persons who have taken on a pattern of co-

dependency are often hostile because of how they have been treated by someone they love, controlling because their situation is so out of control, manipulative because manipulation seems to be the only way to get things done, and indirect and vague in their communication because they live in a family system that cannot tolerate honesty.

11. Because a person who is chemically dependent is seldom able to stop using without the help of a treatment program, a referral for treatment likely will be necessary. However, before attempting a referral, it is best to consult with a treatment specialist on how to approach the client on this matter and how you might handle his or her probable resistance to the idea of securing treatment.

The available options for securing treatment will need to be examined and structured within the client's health insurance program (e.g., HMO, managed care) or applicable tax-supported programs. In some cases, inpatient medical care will be needed to manage physiological withdrawal (detoxification). After undergoing medically supervised detoxification, if needed, the individual will enter a treatment program that will take one of several forms (e.g., inpatient, outpatient, day treatment). Ongoing weekly or twice-weekly outpatient counseling sessions (both individual and group) may continue for six months to one year or longer.

Most recovering addicts will likely be involved in a *12-step program* (e.g., Alcoholics Anonymous, Cocaine Anonymous, Narcotics Anonymous), which provides encouragement and teaches methods of day-to-day coping. These self-help programs emphasize the development of spirituality and help the individual develop a life-style free of alcohol and drugs.

12. The assistance and support of the client's family and friends will probably be needed in making a referral to a treatment program. Thus, it may be necessary to reach out to these individuals and engage them in the assessment, planning, and helping process. However, be alert to the possibility that they too may have a substance abuse problem and/or may be contributing to your client's problem through denial, enabling, or codependency behaviors.

13. Learn about 12-step recovery programs by attending open meetings and talking with members. Members are usually eager to consult with professionals who want to learn about the effects of addiction, the nature of the recovery process, and effective ways of dealing with the challenges presented by clients who are chemically dependent.

14. Encourage family members to make use of Al-Anon and Alateen groups, along with other resources such as COA (Children of Alcoholics), ACOA or ACA (Adult Children of Alcoholics), and programs that address the problem of codependency.

15. Once the individual stops using chemicals, special attention must be given to planning for relapse prevention. This involves helping the individual develop a plan for coping with those times and situations when he or she will be at highest risk of resuming the use of alcohol and drugs. Also, it is important to remember that once an individual has been addicted to one type of chemical, he or she will be vulnerable to become addicted to another type. Help the recovering addict be vigilant with regard to use of both prescription and over-the-counter medications. Recovering addicts should inform their physicians of their prior problems with the abuse of chemicals.

SELECTED BIBLIOGRAPHY

Doweiko, Harold. *Concepts of Chemical Dependency,* 5th ed. Pacific Grove, CA: Brooks/Cole, 2002.

Inaba, Darryl, and William Cohen. *Uppers, Downers, All Arounders,* 5th ed. Ashland, OR: CNS Productions, 2003.

Miller, William, and Stephen Rollnick. *Motivational Interviewing: Preparing People to Change Addictive Behavior,* 2nd ed. New York: Guilford, 2002.

15.12   The Client with Serious Mental Illness

PURPOSE: To adapt social work techniques and approaches to the special needs of a client with serious mental illness.

DISCUSSION: There are three major categories of serious mental illness: schizophrenia, bipolar disorder, and major depression. All three are diseases of the brain caused primarily by biochemical and structural changes in the brain tissue. Each may be episodic and vary in intensity and the degree to which it impairs a person's functioning. Some of those who experience these illnesses may lose touch with reality (i.e., become psychotic), whereas others may only have trouble with memory, judgment, or feelings of low self-worth.

Schizophrenia is a baffling and debilitating illness. About 1 percent of the population is afflicted with this disturbance of the thinking processes. The usual age of onset is between 15 and 25 years old, when the frontal lobes of the brain are rapidly maturing. Symptoms frequently appear between the ages of 18 to 21 and are exacerbated by the stress of emancipation from the family. Many experts believe that a stressful environment, viral infections, and other physiological conditions may trigger the onset of this illness in those predisposed by heredity.

An individual with schizophrenia will exhibit several of these symptoms:

- *Delusions* (e.g., has false beliefs that have no factual basis)
- *Hallucinations* (hearing voices is the most common hallucination; visual hallucination [seeing nonexistent things] is relatively rare but is more likely if the individual is also abusing illegal drugs or psychiatric medications; olfactory and tactile hallucinations are less common but possible)
- *Disordered thinking* (e.g., making loose or illogical connections between thoughts; shifting rapidly from one topic to another; reaching conclusions that are unrelated to facts or logic; making up words or using sounds or rhythms that have no meaning to others)
- *Blunted or inappropriate affect* (e.g., narrow range of emotional reactions; the emotions or feelings do not fit the situation; speaks in monotone)
- *Extreme withdrawal* (e.g., withdrawal from ordinary life experiences and social interaction; deterioration in work or school performance; apathy in regard to appearance and self-care)

About one-fourth of those who have a schizophrenic episode get well and never have another episode. Some have occasional relapses. Between 20 to 30 percent develop symptoms that are persistent throughout life.

The other two types of serious mental illness—major depression and bipolar disorder—are known as *mood disorders* or *affective disorders.* Individuals with a **major depression** experience persistent feelings of sadness and melancholy. They often become tearful, irritable, or hostile for no apparent reason. Other symptoms common to depression include the following:

- Poor appetite and weight loss or increased appetite and weight gain
- Change in sleep pattern (sleeping too little or too much)
- Excessive fatigue; loss of energy
- Change in activity level (either increased or decreased)
- Loss of interest in being with others
- Loss of interest or pleasure in usual activities
- Decreased sexual drive
- Diminished ability to think, concentrate, or make decisions
- Anxiety and rumination over problems
- Feelings of worthlessness or excessive guilt that may reach delusional proportions
- Recurrent thoughts of death or self-harm; wishing to be dead or contemplating or attempting suicide

About 1 percent of the population suffer from **bipolar disorder,** which is characterized by swings between periods of depression and mania (a hyperactive state). Mania is often characterized by these qualities:

- An exaggerated or irritable mood
- Decreased need for sleep
- Inflated self-confidence and grandiose ideas
- Increased energy and activity
- Overoptimism, poor judgment, quick and impulsive decision making
- Unusually high levels of involvement in work, pleasurable activities, and sexuality
- Rapid and pressured speech and racing thoughts
- Distractibility

Most often, the depressive phase follows the manic phase. Sometimes, the two phases are separated by periods of near normal functioning. These episodes may come and go and last from several days to several months. Without treatment, there is usually an increase in the severity of the symptoms and the frequency of the episodes.

Some individuals experience the bipolar disorder with only the depressive or manic symptoms rather than both. These are termed *bipolar disorder, depressive type* and *bipolar disorder, manic type.* Often, a person's mental health history will predict how the bipolar disorder will manifest itself in the future. For example, a person who historically experiences depression in the autumn may continue to

experience more severe symptoms during these months of the year. There is evidence that this disorder has a basis in heredity.

When working with a client with serious mental illness, the social worker should follow these guidelines:

1. These illnesses, especially the mood disorders, can usually be treated effectively with proper medications. Thus, an individual with a serious mental illness should be under the care of a physician, preferably a psychiatrist, who can prescribe medications and monitor their effects. A combination of medication and other forms of mental health care, such as psychotherapy and supportive services, is the preferred treatment for most persons with a serious mental illness. (See Item 15.13 on psychotropic medication.)

2. Because depression gives rise to intense emotional pain and feelings of hopelessness, the risk of suicide must always be considered. (See Item 15.7 on suicide risk.) Of those with schizophrenia, about one in four attempts suicide and about one in ten dies of suicide. Thoughts of suicide or self-mutilation by someone suffering from schizophrenia place him or her at extremely high risk.

3. Delusions are a common symptom in schizophrenia. By definition, a *delusion* is a set of ideas and beliefs that remain fixed, even in the face of clear evidence to the contrary. Be very cautious about how you respond to a person's delusions. Remember that a delusion serves a purpose; it helps the individual cope with or make sense out of some mental or perceptual confusion. The person believes in the delusions because they seem true and provide an explanation. Listen carefully to the delusion and try to understand the assumptions on which it is built, but do not judge, criticize, or argue or use logic in an effort to eliminate this symptom. Do not challenge or confront the delusional thoughts, for that will probably destroy the relationship you have with the individual and cause him or her to feel angry and misunderstood. Also, confronting a delusion increases the risk that you will become part of the delusional system of thought and perhaps defined as an enemy or part of a plot or conspiracy.

4. A very small percentage of persons who become psychotic will experience *command hallucinations,* which are voices that tell these people to hurt themselves or others (e.g., a voice telling them to jump off a bridge or kill the mayor). These command hallucinations, although rare, are very dangerous. If this symptom cannot be controlled by medication, the individual should be hospitalized.

5. The individual with persistent and serious mental illness is usually in need of services that will assist him or her with the everyday tasks of living. Such services include case management, counseling, case advocacy, budgeting, and assistance in securing income, a job, housing, transportation, medical care, and the like. The *clubhouse model*—which provides peer support, acceptance, meaningful work and activity, and other services—is especially helpful and important to persons with a persistent mental illness (see Chapter 6).

6. A family member's mental illness has a profound impact on others in the family. The social worker should address the concerns of the family by doing the following:

- Help family members grieve the loss of their loved one who, because of mental illness, may now seem like a stranger.
- Provide practical information about mental illness. Ask about their possible fear of physical assault and worry over irresponsible financial decisions by the family member who is mentally ill.
- Encourage family members to join a self-help or support group such as the National Alliance for the Mentally Ill.
- Remain accessible to the families, especially during family crises that can be precipitated by relapses.
- Help the parents and siblings recognize their rights to a life apart from the anguish and worry they feel toward the family member who is mentally ill.
- Assist family members to secure services such as case management and respite care to relieve them of the daily responsibility of care giving and provide opportunities for rest and renewal.
- Inform family members of legal issues and rights related to securing and refusing treatment.

7. It should be noted that the treatment and management of a mental illness can be further complicated by the presence of another serious problem such as substance abuse, a personality disorder, or a developmental disability. The term *dual diagnosis* is applied to such a situation. A *personality disorder* is a deeply ingrained, inflexible, lifelong, and maladaptive pattern of emotional responses and behaviors that are often harmful or distressful to others. However, individuals with a personality disorder seldom see anything unusual about their own behavior and typically blame others for whatever difficulties they encounter in life. Because they do not feel inner pain or anxiety, they do not usually seek treatment voluntarily. There are several types of personality disorders. They are not brain disorders and appear to develop in response to family and social influences.

SELECTED BIBLIOGRAPHY

Austrian, Sonia. *Mental Disorders, Medications and Clinical Social Work,* 2nd ed. New York: Columbia University Press, 2000.

Berghuis, Davis, and Arthur Jongsma. *The Severe and Persistent Mental Illness Treatment Planner.* New York: John Wiley and Sons, 2000.

Tansella, Michele, and Graham Thornicroft. *Common Mental Disorders in Primary Care.* Philadelphia: Brunner/Mazel, 2000.

15.13   The Client on Psychotropic Medication

PURPOSE: To provide appropriate guidance to the client taking psychotropic medication.

DISCUSSION: The social worker will encounter many clients who take or are in need of medication to control psychiatric symptoms. These medications fall into discrete groups, each of which alleviates a particular set of symptoms. The major groups are antipsychotic, antidepressant, antianxiety, antimanic, psychomotor stimulants, and sedative-

hypnotics. Each medication has a chemical name, a generic or general name (e.g., Fluoxetine), and a registered trade or brand name (e.g., Prozac). Each has a specific target symptom, contraindications, and potential side effects. The selection of a specific medication is based on the patient's medical history, physical exam, laboratory tests, use of other medications, use and abuse of alcohol or street drugs, and, of course, the disorder being treated. Physicians generally advise against taking psychotropic medications during pregnancy.

Different types and groups of medications have different side effects. Among the side effects associated with certain psychotropic medications are dry mouth; weight gain; drowsiness; oversensitivity to the sun; menstrual cycle disturbance; spasms of eye, face, neck, and back muscles; blurred vision; shuffling gait; and tremors. Children and the elderly are particularly prone to experience side effects. A psychotropic medication may exacerbate nonpsychiatric medical problems such as hypertension, liver disease, epilepsy, and glaucoma. Despite these side effects, it must be remembered that symptom control is of critical importance to persons suffering from a major mental illness. There is a benefit-risk balance with all medications. In general, a physician will reduce side effects by prescribing the lowest dosage that produces the desired effects, discontinuing a problematic medication and trying another, avoiding the simultaneous use of two medications that have a similar effect, and, whenever possible, treating only one symptom at a time.

When an individual is hospitalized and/or experiencing disabling symptoms, he or she may be started on a quick-acting medication or given a fairly large dose. Most will not need to take the same dosage after leaving the hospital or after the symptoms subside, and a physician may reduce the dosage or switch to a medication that is slower acting but has other advantages. A physician will usually reduce the dosage to the minimum effective level. Such a reduction is best done gradually—a process that may take weeks or months. Even when on a maintenance dose, some people find that their symptoms worsen from time to time. This may be due to stress, biochemical changes, or other factors.

Some patients are frightened when a doctor suggests that they take less medication because they fear a return of symptoms. On the other hand, some are reluctant take medication because they fear side effects or because it is perceived as a loss of control or a blow to their self-esteem.

When working with a client who is taking psychotropic medications, keep several guidelines in mind:

1. The decision to prescribe a medication is a complex medical judgment to be made only by a competent physician, preferably a psychiatrist. A social worker must never give medication instructions outside the physician's directions.

2. Encourage your client to maintain regular contact with a medical professional so the effects of the drug can be monitored and dosage can be properly regulated. If you observe what appears to be unusual or unexpected side effects, but your client is unwilling to see a physician, get the name and dosage of the medication and consult with a physician. Also, inform the physician if your client is no longer taking a medication as prescribed.

3. Make sure your client and his or her family and friends understand the dangers of modifying the prescribed daily dosage and of exchanging medications with others. Also, alert your client to the dangers of using alcohol or street drugs while taking any medication. If your client takes more than one medication, an adverse drug interaction could occur. This happens when the two drugs mixed together have an effect very different from when each is taken alone. Side effects can also occur when the client mixes a psychotropic medication with nonprescription drugs such as a cold medicine. Some foods (e.g., aged cheese) may cause adverse reactions when eaten by a person on certain medications.

4. As in the case of other forms of medical treatment, an adult has a right to refuse psychotropic medications. Exceptions are when a court has declared that the individual is legally incompetent to make that decision and/or when his or her behavior constitutes an imminent threat to self or others. Because the decision to reject a needed medication can have tragic results when symptoms recur, you should do everything possible to inform the patient and his or her family of the possible consequences. In the final analysis, however, the decision of a legally competent adult must be respected.

SELECTED BIBLIOGRAPHY

Bentley, Kia, and Joseph Walsh. *Social Work and Psychotropic Medicine,* 2nd ed. Belmont, CA: Wadsworth, 2001.

Dziegielewski, Sophia, and Ana Leon. *Social Work Practice and Psychopharmacology.* New York: Springer, 2001.

15.14   The Client Who Is Gay, Lesbian, or Bisexual

PURPOSE: To consider the special issues that may arise in the provision of services to persons who are gay, lesbian, or bisexual.

DISCUSSION: Regardless of their practice settings, social workers will encounter clients who are gay, lesbian, and bisexual. Although sexual orientation, per se, will seldom be the presenting problem, the fact that many of these clients experience rejection, oppression, and discrimination must be considered in the planning and provision of health and human services.

The term *homosexual* is used to describe an individual whose thoughts and feelings of sexual attraction are mostly for persons of the same sex. By contrast, the term *heterosexual* refers to an individual whose thoughts and feelings of sexual attraction are mostly for people of the opposite sex. The person termed a *bisexual* experiences sexual attraction to both males and females. At one time, the word *gay* was applied to both men and women who were homosexual. In recent decades, *gay* has come to refer to male homosexuals. Women who are homosexual often refer to themselves as *lesbians*.

Because a precise definition of homosexuality is lacking, studies on the number of people in the population who are gay or lesbian yield estimates of from 2 to 10 percent. The developmental processes that may give rise to homosexuality are not well understood; the same can be said about heterosexuality. Researchers are not able to explain why some individuals are sexually attracted to the opposite sex, some to their own sex, and some to both sexes. However, there is growing evidence that one's fundamental sexual orientation is rooted in biological processes and, for most people, firmly established by adolescence. Thus, it is misleading to speak of either homosexuality or heterosexuality as a sexual "preference" or "choice."

In U.S. society and in many others, people who are gay, lesbian, or bisexual encounter disapproval, rejection, and misunderstanding. This can lead to discrimination in employment, housing, health care, social services, and other areas. The term *homophobia* refers to an irrational fear of homosexuality. Sometimes, homophobia gives rise to hatred and violence directed against persons who are known to be or suspected of being gay or lesbian.

Fear of rejection, discrimination, and violence, as well as a desire to protect their families and friends, causes some who are gay or lesbian to hide or deny their sexual orientation. Needless to say, an unwillingness or an inability to openly acknowledge and be at peace with something so basic as one's sexual identity can be a source of emotional turmoil within oneself and tension within one's family and other relationships. Some individuals attempt to resolve this tension by marrying someone of the opposite sex and trying to live a straight life. Such marriages often fail, however.

The following guidelines will be useful in working with clients who are gay or lesbian:

1. Carefully examine your own behavior, attitudes, belief system, and moral standards for signs of possible bias, prejudice, and discrimination toward people who are gay or lesbian. Give special attention to the following:
  - Your beliefs on whether homosexuality is a pathological condition or a normal variation of human sexuality
  - Your level of comfort in hearing descriptions of affection and sexual activity within same sex-relationships
  - Your beliefs and attitudes regarding the parenting of children by persons who are gay or lesbian

If you conclude that you cannot offer this client acceptance, understanding, and compassion, you have an ethical obligation to remove yourself from those activities and assignments that put you in contact with these clients.

2. Do not be afraid to acknowledge your own lack of knowledge and understanding and, if necessary, to face up to your own prejudices. Also realize that an ignorance of homosexuality and prejudice toward persons who are gay and lesbian may exist among those in the helping professions, among clients who are straight, and even among some who are gay and lesbian. Work hard to learn about the perceptions and concerns of gay and lesbian individuals. Become familiar with leaders and professionals within the gay and lesbian community, and seek their consultation when unsure about how best to work with gay and lesbian clients.

3. Realize that it is not uncommon for persons who are gay or lesbian to have gone through many years of confusion and uncertainty before finally recognizing and accepting their sexual orientation. They may deny their sexual attractions. They may become sexually active with the opposite sex as a way of reassuring themselves and others that they are heterosexual. Such periods of inner confusion are especially difficult for the adolescent and may lead some to consider suicide.

4. Although many who are gay or lesbian are comfortable with and open about their sexual orientation, others are not. Recognize and appreciate the turmoil and stress that results when a gay or lesbian individual feels forced by society to hide his or her true self and live in fear of being shamed, rejected, or injured and in fear of embarrassing or offending one's family and loved ones. The client should be helped to express pain and anger and sense of injustice.

5. Because so many who are gay or lesbian have been hurt by prejudice and discrimination, clients who are gay or lesbian are likely to be cautious and fearful when seeking services from an agency or entering into a helping relationship. They may hide their sexual orientation until they are sure the social worker is free of prejudices. A social worker who is gay or lesbian and quite sure his or her client is gay or lesbian may elect to self-disclose in order to lessen the client's fear. The social worker who is straight may use some personal stories to reveal that he or she understands the insidious effect of stereotypes and prejudice and thereby demonstrate to the client a capacity for acceptance and understanding.

6. Do not make "coming out" a goal of your work with a client, unless that is what he or she has decided to do after careful examination of the pros and cons. Also, do not underestimate the negative ramifications of coming out, which may include alienation from one's family or even the loss of housing or a job. On the surface, coming out may appear personally freeing and politically courageous, but the person selecting this course of action often pays a high personal price.

7. When working with a gay or lesbian couple who are in a long-term relationship, expect that their relationship problems will be similar to those of heterosexual couples. For example, their disagreements and conflicts will probably center on matters such as money management, balancing home and work responsibilities, child care, an unsatisfactory sexual relationship, unfaithfulness, domestic abuse, and substance abuse. However, their relationship is more uncertain because it lacks the status and protection that comes with a legal marriage. Consequently, matters such as securing health insurance for one's partner, arranging survivors benefits, inheritance, child custody, hospital visitation rights, and adoption are complex and unpredictable. Help these couples find the resources they need to work out special health care and legal arrangements, such as creating a last will and testament, doing financial planning, naming a beneficiary for life insurance, and preparing a living will and durable power of attorney for health care. Laws providing for same-sex marriages and civil unions, if enacted by state legislatures and if upheld by the courts, will resolve and simplify many of these legal concerns.

8. As a group, gay men have been hard hit by *Acquired Immune Deficiency Syndrome* (*AIDS*), a deadly disease caused by a virus known as *Human Immunodeficiency Virus*, or *HIV*. Many gay men have suffered the loss of friends or lovers to the disease, and others live in fear of contracting the disease. Many women and children have also been infected by the virus. The symptoms of AIDS typically do not develop until several years after being infected. HIV is spread primarily by (1) having vaginal, anal, or oral sex with someone who is infected and (2) by sharing needles for injecting drugs with someone who is infected. The virus can be passed from an infected mother to her baby during pregnancy or childbirth and in rare instances through breastfeeding.

SELECTED BIBLIOGRAPHY

Hunter, Ski, and Jane Hickerson. *Affirmative Practice: Understanding and Working with Lesbian, Gay, Bisexual and Transgender Persons.* Washington, DC: NASW, 2003.

Perez, Ruperto, Kurt DeBord, and Kathleen Bieschke, eds. *Handbook of Counseling and Psychotherapy with Lesbian, Gay, and Bisexual Clients.* Washington, DC: American Psychological Association, 2000.

Van Wormer, Katherine, Joel Wells, and Mary Boes. *Social Work with Lesbians, Gays, and Bisexuals.* Boston: Allyn & Bacon, 2000.

15.15   The Client with an Eating Disorder

PURPOSE: To understand the unique needs of clients with eating disorders (e.g., anorexia, bulimia, and obesity) and identify appropriate intervention techniques.

DISCUSSION: Increasingly, social workers are serving clients with eating disorders. *Eating disorder* is an umbrella term that describes any of several problems linked to compulsive behaviors in a person's relationship to food. At one extreme is the person who self-starves; at the other extreme is the person who eats to excess and becomes obese. Clients with eating disorders typically experience a combination of physical and psychosocial problems. Due to inconsistent definitions of the various eating disorders, little is known about the incidence of these problems except that approximately 90 percent of the people with anorexia and bulimia are women, and the problems are most acute in the teen and young adult age groups.

There are many examples of harmful behaviors related to food and nutrition. It is not uncommon, for example, for male athletes to intentionally overeat to gain weight (e.g., offensive linesmen in football) or lose weight (e.g., wrestlers seeking to reach certain weight divisions). Nor is it uncommon for older people to experience food-related problems when, for example, "cooking for one" seems like too much trouble or when one is expected to adapt to the institutional food in a nursing home. Fad diets and misguided fasting that fail to produce a balanced nutritious diet can disturb body chemistry and contribute to a person's eating disorder. The three most prevalent forms of eating disorders, however, are anorexia nervosa, bulimia nervosa, and obesity.

Anorexia Nervosa

Anorexia nervosa is a condition characterized by intentionally maintaining one's body weight substantially below that expected of a healthy individual (i.e., 15 to 25 percent below recommended weight for a person of that age, height, and gender). This disorder is most commonly found in middle- and upper-class female adolescents, with symptoms typically beginning between ages 12 and 18. The causes of anorexia are not known, but it is thought to be associated with high stress, pressure from one's cultural group, presence of an eating disorder among other members of the person's family, as well as the person's biological predisposition. The literature is mixed regarding whether events during childhood such as extreme diets or eating habits and physical or sexual abuse are associated with anorexia.

Some psychological indicators of anorexia are a distorted perception of one's own body size, weight, and shape; an intense fear of becoming obese; and high self-expectations or perfectionism. Some physical symptoms are excessively low weight, the absence of or irregularity in the menstrual cycle, dry skin, loss of hair, refusal to eat normal amounts of food, and anxiety about eating, with episodes of spontaneous or induced vomiting.

The recommended interventions are first to assist the person to take steps to restore physical health and regain a normal weight and then to implement the necessary interventions to prevent the recurrence of this condition. When a person is literally starving, his or her physical condition must be addressed before the social and psychological factors. Treatment may involve a period of hospitalization and the use of medications. Various drugs may be used in treatment, but the results to date of studies of drug therapy show mixed results.

When intervening with the anorexic (and also the bulimic) person, it is important to be very direct about the person's behaviors and the consequences of those behaviors, as well as to gain the person's trust as a foundation for helping him or her reestablish a sense of self-worth. Specific psychosocial interventions may include individual and family therapy, ongoing supportive treatment of the individual, cognitive therapy, behavior modification techniques, and participation in self-help groups. Recovery from anorexia nervosa requires actions on many fronts, including a team of professionals, family, and other significant people in the client's lives. Eating a sufficient amount of nutritious food is difficult for the anorexic to accomplish without considerable reinforcement from others. It is thought that about one-half of the diagnosed and treated anorexics recover within two to five years. Yet, about 18 percent never recover and, for them, the possibility of death from suicide or conditions resulting from the person's depleted physical condition is quite high.

Bulimia Nervosa

Bulimia nervosa is characterized by a morbid fear of becoming fat. With this disorder, a person usually stays within 10 percent of normal body weight but experiences lack of control over eating behaviors. As opposed to the person with anorexia who avoids food when under stress, the bulimic deals with stress by turning toward food. Periodically (i.e., three times or more a month), the person with this disorder experiences a severe craving for food and he or she binges, followed by induced vomiting, use of laxatives, severe dieting, excessive exercise, or fasting as a means of prevent-

ing weight gain. The bulimic cycle can be understood as the fear of becoming overweight leading to self-starvation, with a periodic eating frenzy followed by guilt and efforts to void the weight produced by the food, thus reinforcing the fear of becoming fat—and the cycle continues.

The causes of bulimia are not known, but symptoms usually begin in adolescence or early adulthood. The typical bulimic is thought to be a successful White woman in her mid to late twenties. Because of this stereotype, bulimia is considered a "woman's disease" and men tend to deny or hide the fact that they experience this disorder. Estimates of the number of young women experiencing bulimia are as high as 15 to 20 percent; however, young men, too, experience bulimia at the substantial rate of about 5 to 10 percent. The binge-and-purge cycle can have disastrous effects, causing fatigue, seizures, and muscle cramps as well as having long-term effects on the person's esophagus, teeth, and bone density.

It is often difficult to determine if a client might be experiencing bulimia because there are no obvious physical symptoms such as the loss of weight or emaciation found in persons with anorexia. However, some clues are periodic consumption of large amounts of food, usually eaten alone or secretly; preoccupation with food or one's weight; excessive exercise or fasting; trips to the bathroom following meals; diminished sexual interest (sometimes); and depression or self-loathing due to inability to control bingeing.

As compared to persons who are anorexic, bulimics are more likely to seek and accept treatment, but their strong need for perfection leads to frustration when there are no immediate cures. Some interventions focus on helping them become more accepting of failure to achieve perfection in their lives, improving nutrition, and the use of antidepressant medication to deal with links to depression if suspected. When social workers are involved in cases of bulimia, cognitive-behavioral therapy is most often used to assist in interrupting the pattern of eating restricted foods and bingeing, while also addressing the client's distorted view of foods and his or her body. The client is helped to reveal the problem with family and other significant people in his or her life and to seek their help in maintaining a balanced diet. Finally, group approaches have been successful in helping bulimics self-disclose to reduce guilt, learn to self-monitor their eating behaviors, gain nutrition information, discuss alternatives to the binge and purge cycle (e.g., relaxation techniques), and address cultural pressures they experience regarding body weight.

Obesity

Obesity results when a person's caloric intake regularly exceeds his or her biological needs. The term *moderate obesity* applies when a person is 20 to 100 percent above the recommended weight for his or her age, gender, and height, whereas a person experiencing *morbid obesity* would exceed the 100 percent level. More than 20 percent of the U.S. population is moderately or morbidly obese. Obese people more frequently experience high blood pressure, diabetes, heart disease, complications of pregnancy, and early death than the general population.

The causes of obesity are not well understood, but psychological, biological, and social factors all are associated with obesity. Psychological factors include overeating as a compensation for boredom, unhappiness, depression, and painful

life events. In addition, between 20 and 40 percent of obese people periodically engage in binge eating. Increasingly, research indicates an association between obesity and one's genetic makeup. Also, the eating patterns of a person's family and the cultural patterns regarding food selection and intake have an effect on both one's weight and the acceptance of being overweight.

Low-income people are prone to obesity because they tend to purchase inexpensive foods that are often high in fat content. Social workers are sometimes in a position to assist with nutrition education and offer guidance on identifying foods that can achieve a balanced diet at a reasonable cost. In family counseling and mental health services, social workers are also likely to provide services to obese people regarding social ostracism and the resultant poor self-image that results.

Treatment for obesity begins with a reduction of calorie intake but is sustained when combined with exercise and various behavior modification techniques intended to change patterns of eating. The obese person who has low self-esteem or is socially isolated is best treated with individual therapy, whereas groups have proven most successful with children who are more influenced by peer group discussion. Drug intervention has not proven successful in most cases, and surgery designed to reduce food intake is recommended only for persons far above their recommended weight, under age 50, and at great health risk because of their obesity.

The goals of a social worker's interventions should include helping obese clients learn to self-monitor their food intake, create environmental conditions (e.g., family and friends) that have a positive influence on eating patterns, provide individual and group therapeutic services when warranted, facilitate involvement in appropriate exercise programs, and help the client connect to social groups where isolation can be diminished. Meaningful weight loss will be a long-term process, Without continuing support and encouragement for maintaining the activities that have resulted in weight reduction, there is a high probability that the weight will be regained.

SELECTED BIBLIOGRAPHY

Bryant-Waugh, Rachel, and Bryan Lask. *Eating Disorders: A Parents' Guide.* New York: Brunner-Routledge, 2004.

Goldstein, David J., ed. *The Management of Eating Disorders and Obesity,* 2nd ed. Totowa, NJ: Humana Press, 2005.

Menassa, Beverly Neu. *Preventing Eating Disorders among Pre-Teen Girls: A Step-by-Step Guide.* Westport, CT: Praeger, 2004.

15.16 The Client Experiencing Grief or Loss

PURPOSE: To understand the needs of clients who are experiencing grief or suffering from the loss of a loved one and to identify appropriate intervention techniques.

DISCUSSION: The experience of grief is as old as humanity. Virtually every social worker will, at some time, deal with a client who is experiencing the pain and turmoil of grief and loss experiences. *Grief* is defined as the intense emotional suffering brought on by the loss of or separation from someone or something that is deeply loved. A sudden

and unexpected death is one of the most common precipitators of intense grief. A grief reaction to the death of a loved one, and the mourning of this loss, typically moves through four phases:

1. *Numbness.* The person is shocked, dazed, confused, and overwhelmed. Physical symptoms might include nausea, tightness in the chest and throat, shortness of breath, disturbed sleep, loss of appetite, headaches, and so on. This phase lasts from several days to several weeks.
2. *Yearning.* The person may seek somehow to recover the loved one who has been lost. He or she may become preoccupied and withdrawn and may seem to wander about as if in search of the deceased person; he or she may even report seeing and being with the deceased individual. Intense crying and feelings of anger, guilt, anxiety, and frustration are common.
3. *Despair and disorganization.* As the reality of the loss settles in, the person experiences feelings of helplessness, despair, depression, and extreme fatigue.
4. *Recovery and reorganization.* Over a period of many months, the person gradually resumes his or her usual routines at home and at work. He or she feels less depressed, sleeps better, and has more energy. Various events and recollections may bring on periods of crying and sadness, but these, too, become less frequent and less intense.

Other types of loss may also precipitate grief reactions: for example, experiencing the separation or divorce of one's parents, placing one's child in foster care, delivering a stillborn child, having a planned or spontaneous abortion, voluntarily relinquishing one's parental rights, experiencing a decline in one's physical or mental functioning, retiring or losing a job, receiving a terminal diagnosis, losing a pet, and facing the loss or destruction of one's personal possessions in a robbery, house fire, or natural disaster. Sometimes, one loss triggers others. For example, a divorce may change a family's financial circumstances so that a child not only loses his or her two-parent family but may also have to move to another neighborhood and change schools. These *secondary losses* can be very significant sources of grief. Whatever the cause, the social worker should be alert to the manifestations of grief and know of possible interventions. Experiencing one serious loss after another can have a devastating effect on a person's functioning.

The term **acute grief** is often used to describe the reaction that occurs at the time of the loss, such as a parent's immediate reaction to his or her child being killed in an auto accident. Acute grief typically occurs in response to a sudden and unexpected loss. A pattern of grieving known as **anticipatory grief** is set in motion by the realization that a serious loss will occur in the near future; the diagnosis of a terminal illness may prompt this sort of grief. The term **anniversary reaction** is used to describe a recurrence of grief precipitated by remembering a previous loss, such as the sadness that occurs each year during the month when one's child or spouse died.

In order to grieve successfully, people must work through certain tasks:

■ Accepting the reality that the loved person or object is indeed dead, gone, or lost
■ Experiencing and resolving the emotions and conflicting thoughts associated with the loss

- Readjusting to life without the loved person or object
- Reinvesting emotional energy in other relationships and the usual activities of life
- Retaining or honoring the memory of the lost person or object

These tasks are overlapping and the individual will revisit each one many times before achieving a satisfactory adjustment.

Expressions of grief are affected by one's relationship to the lost person or object, age or developmental stage, cultural background, gender, the suddenness or type of death or loss, the person's coping patterns, and so on. In Western culture, for example, women grieve more openly than men, and religious beliefs and cultural rituals vary widely in regard to accepting death and bringing closure for the survivors.

The intense grief period typically diminishes in six months to a year, but the process of grieving often takes up to three to five years (or even longer). Over time, most people are able to resolve the loss and reduce the intensive pain experienced without the assistance of professional helpers (i.e., through the support of family and friends). In fact, personal growth often occurs as a person successfully deals with grief, and the outcome can be viewed as positive. For example, people sometimes gain increased independence and self-confidence, find new areas of interest and talent, develop new and rewarding relationships, and so on.

Time is the greatest healer. Most people eventually recover to the point where they can again function effectively, even though the pain of the loss may remain with them for the rest of their lives. Sometimes, however, the normal healing process stalls and the person develops dysfunctional patterns of thought and behavior. In these situations, the social worker must use a more clinical approach.

Basic *supportive counseling* is perhaps the most useful form of social work intervention. People should be encouraged to grieve, to identify the scope of the loss they have experienced, to talk about the events of the loss, and to gain information about the process of grieving. When clients are focused on accepting the reality of the loss, it is helpful to encourage talking about the experience (usually repeatedly) and to take concrete actions related to the loss such as planning the funeral, taking care of financial matters, and so on. As acceptance of the loss begins, a worker might then help the person recall positive experiences from before the loss occurred. This might be done through talking about photographs, visiting places of special significance, or encouraging the client to use art, stories, poems, or other forms of expression. In addition, it is important to assist people in moving forward with their lives through solving problems that may have arisen from the loss (e.g., insurance claims, managing day-to-day issues, etc.), developing new roles and relationships, and engaging in new activities.

When the normal grief reaction does not begin to be resolved over time, depending on the specific circumstances, *individual, couple,* or *family therapy* might prove useful. When using therapeutic approaches, a social worker might draw from almost any of the practice frameworks described in Chapter 6 (e.g., psychodynamic, person-centered, cognitive-behavioral, task-centered, exercise, relaxation techniques, or the several family intervention approaches). One specific approach used when dealing with grief is termed *regrief therapy.* It is utilized when the person has not been able to complete the tasks in the grief process. Using this approach, the

social worker invites the client to bring to a session items that are symbolic of the lost person or object and the client is helped to revisit the relationship and find emotional release. Another specialized technique is *guided mourning*, a cognitive-behavioral approach in which the client is encouraged to recall the details of the painful loss experience and to find appropriate ways to say good-bye through ritual and journaling about one's emotional reactions.

Support groups are useful in assisting people to deal with grief. These groups can offer advice about day-to-day tasks such as handling finances or taking on new household tasks, giving emotional support by providing an safe place where the grieving person can talk about the loss, and sharing experiences as a way of helping others see that their emotions are normal and to anticipate grief symptoms that may emerge.

SELECTED BIBLIOGRAPHY

Cook, Alicia Skinner, and Kevin Oltjenbruns. *Dying and Grieving: Lifespan and Family Perspectives*, 2nd ed. Fort Worth, TX: Harcourt Brace, 1998.

Corr, Charles A., Clyde M. Nobe, and Donna M. Corr. *Death and Dying, Life and Living,* 4th ed. Belmont, CA: Wadsworth, 2003.

Daka, Kenneth, ed. *Disenfranchised Grief: New Directions, Challenges, and Strategies for Practice*. Champaign, IL: Research Press, 2002.

15.17   The Client with Concerns Related to Spirituality and Religion

PURPOSE: To respond appropriately to clients who have problems, concerns, or needs intertwined with spirituality and/or religion.

DISCUSSION: Survey and opinion poll data suggest that about 90 percent of adults in the United States believe in a god and that religion is an important part of most people's lives and spirituality (Stark 2004, 395–400). Many others who are not affiliated with a religion and many who do not believe in a god also strive to develop their spirituality. Thus, if a social worker serves a cross-section of the population, religion and/or spirituality will be important to most of his or her clients. Yet many social workers feel poorly prepared to discuss these matters with clients.

For good reasons, social workers, psychologists, and other professional helpers are often taught to steer discussions with clients away from matters of religion and spirituality, for several reasons: namely, to keep from imposing their own beliefs and values on clients, to avoid inadvertently offending clients, and to avoid the appearance of attempting to proselytize clients. Even folk wisdom warns against discussing religion (and politics) with friends because these discussions often turn into arguments and create hard feelings. So when it comes to the question of how to respond to clients who have problems, needs, or requests related to religion, spirituality, and faith, the social worker faces a dilemma. On the one hand, it is clear that religion and/or spirituality are important to most clients and even a source of personal strength, a means of coping, and a resource in the helping process for many clients. Moreover, information about a client's religious and spiritual beliefs and practices

may be a key to understanding his or her motives, decisions, and behaviors. Even so, a social worker's attempt to discuss these aspects of the client's life can be easily misinterpreted and may inadvertently alienate the client.

As suggested by the definitions of *spirituality* and *religion* offered in Chapter 2, both the cultivation of a spirituality and the practice of a religion draw one into the realm of the sacred and a recognition that some invisible creative power, life-giving force, or divine presence is part of his or her life. Spirituality is inherently difficult to describe because it is deeply personal and unique to each individual. Even if two people belong to the same religion, their spirituality may be different.

The word **spirituality** has its origin in an image of the "breath of God." For many, spirituality involves an awareness of or a mindfulness of the mystery, beauty, and awesomeness inherent in human life as well as the world and the universe. Spirituality refers to a sense of wholeness and integration and a connectedness between the inner self and a higher power or ineffable presence that many name *God.* Spirituality has been variously described as a holy longing or yearning for meaning; as one's most cherished and enduring values; as the essence of a person's character; as the way one lives his or her life; as how a person channels his or her deep, inner unrest and desires; and as one's lived experience with the mystery of life. The idea of *mystery* is a common theme in people's efforts to describe their spirituality. In this context, *mystery* refers to an experience or spiritual presence that the person knows to be real but that is beyond description and understanding. To live one's spirituality is to consciously allow one's core beliefs and values to permeate all his or her relationships and daily activities. Spirituality helps people distinguish the important from the unimportant, the end from the means, and the lasting from the fleeting.

Spirituality is the root of all religion. Broadly speaking, a **religion** is any set of beliefs and traditions that attempts to answer the overarching questions of life, such as Who am I? What is the meaning and purpose of my life? How should I live my life? Why does evil exist? What happens after death? How am I to pray (i.e., relate to my god)? Many who seek the spiritual life embrace a religion because it guides and nourishes their spiritual growth. Others seek spiritual growth apart from a religion, either because they are not attracted to the concept of a religion or because their experiences with belonging to a religion have been negative.

Given the complexity of these matters, a few guidelines are in order for the beginning-level practitioner who is working with an individual client, a group, or a community for whom spirituality and/or religion is important and related in some way to client concerns:

1. Carefully and honestly examine your own experiences with and attitudes toward religion and spirituality. Be alert to any prejudices or presumptions that may limit your ability to serve clients who have beliefs or experiences different from your own. This means that you will need to be open to and accepting of persons with strong religious beliefs and those with none at all. Addressing issues and concerns related to a client's religion and spirituality requires of the social worker a high degree of self-understanding and self-discipline (see Item 16.2).

2. Approach matters related to a client's religion much as you would approach matters related to a client's culture (see Item 8.10). A person's religion is, in fact, like a culture in that it is a "lens" through which he or she views and interprets life's

experiences. As such, religion can influence what the client defines as a problem, sees as the cause of a problem, and believes will be a solution to a problem. The social worker must be nonjudgmental when addressing matters related to the client's religious beliefs and practices. To do so can be a challenge if these beliefs and practices are unfamiliar or seem unusual or unreasonable. It is helpful to remember that a client's own religion, like a culture, will make sense to him or her and seem more reasonable and believable than other religions.

3. In all cases, the social worker must demonstrate an accepting attitude and readiness to discuss spiritual and religious matters if the client wishes to do so. If the client does not perceive that acceptance and openness, he or she may withhold important information out of fear of being misunderstood, judged, or ridiculed for holding certain beliefs. Also, the worker must avoid redefining a client's spiritual or religious concern as being only a psychological issue.

For many clients, religion and/or spirituality is a source of personal worth, identity, motivation, and hope, and it provides a sense of belonging and direction. For others, religion and/or spirituality is a cause of inner turmoil, family conflict, shame, and guilt. As noted earlier, people's religion and spirituality will often determine what they define as right and wrong (i.e., the client's moral standards) and will likely be a source of norms and expectations that shape key family relationships (e.g., the parent-child relationship). Self-respect and self-esteem are related, in part, to an individual's judgments about whether he or she is following the dictates of his or her conscience. It is difficult for anyone to maintain self-respect when deep down, one knows he or she is behaving in ways that are defined as morally wrong.

4. During the data-gathering and assessment phase, the social worker should do at least a cursory exploration of the client's spiritual and/or religious beliefs, values, and activities in order to identify possible client strengths and resources and to assess whether the client's presenting problem or concern is intertwined with his or her spirituality and/or religion. Simple and straightforward inquiries will usually suffice—for example, What do I need to know about your values and beliefs to better understand what is really important to you? Is religion and spirituality a part of your life? Are you a member of a church or a faith community? How do you find encouragement during difficult times? What sense do you make out of the hardship you have experienced? The nature of the client's responses to such exploratory questions will dictate if a more in-depth assessment is necessary and appropriate.

In every situation, the questions asked of a client and the information gathered about a client must be relevant and pertinent to his or her presenting concern and the reason the social worker and the client are meeting. In certain situations, however, it may be necessary to probe more deeply. A worker in direct practice (e.g., counseling, case management) might ask specific questions about the client's spirituality and/or religious beliefs and background when the client is experiencing certain troublesome thoughts and feelings, such as guilt, grief, despair, and meaninglessness or when the client is struggling with a moral dilemma. Client statements such as the following illustrate these situations: "I feel like a failure as a parent because none of my children go to church or have any interest in developing their spirituality." "I have hurt so many people; I need to make amends for the harm I have caused." "My life is empty and meaningless." "I wish I had some type of faith, but I

don't know how to develop one." "The people in my 12-step program talk about their Higher Power, but I'm not sure I even have one." "So often, I pray that my illness will be cured, but my medical condition is getting worse." "As I approach my death, I wonder if there is an afterlife. Do you think there is?" "My daughter is under the influence of evil spirits." "I want to forgive my father for what he did, but I am consumed by bitterness and festering with anger."

The social worker in indirect practice (e.g., community organization, agency administration, program management) must understand the religious beliefs and practices common to a neighborhood and a community. Doing so is necessary for developing programs and policies that are sensitive, respectful, and relevant to the people who are to benefit from the social worker's actions.

5. When working with a client who desires a more fulfilling spiritual life but feels a lack of progress toward that goal, it may be helpful to explain the difference between a spiritual *search* and a spiritual *journey.* A person on a search is always looking for something more satisfying and exploring new possibilities; this often gives rise to a sense of restlessness. By contrast, a person on a journey has made a choice about where he or she wants to go and is heading in that direction; consequently, he or she can achieve a sense of inner freedom. Real spiritual growth can begin only after one chooses a path and is walking along it. In every person's spiritual search, there comes a time when, despite doubt, he or she must take a leap of faith and say, in effect, "I choose to live my life this way." The fear of choosing the wrong path will delay the development of a meaningful spirituality. Regardless of the path taken, the person will need to set aside a regular time for quiet reflection, prayer, or meditation. All of the great spiritual traditions and world religions agree on that point.

Spiritual growth is mostly a process of letting go of one's desire to have control, prestige, possessions, and power and instead embracing truly important and enduring values. The fear of letting go is, of course, the greatest barrier to the formation of an authentic and lasting spiritually.

The spiritual life is not a solitary activity. Rather, it is communal and relational in the sense that people's deepest questions can only be answered through engaging in dialogue with others. Spiritual growth requires the support and guidance of others, especially persons who are more experienced in living a spiritual life, for they can help the beginner avoid problems of discouragement, self-absorption, self-deception, and spiritual arrogance. Religious institutions are centers of spiritually and exist to cultivate spiritual living. While composed of and led by persons who are flawed and very human, religious organizations are the primary means of passing on spiritual wisdom and are an invaluable spiritual resource to many.

One's spirituality is reflected in his or her everyday and ordinary choices, decisions, and interactions with others. Thus, a person's spirituality and his or her moral behavior are interconnected. The person who seeks spiritual growth must be true to his or her conscience and beliefs about what is right and wrong. To behave in ways that violate one's own moral code precludes achieving a sense of integration and wholeness.

6. Understand the dilemmas faced by deeply religious and/or spiritually oriented individuals as they try to live, work, and raise a family within a social environment that does not support and often undermines their cherished beliefs and values. The

dominant values of U.S. society are materialism, consumerism, competition, and individualism. Holding these values often leads people to create a self-centered lifestyle and to place great emphasis on the acquisition of things, power, status, and the attention of others. By contrast, authentic religion and spirituality emphasize a very different set of values and virtues, such as honesty, truthfulness, justice, humility, modesty, compassion, reconciliation, forgiveness, and service to others.

Much like those who belong to an ethnic or cultural minority group, many people who are religious and spiritual must struggle to live in "two worlds" and negotiate, socially and economically, within an environment they perceive as foreign, often unsympathetic, and sometimes hostile to their values and way of life. Parents, especially, will take action to protect their children from societal influences they perceive as destructive to their children's psychological and spiritual well-being. When people feel that their religious and spiritual beliefs and practices are threatened, they may strike out at the perceived threat. Another response is to withdraw from the mainstream societal activities they view as threatening to their values. Some, including social workers, may mistake this response for unhealthy social isolation.

7. Direct social work practice can become especially complex when the client's presenting problem involves a clash between his or her conscience, or personal moral code, and the existing legal code. For one client, a certain action (e.g., abortion, blood transfusion, war) could be judged as legal but immoral. Another client, however, might judge an illegal action to be morally correct (e.g., refusing to pay taxes that support a war, use of abusive punishment in childrearing). Helping a client think through and resolve such dilemmas may call for consultation with an attorney and with those religious or spiritual leaders who have an in-depth understanding of the client's moral reasoning. It is important to recognize that some individuals misunderstand the moral principles of the religion that they purport to follow.

8. A social worker faces a challenging situation when his or her client's religious and/or spiritual beliefs and practices are unhealthy and harmful to the client or to others. In such cases, the social worker can at least try to help the client examine the effects and observable consequences of these beliefs and practices. However, the worker must realize that people hold tightly to their core ideas and values and are not easily swayed by what others view as reasonable and logical arguments.

A healthy religion or spirituality recognizes that humans are complex creatures and have many interrelated dimensions (i.e., physical, spiritual, psychological, emotional, intellectual, sexual, social). Thus, in a healthy religion and spirituality, there is an appreciation of all these dimensions, not just the spiritual. In other words, there is an emphasis on the wholeness of being. In fact, the word *holy,* as in the term *holy person,* refers to a person who has integrated these many dimensions of life and achieved a holistic balance, integration, and sense of wholeness. By contrast, an unhealthy spirituality or religion causes imbalance, division, and fragmentation internally, or within the person (e.g., a spiritual practice that harms one's body or mental health), and also externally, as for example, when one's religious beliefs fracture families and friendships or sow the seeds of violence or oppression.

9. It is important for social workers and human services programs to build working relationships with a variety of local clergy, leaders of faith communities, and

trained spiritual directors so that these individuals can be consulted on how best to approach issues related to clients' religion or spirituality. When a client's concern or need is primarily within the realm of religion, faith, and spiritually and therefore outside the domain of professional social work, the social worker should refer the client to the appropriate religious or spiritual counselor or clergy person. (See Chapter 1 for a discussion of social work's domain or area of expertise.)

10. When a client is an active member of a faith community (e.g., a church, synagogue, mosque), that faith community may be a potential helping resource. Depending on the client's concern or need, the possible use of this resource might be explored. However, it is important to understand that some individuals will describe themselves as belonging to a certain religion or faith community when, in fact, they have only a tenuous or occasional connection to it. Thus, a client's self-identification with a particular religion or faith does not necessarily signify that he or she will have access to the informal social support network or other resources usually associated with active membership (see Item 12.7).

11. The social worker must avoid assuming that he or she knows about a client's specific religious beliefs and practices when all the worker knows is that the client identifies with a particular religion. Within the major religions, there are various subgroups or branches that differ in a variety of ways. For example, there are many denominations within Christianity, and each often comprises further divisions along a conservative-progressive continuum. Not infrequently, the various traditions overlap with certain nationalities and ethnic and cultural groups.

Each of the world religions has a body of writings that are viewed as extraordinary and sacred. These writings (e.g., scriptures) shape the religion's belief system and are read for inspiration and moral guidance. Within the major religions (e.g., Hinduism, Buddhism, Judaism, Christianity, Islam), different subgroups interpret their scriptures from different vantage points. For example, some utilize a literal approach, whereas others utilize a contextual, historical, and/or critical approach. Those who read the scriptures in a literal manner assume that the words mean exactly what they say. Those who apply the contextual method to reading the scriptures assign meanings to the words only after considering, for instance, the historical and cultural time in which the document was written, the writer's purpose, the intended audience, and the writer's use of symbolic language, metaphor, and other literary devices.

12. A social worker must be prepared to respond to the questions a client may ask about the worker's own religion or spiritual beliefs and practices; at the same time, the worker must recognize the need to maintain an appropriate professional boundary. A client may have several motives for asking about the worker's religion and spirituality. As a general rule, most people feel at ease with those who share their beliefs and values and have had similar life experiences. Thus, a client may want to know if the worker is capable of understanding his or her spiritual and religious beliefs and practices and perhaps whether the worker is going to be judgmental. Some clients may ask about the worker's religion simply because they are curious about how the worker approaches the "big questions" of life. Still other clients may be trying to manipulate the worker into taking their side in some interpersonal or family conflict.

How a social worker responds to such questions will depend on his or her assessment of why the client is asking them and how providing various answers will affect the professional relationship and their ongoing work together. (See Item 8.4 for guidance on how a social worker might respond to personal questions posed by a client.)

SELECTED BIBLIOGRAPHY

Canda, Edward, and Lee Furman. *Spiritual Diversity in Social Work Practice.* New York: Free Press, 1999.

Ellor, James. *Religious and Spiritual Aspects of Human Service Practice.* Columbia: University of South Carolina, 1999.

Richards, P. Scott, and Allen Bergin, eds. *Handbook of Psychotherapy and Religious Diversity.* Washington, DC: American Psychological Association, 2000.

Stark, Rodney. *Sociology,* 9th ed. Belmont, CA: Wadsworth, 2004.

Van Hook, Mary, Beryl Hugen, and Marian Aguilar. *Spirituality within Religious Traditions in Social Work.* Pacific Grove, CA: Brooks/Cole, 2002.

15.18 The Client or Community Experiencing an Emergency or Disaster

PURPOSE: To understand and respond to clients caught up in the aftermath of a disaster or catastrophic event.

DISCUSSION: A variety of natural disasters and catastrophic events have the power to disrupt whole communities and inflict death, injury, trauma, social insecurity, and financial hardship on large numbers of people. Examples include earthquakes, floods, hurricanes, tornadoes, forest fires, airline crashes, terrorist attacks, school shootings, accidental spills of toxic chemicals or dangerous radiation, and war-related invasions and bombings.

The defining characteristics of a *disaster* are that it affects many people at the same time and that its immense scale requires a highly organized and disciplined emergency response by a range of governmental officials and organizations. The roles and activities of social workers at the site of a disaster must fit within the purposes and methods of an organized rescue and emergency response—one characterized by a military type of decision making and coordinating structure. The leaders of emergency response organizations will have certain objectives and priorities that will determine what social work services are most needed and when, where, and to whom they will be provided. In an emergency or disaster situation, the highest priorities are the following:

1. To rescue or evacuate people in danger, to treat people who are injured, and to prevent an outbreak of contagious diseases through inoculations, proper care of the dead, and reestablishment of basic sanitation facilities
2. To address the immediate physical needs of the survivors by providing emergency shelter, water, food, blankets, and the like
3. To maintain public order to prevent accidents, social chaos, and looting (This will require the use of police or military units.)

Once these priorities have been addressed, the emergency or disaster response organization will attempt to address the psychological needs of the survivors by dispatching mental health and pastoral personnel. They will assist individuals who are undergoing a mental health crisis and/or grieving the loss of loved ones and/or property.

Individual and Family Responses

How an individual responds to and adjusts to a disaster is related, in part, to the nature of the disaster and whether he or she had time to prepare for what was to occur. For example, a person who has lost his or her house to a flood or a forest fire usually had a day or two of warnings in advance of the disaster. Given that, he or she had likely considered the possibility that the water or fire could destroy the house and had discussed these fears and worries with family and friends. By contrast, to experience the effects of, say, a terrorist bomb that exploded without warning in a crowded shopping mall is quite a different type of human experience. The element of surprise that exists in the case of an earthquake, bombing, or plane crash gives rise to intense feelings of fear, horror, shock, and confusion.

People's response to a disaster often unfolds in three stages or phases: impact, recoil, and posttrauma. During the first stage, *acute impact,* people are just grasping the reality of what has happened or is happening. During this phase, which usually lasts for an hour or two, people respond in a variety of ways, particularly when some are still in danger of injury. While a few manage to remain surprisingly calm, make rational decisions, and care for themselves and others, most are in a state of emotional shock, confusion, and disorientation and experience the physical signs of fear and anxiety, such as sweating, trembling, and having an upset stomach. These individuals are, however, able to communicate and follow the instructions given by emergency personnel. A third group—usually a small percentage—are hysterical or paralyzed by their fear. These individuals are unable to make rational choices and may run about, speak wildly, or behave in ways that are dangerous to themselves and others.

Certain individuals require special attention during the acute impact phase, even when they have escaped the disaster without physical injury. These include, for example, young children, the elderly, those who were physically or mentally disabled prior to the disaster, those who cope with life in unhealthy or self-destructive ways, and those without access to family or a social support network.

It is during the second phase, the *recoil phase,* when the survivors become fully aware of what they have been through. During this phase, which typically begins some hours after the disaster has hit, many people are in a state of emotional exhaustion; many break down and weep. Most feel a strong need to talk about their experience. Mental health counseling and crisis intervention work should begin when people are in this phase (see Item 15.5). In addition, attention must be given to meeting the immediate needs of the victims, such as food and water and shelter and sleeping arrangements. Victims also will need help securing the items needed for grooming and personal care, arranging access to communication networks (so they can contact worried relatives and friends), and replacing lost eyeglasses, prescription medications, and so on.

The third phase of adjustment to a disaster or catastrophic event is termed the *posttrauma phase.* This phase may last for months, years, or the rest of a person's

life, depending in part on the adequacy of the crisis intervention services available to and used by the individuals impacted by the disaster. Often, the survivors of a disaster or a catastrophic event experience the following:

- Overwhelming feelings of grief and horror over what they experienced
- Preoccupation with death brought on by remembering the sights and sounds of people dying, persons with severe injuries, and corpses
- Preoccupation with what they have lost, such as a loved one, a house, important papers, and other meaningful possessions
- Worry over whether they ever will be able to reestablish a normal life and manage financially in the future
- Feeling that they survived at the expense of those who died (i.e., survivor guilt)
- Feelings of helplessness and a loss of trust, self-confidence, and sense of control

The major adjustments that individuals and families must make after experiencing a disaster are basically those of dealing with and grieving for their losses, rebuilding their lives, and reestablishing ordinary and predictable patterns of living. The stages or phases commonly observed among people going through these adjustments are the following:

- Accepting the reality of their loss (e.g., my child has really died; my house is gone forever)
- Acknowledging the pain of their loss (e.g., expressing rather than suppressing intense feelings)
- Adjusting to their changed personal, family, social, and economic circumstances
- Reinventing and reestablishing their sense of identity and purpose and the normal rhythms of life in the absence of whom and what has been lost

Community Responses

Webster (1995) observes that communities that have experienced a disaster typically move through four rather predicable phases: heroism, honeymoon, disillusionment, and reconstruction. The *heroism phase* occurs immediately after experiencing the disaster or during the time of the emergency, when the people of the community bond together, provide mutual support, and display cooperative behavior. Former divisions of social and economic class and race/ethnicity are set aside. During this phase, people often experience a positive sense of community and belonging. They take pride in how they have been helpful and in how well they are working together.

During a second phase, the *honeymoon,* the former or predisaster conflicts and tensions within the community are temporarily forgotten or diminish in importance. The community feels hopeful and confident that it can and will recover and perhaps be stronger than ever before.

The honeymoon phase gradually gives way to a sense of disappointment, known as the *disillusionment phase,* when the people of the community realize the enormity and complexity of rebuilding. Typically, the emergency relief programs available to the community are time limited and provide less than what people ex-

pect. These limitations and the associated eligibility rules and regulations often elicit anger and a sense of unfairness. It is during this phase that former community conflicts reappear and that people fragment into competing groups. Rumors and misinformation are special problems during this phase, which means that community meetings and disseminating accurate information are critically important.

Eventually, the community moves beyond its disillusionment and enters the long, difficult phase of *reconstruction.* Some communities are successful in rebuilding after a disaster, whereas others never recover. Among the variables that affect the capacity for and level of recovery are the nature of the disaster, the level of the destruction, the strength of the community's economic base, the abilities of the existing leadership, the cohesion of the predisaster community, and the availability of needed resources.

Guidelines for a Disaster Response

The following guidelines will help social workers to respond to the human needs and problems created by a disaster or catastrophic event:

1. Representatives of large social agencies and of social work organizations, such as the National Association of Social Workers (NASW), should be involved in statewide and local disaster-planning activities. In order to provide the appropriate services at the time of a disaster, social workers and agencies must already have a working knowledge of how emergency and disaster relief organizations function and of what is likely to happen when these organizations actually respond to a disaster or catastrophic event. In addition, each social and mental health agency should formulate its own plan as to how it will respond to a disaster in the community. An agency's plan must, of course, address the questions of how it will work with the emergency response organization and with disaster relief organizations such as the American Red Cross. Social workers who expect to work at the site of a disaster must understand that they can do so only after securing the proper authorization from those directing and coordinating the emergency response.

2. In the first hours and perhaps days following a disaster, the collection of accurate information is of critical importance to the conduct of rescue operations and other emergency responses. It is important to identify who is still missing and who has been killed or injured. Also, it is important to document where each survivor is located (e.g., whether the person was taken to a shelter, transferred to a specific hospital, etc.). Obtaining accurate and complete information will reduce the level of confusion, facilitate communication between the survivors and their worried relatives and friends, and allow for the reunification of families.

3. Information and referral services are of critical importance in the months that follow a disaster. Social workers who are in contact with survivors must acquire a basic knowledge of state and federal disaster assistance programs that may provide direct money grants, low-cost loans, temporary housing, and other resources to victims of a disaster. Informational meetings related to these programs and eligibility criteria should be made available in the community. In order to cope as best they can, survivors need access to accurate information about the actions or anticipated

actions of government agencies and emergency relief organizations. When such information is lacking, rumors develop, sometimes causing unnecessary worry, fear, and even violence.

4. In times of crisis, people naturally turn to their families and friends for social support and material resources. They also turn to informal helpers before turning to professionals and formal resources such as mental health and social agencies. To the extent possible, contact with family and friends should be encouraged and facilitated.

5. Because children are especially vulnerable to turmoil and social disruption, they should not be separated from their families at times of crisis. If at all possible, families should be evacuated as units and housed together in emergency shelters.

6. If a hundred people die in a disaster, thousands of survivors must cope with the loss of a loved one in addition to the loss of property and possessions, the possible loss of jobs, and a fundamental disruption to their usual way of life. Many of the people who live through a disaster will experience adjustment problems and psychological symptoms many months and even years after the event. Many will develop Posttraumatic Stress Disorder (PTSD) (which was described in Item 15.5). Increased levels of financial problems, depression and anxiety, suicide and homicide, domestic violence, problem drinking and drug use, psychosomatic illness, poor job performance, and the like can be anticipated, as well. Thus, mental health and social services agencies should formulate plans to address an increased need for their services and engage in case finding and active outreach to those who may need them.

7. Be alert to the possibility of a professional or emergency worker developing what is known as *vicarious trauma.* After repeated exposures to clients who have been traumatized and are in great distress, social workers and other helpers may develop symptoms of trauma themselves, such as intrusive thoughts and images, sleeplessness, bystander guilt, and feelings of vulnerability, helplessness, self-doubt, and rage. Workers who feel especially overwhelmed by a disaster, those who have had a prior experience of severe emotional trauma, and those who are inexperienced in disaster-related work are especially vulnerable to developing these symptoms. Ongoing self-care, including the opportunity to talk about one's experiences and feelings and to receive reassurance and support from peers and other professionals, is of critical importance in helping social workers cope with the stress of disaster-related work.

SELECTED BIBLIOGRAPHY

Gist, Richard, and Bernard Lubin, eds. *Response to Disaster: Psychosocial, Community, and Ecological Approaches.* Philadelphia: Brunner/Mazel, 1999.

Webster, Stephen. "Disasters and Disaster Aid." In *Encyclopedia of Social Work,* 19th ed., pp. 761–771, edited by Richard L. Edwards. Washington, DC: NASW, 1995.

Zakour, Michael, ed. "Disaster and Traumatic Stress Research and Intervention." *Tulane Studies in Social Welfare,* 11/12 (Winter/Spring, 2000), Special Issue.