Welcome to the inaugural edition of Cross-Sections. Section members told us they wanted to see what other section members read. Cross-Sections will highlight stories and information from all 11 practice areas: Administration/Supervision; Aging; Alcohol, Tobacco & Other Drugs; Child Welfare; Children, Adolescents & Young Adults; Health; Mental Health; Private Practice; Schools of Social Work; Social & Economic Justice & Peace; and Social Work & the Courts. Members will be given the opportunity to learn about trends and social work techniques outside of their own specialties. It is our hope that social workers who are Section members will find Cross-Sections a helpful resource when navigating within multidisciplinary communities that emphasize the need to know about different fields of practice.

“Social workers are leaders of change and strengthen the safety net of society. They bring hope, and inspire people to find their courage and fulfill their potential.” This is the theme for NASW’s meeting of the profession—the 2014 NASW National Conference. The event will be held July 23-26, 2014. Readers of this first edition of Cross-Sections will immediately see how the 2014 conference theme is more than just a tagline. The concept rings true for social work. The article on geriatric social work explores how those working in aging will be leaders of change as the healthcare landscape shifts with the implementation of the Affordable Care Act. Helping others fulfill their potential is the premise behind the school social work article. It shows how group work can be used by school social workers to help some students of color overcome educational challenges and achieve success academically. These articles and the others written support the notion that social work does strengthen the safety net of society.
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The Benefits of an Effective Documentation System
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NASW Standards for Social Work Practice in Health Care Settings discusses the merits of documentation in this way: “The importance of clear, concise, and organized documentation reflects the hallmark of quality social work services and often serves as the mode of communication between a social worker and other professionals and clients” (NASW, 2005, p.27). Documentation has historically served as a communication tool among providers both within and outside an agency, with improved patient outcomes being the primary goal of good documentation.

Regardless of the practice setting, the importance of good documentation practices cannot be underestimated. Supervisors and administrators have the often daunting task of ensuring an agency has sound documentation practices in place and that they are being followed. Documentation can be the most critical aspect of a social worker’s role as they are required to effectively and accurately document the various services and interventions they provide to clients. Recent changes in expectations regarding documentation practices have emerged in both private and public entities with the advent of performance measurement and benchmarking. In addition to being a source of communication, effective documentation practices have become essential as a tool to manage and monitor the effectiveness of agency practices.

DOCUMENTATION AS A DATA COLLECTION TOOL
A well designed documentation process will allow data collection to take place that can be used by agencies to monitor the effectiveness of services provided. (Kettner, Moroney, & Lawrence, 2007). Patterns and trends identified through data collection elements built into a documentation system can be compared to expected outcomes. Performance measures can then be used to modify or realign agency practices through performance improvement processes to promote improved client outcomes and streamline agency practices.

THE IMPACT OF DOCUMENTATION ON TRANSITIONS IN CARE AND CLIENT SAFETY
In 2006 the National Transitions of Care Coalition (NTOCC) was formed, its goal has been to improve the quality of coordination and communication when patients are transferred from one care setting to another. NTOCC concepts apply broadly across a multitude of care settings. The need for various providers to effectively collaborate to ensure smooth transitions occur is paramount. In fact, failure to effectively communicate discharge instructions from any environment can create serious issues for patients, their caregivers, and their families resulting in potentially negative outcomes in the individual’s safety and quality of care. In his article “What Will It Take to Ensure High Quality Transitional Care?” Eric A. Coleman (2011) discusses cross setting communication as a central core competency and the need to establish standards around procedures related to the content, timeliness and mode of information exchange. The Joint Commission has also identified poor outcomes related to documentation issues such as medication errors due to sound alike/look-alike drug names and potentially dangerous abbreviations that have the potential to be misread or misinterpreted by the reader. What may have one meaning in a particular setting of individuals who are aware of the meaning of an accepted abbreviation may have quite another meaning elsewhere. As a result, the Institute for Safe Medication Practices presently maintains a list of the identified medications and in 2004, the Joint Commission created its “do not use” list of abbreviations as part of the requirements for meeting a National Patient Safety Goal surrounding this issue. (Joint Commission, 2004).

DOCUMENTATION AS A LIABILITY SHIELD AND RISK-MANAGEMENT TOOL
Although historically the purpose of documentation has been as a communication and planning tool, it eventually has become recognized as having a risk management component. Documentation has become recognized as a tool for risk management purposes in a multitude of arenas, including supervision, management, and administration. Reamer (2005) indicates that “Documentation in social work—whether it concerns clinical, supervisory, management, or administrative duties—now serves six primary functions: (1) assessment and planning; (2) service delivery; (3) continuity and coordination of services; (4) supervision; (5) service evaluation; and (6) accountability to clients, insurers, agencies, other providers, courts, and utilization review bodies (Reamer, 2005, p.326).” Sound documentation, combined with timely intervention can go a long
way in reducing risk when dealing with a multitude of client scenarios, such as the non-compliant individual (CNA, 2008). In addition, providers in a number of settings rely on documented evidence of services provided and effective outcomes for payment. Establishment and measurement of progress towards goals is crucial for payment in many health care and private practice settings, thus inaccurate or incomplete documentation can result in financial risk to an agency.

HITECH AND THE ELECTRONIC HEALTH RECORD
Currently there is the opportunity for some health care settings to receive payments for the development of viable electronic health record (EHR) systems. With the enactment of the Health Information and Technology for Economic and Clinical Health Act (HITECH) in February 2009, the Office of the National Coordinator for Health Information Technology (ONC), the Centers for Medicare & Medicaid Services (CMS) and other Health and Human Services (HHS) agencies have been laying the groundwork for a national investment in the EHR. Under HITECH, federal incentive payments will be made available to various practice settings when they adopt EHRs and demonstrate use in ways that can improve the quality, safety and effectiveness of care.

The Medicare/Medicaid EHR Incentive Program will provide incentive payments to eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) that demonstrate their EHR meets specific requirements that have been developed to ensure that an EHR offers the necessary technological capability, functionality, and security that meets specified criteria. A certification process has been developed to ensure that the electronic health IT products and systems used are secure, can maintain data confidentially, and can work with other systems to share information (www.cms.gov/ehrincentiveprograms).

CHOOSING THE RIGHT DOCUMENTATION SYSTEM
It is impossible to always know when what has been documented will be needed. Clearly delineated and well-executed documentation processes are an important aspect of day to day agency operations and a well managed documentation process can greatly reduce the liability and adverse consequences associated with poor documentation in any agency setting. In making choices regarding implementing or updating documentation processes, keeping the practice setting in mind in relation to the concepts outlined here will ensure that the documentation system that is implemented will benefit both the client and the agency by improving outcomes and maximizing efficiency while minimizing risk. Implementing and maintaining an effective documentation system should be a critical component of every agency’s operational strategy.

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REFERENCES
The Affordable Care Act (ACA) was signed into law in 2012 and is set to be implemented in January 2014. Many states are currently preparing for what appears to be a major change in our current health care services. It is anticipated that many changes will affect current private insurance, Medicare, Medicaid (MediCal in California), and dual benefits for those who receive both Medicare and Medicaid. In many cases, it is not unusual for many health care plans to begin implementing some aspects of the ACA, such as providing preventive health services with no co-payment in preparation for this policy change. The key issue is for geriatric social workers to be prepared for changes and the effects they may have on our current methods of practice.

In 2004 the National Association of Social Workers (NASW) Center for Workforce Studies was established to look at our current workforce and to offer insight and information on the social work profession and practice. The National Survey of Licensed Social Workers provides perspectives of licensed social workers on aspects of professional social worker employment and training (Whitaker, Weismiller & Clark, 2006). Although the study does not take an independent look at practitioners and their specific clientele in the field of aging/geriatrics, it does examine the skill sets and working environment of areas where most geriatric social workers likely work: hospitals, health clinics, home health/hospice agencies, and/or private practice. Within each of these settings, geriatric social workers are “drawing” salaries or reimbursements from either private insurance, Medicare, or the combined resources of Medicare and Medicaid. In some instances, geriatric social workers receive direct payments from their clientele for their consultative services.

CURRENT ROLE OF THE GERIATRIC SOCIAL WORKER

Traditionally, geriatric social workers have tended to work with low-income seniors, disabled seniors, ethnic minorities, and new immigrants (legal or illegal). In these traditional roles of the geriatric social worker, they assist clients with community resource referrals educating their clients on the various entitlement programs. Geriatric social workers also provide their clients with one-to-one mental health counseling.

In many cases, clientele demographics have changed dramatically since the early 1970s. It is anticipated that in the next 30 years, there will be a decline in non-Hispanic whites from 84 percent (today’s elder population of 70 and older) to 78 percent. It is anticipated that in 2040, the population of retiring Hispanics will make up 12 percent of the elder population, compared with a current 4 percent (Schafer et al., 2000). This change is expected to affect the delivery of primary care services, especially in the field of geriatric medicine.

More than a third of health center patients are uninsured, and almost 40 percent are covered by Medicaid (KFF, 2013). In 1970, 25 percent of individuals ages 65 years and older were at the poverty level. Today, one in 10 lives in poverty (Schafer et al., 2000). Geriatric social work practitioners are well aware that our aging population is living longer and that the majority will want to continue living in their own homes. Of major concern for current practitioners is how many of these aging and poor seniors will be able to afford to continue living in their current places of residence. Along with the changes in ACA that shift care toward more preventive approaches, the shift in services will affect how geriatric social workers approach their practices.

It is not uncommon to find private-practice geriatric social workers working with Baby Boomers who are dealing with aging parents. It is also not unusual to see a disparity in the level of services provided for those who have financial resources and those who do not. For example, current observations show that one of the fastest-growing industries is home care and home health care agencies. This industry is ramping up to address the needs of the growing aging population of seniors who want to stay in their homes with care. Running parallel to this industry’s growth is the rapidly growing population of aging adults; however, the majority of them are going to be minorities who may not be able to afford in-home private duty care. At issue here is that 81 percent of non-Hispanic whites own their homes.
and thereby may have equity to use to pay for in-home care. By comparison, 50 percent of African Americans and 57 percent of Hispanics in this same age group own a home (Schafer et al., 2000). This means that many aging minorities are going to look to government or family financial support in order to stay in their homes as they age.

**CHANGING ROLE OF THE GERIATRIC SOCIAL WORKER**

It is not unusual for policy and decision makers to consider using nurse practitioners and physician assistants to help meet the growing demand on primary care services. The Health Resources and Services Administration (HRSA) reported in February 2012 that in some states (California, Texas, Florida, Illinois, and New York) there will be an anticipated need of 1,057 to 1,623 health care professionals, mostly doctors and nurses, to address this need in services.

As reported in AARP Bulletin’s March 2013 issue, many graduating doctors are seeking the more lucrative specialty practices, as opposed to primary care practice, due to school debt. The article further mentions the use of a team approach to help address the need of caring for more patients in a primary care practice; however, most scenarios exclude the use of geriatric social workers. The one problem many social workers have encountered in working in team-like environments has been acceptance by the primary care physician (Leipzig et al., 2002). Perhaps this is a reflection on the geriatric social worker’s education and training along with our perceived roles as discharge planners and case managers. There are other models of primary care teams working with social workers in the delivery of health and mental health services. In many states, adult day health care centers, which are reimbursed through Medicaid, employ a team approach with licensed clinical social workers to address specific health, physical, and psychological needs in order to prevent unnecessary emergency/urgent care services. The clinical social worker is a key professional who works with center nursing and social work staff by coordinating care with the participant’s primary care physician. In addition, geriatric social workers consult in assisted and skilled living environments, providing mental health evaluations, counseling, and group therapy.

It would seem that based on the long-term plans of our aging population, geriatric social workers may find themselves making more home visits and consulting with families on the various issues related to keeping their aging parents in their homes longer. This would include identifying their personal, legal and financial plans for aging in place. It may become common procedure to refer families to an elder law attorney and financial planner in order to educate families on long-term care options and pricing. Such discussion would also explain the differences between skilled care and assisted living environments, and provide cost estimates. The geriatric social worker will continue to be seen as an expert in the various entitlements and qualifications for eligibility.

Many geriatric social workers have additional training and experience in medical social work, hospice, oncology, rehabilitation, and dialysis, to name a few fields, and can draw on this experience to further educate clients in their homes on preventive care and treatment. Geriatric social workers may also find that it will be easier to provide clients face-to-face counseling and consultation in their clients’ homes due to transportation and access difficulties. Further, with proper consents, the geriatric social worker can communicate directly to their clients’ personal care physicians any changes in their patients’ health care needs.

**PREPARING FOR A CHANGING ROLE**

In order for geriatric social workers to be professionally prepared for the upcoming challenges of ACA and for working with a primary care team, they will need to focus on adding training and education in health and wellness. Some topics may include:

- Pharmaceutical and drug interactions
- Nonmedical wellness education
- Chronic health and illnesses among aging adults
- Supportive treatment plans that can be used with pharmaceutical treatments
- Providing mental health consultations in the home environment
- Working with nursing and other ancillary professionals in a primary care setting

**SUMMARY**

In closing, during the next months and coming year, it will be a challenge for all primary care practices and consumers to address the changes to our national health care landscape with the implementation of the Affordable Care Act. As one part of the professional network that provides care and treatment to an aging population that is aging healthier and living longer, we also face the challenges of helping families overcome the various roadblocks and detours to an effective long-term care plan. It would seem that in order for geriatric social work to function under ACA in January 2014, we will need to make our own professional shift from current roles to future roles. Perhaps the best way to help our clients is for all of us to begin understanding our various professional roles and expectations, along with the goal of learning how to best work together to achieve affordable care for all.

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**REFERENCES**


**RESOURCES**

Federal Resources on the ACA
www.healthcare.gov

NASW Healthcare Reform – Member Resources
www.socialworkers.org/advocacy/healthcare reform/default.asp
Recent news in the addictions field may leave some of us scratching our heads. In fall 2012, an article titled “Acceptance of non-abstinence goals by addiction professionals in the United States” was published in *Psychology of Addictive Behaviors*. Key findings showed that nearly 50 percent of addiction professionals in the United States supported nonabstinence goals for their clients in certain situations (Davis & Rosenberg, 2012). The Partnership at DrugFree.org newsroom report on the study’s findings has drawn comments from some of the most notable professionals in the addictions field, including Dr. Phyllis Gardner, president of the International Certification and Reciprocity Consortium, on one end of the argument, and Dr. Mark Willenbring (noted alcohol researcher) at the other *(www.drugfree.org/join-together/addiction/commentary-learning-as-we-go-critical-assessment-of-addiction-research-and-practice)*. My perspective lies somewhere in the middle of the debate.

Continued research and dialogue are essential, and it is paramount to keep the argument at the forefront of our minds as we treat people who have the potentially fatal disorder that is addiction. The following discourse will begin with an overview of Rosenberg and Davis’s (1994) and Davis and Rosenberg’s (2012) studies, followed by a few thoughts of my own and points for continued discussion in the addictions field.

In 1994, Rosenberg and Davis published the first study to measure alcohol treatment services’ acceptance of moderation goals for clients with alcohol use disorders. Overall, 77 percent of their sample rejected moderate drinking as a viable treatment goal. Of that group, 17 percent stated that moderation was acceptable for clients in other treatment programs and for some of their own clients after discharge. For the nearly 25 percent who supported moderate drinking as a treatment goal, the majority were in outpatient settings, and 70 percent stated that moderation goals were acceptable for only 1 percent to 25 percent of their clients.

There were two additional study questions and outcomes that caught my attention. First, *what conditions are considered when making the determination for moderate drinking goals?* The most important determinants included dependence severity, drinking history, psychological dependence, previous treatment episodes, liver functions tests, criminal behavior, and client attitude regarding abstinence and controlled drinking (Rosenberg & Davis, 1994). The other question was *how does counselor educational and professional level affect recommendations for nonabstinence treatment goals?* Interestingly, there were no significant differences between groups relative to level of education and experience (Rosenberg & Davis, 1994). It is important to note, however, that the majority of the sample was well educated: 54 percent completed at least some graduate work, and 60 percent had at least 10 years of experience in the field.

In contrast to Rosenberg and Davis’s 1994 study, Davis and Rosenberg’s study published nearly 20 years later (2012) showed that acceptance of nonabstinence goals had increased significantly. Nearly 50 percent of addiction professionals in the United States accepted nonabstinence goals for some of their clients. It is important to clarify that only 16 percent of addiction counselors supported nonabstinence as a final outcome goal for clients with alcohol dependence. In contrast, at least 30 percent of addiction professionals accepted nonabstinence as an acceptable goal for clients with alcohol abuse. The 2012 study also examined attitudes of acceptance/nonacceptance of moderation goals relative to drug use. Nearly 50 percent of addiction professionals reported acceptance of nonabstinence goals for drug abuse as an intermediate goal, and 32 percent accepted nonabstinence as a final outcome goal for drug abuse.

Nonabstinence received significantly less support from addiction professionals when treating clients with drug dependence: 27 percent accepted nonabstinence as an intermediate goal, but only 15 percent supported nonabstinence as a final goal.

Similar to the 1994 study, Davis and Rosenberg (2012) asked respondents to consider specific client characteristics when assessing acceptance of nonabstinence goals. Nineteen characteristics were included, but the following list identifies the most important considerations noted by survey respondents: health problems, previous treatment episodes, co-morbid psychiatric disorder, being less than 18 years old, emotional stability, polydrug use, having children, and drug of choice (Davis & Rosenberg, 2012).

I have a few thoughts of my own. First, addiction occurs along a continuum and research now supports that our view of addiction as a binary disorder—one either has it or doesn’t, abuse or dependence—is too limiting. More than 50 years ago, Jellnik (1960) delineated alcoholism into five subtypes in his book *The Disease Concept of Alcoholism*. A 2007 study conducted...
by Moss, Chen, and Hsiao-ye Yi (2007) also identified five subtypes of alcoholics. Those familiar with Alcoholics Anonymous (AA) literature know that it identifies different types of alcoholics. For example, in the AA Twelve and Twelve on page 23 and in the Tradition Three chapter, there is much discussion about other types of alcoholics and how it was “necessary to raise the bottom to a point where it would hit them” (Alcoholics Anonymous, 1952).

Second, because of our limited ideas on how to treat people with substance use disorders, we have likely lost a few along the way. People who fall into what Moss and colleagues (2007) term the “functional subtype (~20 percent) and young adult subtypes (~31.5 percent)” of alcoholics may not consider an inpatient treatment option, which has been the dominant model for decades. That high level of service is not appropriate for these subtypes of alcohol dependence patterns, but until recently few other options existed. Additionally, those who are not ready to accept nonabstinence as a treatment goal have avoided services because in the United States abstinence has been the only acceptable treatment goal. My experience in the addictions field has shown me that the majority of people with substance use disorders enter treatment in the precontemplation or contemplation stages of change. Few are ready upon treatment admission to consider lifelong abstinence. My job is to help increase their motivation to change. Although a client may not enter treatment with a desire for lifelong abstinence, the process of treatment will hopefully support their motivation to change and increase their openness to abstinence as the most healthful outcome.

Further, we can treat people without necessarily supporting their desire to moderate their use. What? I have an ethical responsibility to say to my clients, particularly those who have more severe forms of the disorder, that “based on my knowledge of addiction and the criteria for the disorder, I have serious concerns about the decision to moderate your use.” By definition, “addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response” (American Society of Addiction Medicine, 2011, para. 2). Even though we may not support the client’s nonabstinence goal, we can support the client. We hope that the client will find out through his or her experience—and the support of a knowledgeable clinician—that moderation may be an unsafe goal. There are no guarantees, however, for those with addiction disorders if use continues. There may not be another chance for treatment or another opportunity to pick up a white chip.

Finally, client goals should not be determined by the practitioner alone; goal setting should be a collaborative effort. When considering nonabstinence goals, it is crucial to take into account specific client characteristics, as was noted in both studies (Rosenberg & Davis, 1994; Davis & Rosenberg, 2012): severity of the disorder, state of client’s health, treatment history, drinking history, whether client has children, co-morbidity of psychiatric disorder, emotional stability, and clients’ desired goals.

For many of us, nonabstinence as a treatment goal may be difficult to accept. It certainly is for me. Over the years, I’ve lost too many clients to name, and I don’t want to put my clients in danger; they’ve suffered enough. So what are the next steps? Continue the debate. Continue the research. Use your best motivational interviewing skills to keep clients engaged in treatment and help them understand that abstinence is the most healthful outcome goal, while coming to our own understanding that moderate or controlled drinking is safer than abusive, uncontrolled drinking—regardless.

Whatever its prevalence and stability, controlled or moderate consumption by recreational, abusive, and dependent drinkers and drug takers has several health benefits. For example, reduced consumption may arrest an escalating pattern of drinking or drug taking that could result in negative consequences later in life. In addition, supporting clients to pursue controlled or moderate substance use might increase the appeal of treatment for many potential clients with SUDs (substance use disorders).

Openness to discussion of nonabstinence goals may attract and retain substance misusing or addicted individuals who are ambivalent about the prospect of lifelong abstinence, and who would otherwise not seek or participate in therapy. Furthermore, nonabstinence is an attractive and healthier intermediate goal for people who might decide to abstain after successfully (or unsuccessfully) attempting to moderate their consumption (Davis & Rosenberg, 2012, p. 1).

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RESOURCES
NASW Standards for Social Work Practice with Clients with Substance Use Disorders socialworkers.org/practice/standards/NASWATOD-Standards.pdf

In 1980, armed with nothing more than good intentions and big dreams, my husband and I walked into our local adoption agency and announced that we wanted to adopt a child. Because I was carrying our six-week-old baby in my arms, our request was met with looks of surprise and even incredulity. Clearly—although we were quite young—we were not the infertile couple seeking a newborn baby that the agency was expecting when they made our intake appointment. The social worker who interviewed us began by asking what type of child we thought we might want to adopt, and we were ready with our answer: “a child most in need of a home…and least likely to get one.”

The 1980 event I attended was hosted by one of the first agencies to take this approach of introducing prospective families to waiting children; by the mid-1990s, “match parties” had become de rigueur within the adoption community. From the beginning, the practice had its supporters and its detractors. The venerable Christian Science Monitor published opinion pieces 10 years apart, and their titles alone—“Adoption parties: Caring or cruel?” (Paulson, 2001) and “Adoption fairs are speed dating for kids. Families need ‘arranged marriages’ instead” (Morga, 2011)—demonstrate that the controversy has not abated. As is often the case after working for decades in the same profession, my thoughts and opinions on this recruitment strategy have shifted over the years. As I have learned more about evidence-informed practices for permanency planning, developed relationships with hundreds of youth who have been in foster care, and, most important, learned more about the impact of trauma on children in the child welfare system, I can now recognize both the positive elements and the significant pitfalls that such events present.

In considering whether such events are harmful or helpful, we first need to step back and ask a couple of preliminary questions: “Who are these individuals and families who are willing to make a lifelong commitment to older youth in foster care?” or “Who adopts older children who have histories of abuse, neglect, and trauma?” Experience and research show that children in foster care most often achieve permanency through people who already know them—birth family, kin, “fictive kin,” current or former foster families, parents of friends, and so forth (Avery, 2010; Bussiere, 2006; Casey, 2003; Child Welfare Information Gateway, 2006; Flynn, Paget, & Welch, 2004; Groh, 2009; Howard & Berzin, 2011; Maza, 2002; Report to Congress, 2005). With the firm belief that all children, including our oldest youth, need and deserve lasting families in which to both grow up and “grow old,” the most important permanency planning practices center around keeping children safely and securely connected to their families of origin (Bronson, Saunders, Holt, & Beck, 2008; Child Welfare Information Gateway, 2006; Doyle, 2007; Groh, 2009; Howard & Berzin, 2011; Koh & Testa, 2008; U.S. Department of Health and Human Services, 2005).
When this cannot be accomplished, the next best approach is to identify those people with whom the youth has a natural potential connection—for example, finding relatives who had previously not been located or reexploring former foster families. Such practices as “case mining” and “extreme recruitment” utilize these strategies (Annie E. Casey Foundation, n.d.; Avery, 2010; Boo, 2010; Bussiere, 2006; Child Welfare Information Gateway, 2006; Sittenfeld, 2011). Yet we all know that some children—even those who have lived long periods of time in residential settings where they have not formed the kinds of attachments that youth in more normalized family and community settings have formed—have a scarcity of these “naturally occurring” relationships; therefore, more creative strategies must be employed if these seemingly “disconnected” youth are to attain permanence before “aging out” of care.

If a young person has few existing relationships, and yet most youth in need of adoption are adopted by people who already know them, a challenge presents itself. How do we help these youth to widen and broaden the circle of contacts? We must help them get to know more people so that their opportunities for relationships, connections, and, eventually, permanence can be expanded.

In this context, perhaps the old, original concept of “match parties” can be updated and brought into line with current child welfare thinking, values, and evidence-based practices. Using structured events to bring children and youth in need of permanence together with community members who are approved to become (or who already are) resource parents in settings that are comfortable—emotionally as well as physically safe—and engaging can be a constructive idea. The name and purpose for such events should be changed. The goal is not “matching” and certainly not that adoption will result, but rather that the youth will have increased opportunities to form natural, mutually satisfying relationships based on shared interests and experiences with caring adults in their communities. When these events are done well, such relationships may blossom into something deeper and permanent connections may be born and nurtured. Even when neither adoption nor other forms of permanence directly result from such events, youth can gain self-confidence, self-esteem, and life skills as well as friends or mentors, which, in the long run, are likely to enhance the success of permanency planning efforts.

Social workers and agencies exploring such events as part of a broad permanency-focused strategy should carefully consider two important factors. The first is how to structure the event so that it is meaningful and constructive. The second is how to prepare and support the young person’s participation so as to decrease any possibility of adding to or triggering a trauma response, while managing appropriate expectations.

In terms of the structure, I suggest that events based on meaningful activities—rather than on “show and tell”—will be more effective and create an atmosphere of physical and psychological safety. One such example is a day of community service where a group of youth and adults work together on a volunteer project. Another example, tried in New Jersey, was when a group of youth and adults came together for a dance workshop. They learned to dance and created their own rap music under the direction of an accomplished rap artist and dance choreographer. Pat O’Brien, director of New York’s You Gotta Believe agency, produces a public-access television talk show that is hosted by young adults who discuss topics of their choosing; adults comprise the studio audience. In Vermont, an agency offered a poetry-writing workshop for younger children and adults, where they collectively wrote poems, drew pictures, and created books. In each of these examples, the young people and adults are doing something positive and constructive together; perhaps a relationship that merits further exploration might develop. Each of these events is a far cry from the old-school “match party,” and yet each offers an opportunity for youth who have few positive adult connections in their lives to interact with adults in a safe and structured environment.

The second important consideration is providing adequate pre-, mid-, and post-event preparation and support to any youth who are invited to participate in such activities. The event will be less likely to incite a traumatic response when the youth is well-informed and prepared ahead of the event and kept informed afterward. Youth who have found these events awkward, uncomfortable, or even traumatizing often cite not knowing what to expect, having unrealistic expectations, and/or not knowing what happens after the event is over.

Workers should describe and explain the event to the young person ahead of time: who will be present, what will happen, what the purpose of the event is, and what their own roles will be. Enlist the youth as a partner in the project, offering them the chance to consider what they can do to make the event successful. Go through a similar preparation process with the child’s foster parents or the staff at the residential facility where the young person lives—everyone must be on board to maximize success. As you get closer to the event, talk to the youth about her or his hopes and concerns. Work together to make a list of topics the teen would feel comfortable discussing, such as hobbies, favorite subjects in school, or future goals. Role-play some of the possible conversations that might emerge and ensure that the young person knows how to respond to intrusive or uncomfortable questions, should they arise. After the event, provide “debriefing” opportunities for the youth. Likewise, follow up with foster parents or residential staff. Stay in touch with the young person, keeping her or him apprised of any future opportunities to interact with any adults met at the event. Also keep the youth informed about positive results that came from the event, such as the completion of the volunteer project.

As we continue to pursue permanency opportunities for those youth who have been in care the longest and seem to have the least viable connections in the community, it is important to be careful and “do no harm” while also being strategic and creative about giving these young people future opportunities for engaging and interacting with adults who may serve as resources for them. It is a difficult balancing act and hard work, but it is important and has valuable potential for those youth with the least apparent permanency options.

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RESOURCES


Despite crisis being usually understood as an expected and disruptive event, the Chinese translation of the word “crisis” consists of two separate characters: 危 and 機. The word 危 usually means “danger.” Also, it can mean unsafe, disaster, or even death. The word 機 can refer to significant turning points or things that can be turned or moved. In addition, there is a time dimension to it, signifying that it is the right time to take a different course. The word 機 also has an action dimension that describes a sense of quickness to seize the opportunity for positive change or to go with the tide of change. Taken together, the Chinese translation of the word “crisis” is fascinating because of the polarized process being described: crisis can potentially be a time of danger, unsafe, disaster, or even death. The other side of it, however, is exactly the opposite of danger: it is a turning point—the exact right time—for positive change that requires quickness and flexibility to flow with the change process. In some ways, the meaning of crisis coincides with that of the yin-yang symbol: the presence of two seemingly opposite but closely connected parts of a phenomenon.

In many ways, a solution-focused approach to crisis captures the essence of crisis as represented in the word 機. Based on a systems perspective, solution-focused therapy views change inevitably and continuously (Kral & Kowalski, 1989). Because change is constant and there is movement in any system, every problem pattern will include some sort of exception to the pattern (de Shazer, 1985). In other words, despite the multitude of deficiencies or problems people may perceive they have as a result of a crisis event, there must be times when they handle their life situation in a more satisfying way or in a different manner by leveraging the fluctuations in any system. These exceptions provide the clues for solutions (de Shazer, 1985, 1988) and represent “unnoticed” strengths and resources of a person or the community. The task for the solution-focused practitioner is to assist clients in noticing, amplifying, sustaining, and reinforcing these exceptions regardless of how small and/or infrequent they may be (Berg & Kelly, 2000; Lee, Sebold, & Uken, 2003). Once clients are engaged in nonproblem behavior, they are on the way to a solution-building process (Berg & Steiner, 2003).

Solution-focused brief therapy (SFBT) approaches crisis response with an emphasis on the crisis as a potential “window for change.” Solution-focused brief therapy makes a conscious choice to focus on solutions, strengths, and health—that is, to focus on what clients can do instead of what clients cannot do as well as on their successes and accomplishments when they are able to satisfactorily address their problems (Berg & Kelly, 2000; de Shazer, 1985). The emphasis on solutions and successes is neither a consequence of “naive” beliefs regarding strengths in clients nor simplistic “positive thinking.” This is a deliberate therapeutic choice, which is supported by repeated clinical observation about how clients discover solutions faster if the focus is on what they can do, what strengths they have, and what they have accomplished (de Jong & Berg, 2013). Such a conscious effort also grows out of a concern about the role of language in creating or sustaining reality. Solution-focused brief therapy views language as the medium through which personal meaning and understanding are expressed and socially constructed in conversation (de Shazer, 1994). Solution-focused therapy’s emphasis on strengths and solutions “helps to build the expectation that change is going to happen” (de Shazer et al., 1986, p. 79). “What is noticed becomes reality and what is unnoticed does not exist” (Lee, Sebold, & Uken, 2003, p. 31). Consequently, the more the therapeutic discourse concerns alternate futures and solutions, the more clients expect change to occur. Gingerich, de Shazer, and Weiner-Davis (1988) found that when clinicians intentionally engage in change talk, clients are more than four times likely to discuss change in their next speaking turn. Such a finding is consistent with the assumption of solution-focused therapy that a small change at the first step constitutes what is required to initiate the change process (O’Connell, 2012).

The Solution-Focused Treatment Manual adopted by SFBT Association succinctly describes the basic tenants of solution-focused brief therapy:

- It is based on solution building rather than problem solving.
- The therapeutic focus should be on the client’s desired future rather than on past problems or current conflicts.
- Clients are encouraged to increase the frequency of current useful behaviors.
- No problem happens all the time. There are exceptions—that is, times when the problem could have happened but didn’t—that can be used by the client and therapist to co-construct solutions.
- Therapists help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within the clients’ repertoire or can be co-constructed by therapists and clients as such.
- Differing from skill-building and behavior-therapy interventions, the model assumes that solution behaviors already exist for clients.
- It is asserted that small increments of change lead to large increments of change.
- Clients’ solutions are not necessarily directly related to any identified problem by either the client or the therapist (Trepper et al., 2010, pp. 1–2).

In sum, a solution-focused approach emphasizes identifying and amplifying the clients’ and community strengths...
Significant convergence in practice should not, however, overshadow the differences of both approaches, especially with respect to their target problem situations. Solution-focused therapy perceives that problems are developed and maintained within the context of human interactions that are oftentimes strained by developmental challenges (Berg, 1994; de Shazer et al., 1986). As such, problems are perceived as interpersonal in nature. Building on such a perception of the nature of problems, solution-focused therapy assumes clients are resourceful and that both complaints and solutions are clients’ construction of their realities (Lee, 2011). The purpose of therapy is to help clients meet their needs by using what clients bring with them (de Jong & Berg, 2013). In contrast, crisis usually involves unexpected stressful events that may or may not be interpersonal or developmental in nature. Community tragedies such as the Newtown, Connecticut, school shooting or the 2011 tsunami in Japan represent manmade and natural disasters. Besides focusing on clients’ strengths, a crisis worker usually needs to provide concrete, practical support or information that will help to alleviate their clients’ immediate disequilibrium within their situations (James & Gilliland, 2013). These actions are usually not perceived to be important in the traditional solution-focused approach. Flexibility and individualized treatment may best describe the wisdom required in applying a solution-focused approach to crisis intervention (Greene et al., 2000). On any hand, any useful adaptation echoes the basic tenet of a solution-focused approach: if it works, then do more of it, and if it doesn’t work, then don’t do it again (de Shazer et al., 1986, p. 76).

In sum, consistent with the Chinese conception of crisis as opportunity (機), a solution-focused approach intentionally chooses to emphasize crisis as a potential window for change. It is assumed that clients and communities, in spite of their crisis situation, come with a diverse repertoire of coping skills, although some of these useful skills and resources are not being noticed. A solution-focused approach to crisis intervention can help clients and the community discover and amplify their strengths and resources—an intervention approach that envisions clients’ and a community’s new learning and new strengths through the passage of life.
Neuroscience and The 49% Rule: How to Avoid Overworking the Therapist and Underworking the Patient

Stephan Gombis, LCPC, MFMFT • Dawn Gilliam, LCSW

In the book *The Talent Code*, author Daniel Coyle interviewed UCLA Professor of Neurology Dr. George Bartzokis. In the interview, Dr. Bartzokis described learning as a skill that boiled down to three simple facts:

1. *Inside the brain, every human movement, thought, or feeling is an electrical signal that moves through a chain of neurons;*
2. *Myelin is the cellular insulation that wraps the chain of neurons to increase strength, speed, and accuracy of that electrical signal;* and
3. *The more you fire the chain of neurons, the more myelin optimizes that circuit, making the electrical signal stronger, faster, and fluent* (Coyle, 2009, p.32).

The discovery that myelin wraps chains of neurons, thereby making the most used chains stronger, faster, and fluent, means that our patients can increase capability in any area by thinking, moving, or feeling more about that area. As therapists, we may be taking on work that would be beneficial for our patients to handle. Whether it’s learning to drive a car or learning to maintain a healthy weight, “every human movement, thought, or feeling” is part of a chain of neurons that can be automated when fired repeatedly. So, if our patients are more capable than we think—or than they let on—should that change how therapy is done? How well do we foster the firing of our patients’ developing neuronal chains in therapy? And who is in the driver’s seat? These questions led me to a strategy called The 49% Rule.

**SO, WHAT IS THE 49% RULE?**
The Rule: Regardless of the problems a patient faces, the therapist will not be in the driver’s seat for them more than 49% of the time.

We may think we can do a better job than our patients of solving problems—and so may our patients. But solving problems for them prevents their neurons from firing. It tells them they can’t do or be something they want, when really they just need more time in the driver’s seat. Easy enough, right? Even new therapists know not to jump in and directly fix a patient’s problem, but applying The 49% Rule can be tricky.

**HERE’S HOW TO AVOID MISSTEPS.**

**Step #1: It’s really a principle. They work; you guide.**
It’s so critical, it bears repeating: no myelin grows if the patient isn’t thinking, feeling, and moving.

**Step #2: Break it down.**
First, have patients identify an area of focus and then have them pick one simple action. How do you do this exactly?

- **Ask questions rather than give answers.** When we ask questions, we are helping to activate a patient’s mind. When we give answers, we activate our own minds. But sometimes we can feel like we’ve run out of questions to ask. So here are a few ways to keep them coming:
  - **Test your assumptions.** Ask your patient What, When, Where, Who, and Why questions. **Note:** Avoid Why questions, which often create more assumptions than facts.
  - **Play dumb.** Ask the questions you think are SO simple you probably already know the answers. Your patient might surprise you.
  - **Be curious.** Imagine you’re an explorer and use your questions to discover new insights, different perspectives, and opposing views. Your genuine interest in who your patient is will make her or him more likely to fire those neurons.
- **View your patient as the expert of his or her own life.** When a person is viewed as an expert, he or she tends to take the lead. And isn’t this what we expect experts to do? As your patient senses your confidence in his or her abilities (if only because you read what Dr. Bartzokis said about myelin), his or her confidence will increase.

- Listen more than talk. It’s challenging to hold your tongue when you have something to offer that can help. But giving patients the extra space to think and fire their neurons conveys that you value their thinking. And with practice and time, that space and confidence will help your patients grow.

**An Example of Step #2**
A patient recently decided to focus on weight loss as his desired outcome. He identified after-meal snacking as a barrier to his goal. So, we worked to isolate an action he could focus on for one week, and he decided to e-mail me if he ate anything between dinner and bedtime.

**Step #3: We learn by feedback, so create feedback loops.**
In the above example, the feedback loop was the e-mail to me; I have also used text messaging, posting on a blog, phone calls, and old-fashioned journaling. No matter what method you and your patient select, make sure that the simple action has a feedback loop between you and the patient so you can offer insight on whether the selected action works.
Step #4: Make sure to avoid the two biggest traps—doing too little and doing too much.

I’ve seen two traps, missteps really, that can cause this process to break down. So, let’s look at each one.

Asking for too much too soon. Patients are often overwhelmed or inexperienced, so expecting them to go it alone is unrealistic. And if I had them attempt to take too much action before developing a process (a resourceful chain of myelinized neurons), then they would regress.

A slightly different way of doing too much too soon is when the patient wants to take on a complex action—say, working out four times a week—rather than a simple one—like just getting to the gym even if you only watch TV there.

The second action (just getting to the gym) seems less helpful to the patient, and so they avoid choosing this type of act as “too easy.” It is a mistake to think a small action is simple; after all, growing the myelin is what we’re after.

Not challenging patients to do anything. Patients come into therapy thinking their problems are too big and their ability to face them is too small. And if we never gave our patients the opportunities to challenge their own assumptions (by taking the lead themselves), then we would rob our patients of seeing their true capacity. By positioning them to take the lead with small steps that lead toward their goals, we’re helping them see what’s possible. And to me, this is what Dr. Bartzokis’s insight about firing chains of neurons is really all about. This process gives our patients hope. Now that we’ve covered the four steps of The 49% Rule, it’s time to head to the summary.

The 49% Rule Summary:
- Step #1: It’s really a principle. They work; you guide.
- Step #2: Break it down.
- Step #3: We learn by feedback, so create feedback loops.
- Step #4: Make sure to avoid the two biggest traps—doing too little and doing too much.

Next Step:
If you’d like to try The 49% Rule in your own practice, I recommend starting with the following steps:
1. Ask questions rather than give answers.
2. Think of your patients as the experts of their own lives.
3. Don’t speak more than your patients do.

These steps are a good start for firing your patients’ chains of neurons. It’s worth repeating: the more you fire the chain of neurons, the more myelin optimizes that circuit, making the electrical signal stronger, faster, and fluent.

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REFERENCE
In the 1990s, advocates of clients/consumers, family members, and some providers began to challenge many of the old assumptions and stereotypes about mental illness and the lives of those with mental illness. These advocates—some speaking from personal experience and others from observation—argued that being diagnosed with a mental illness, even a serious one, is not a death sentence in terms of hope for the future. Instead, many people who have mental illness can lead fulfilling lives and can achieve universal goals: friendships, romantic partnerships, meaningful work, enjoyable recreational pursuits, and independent living. In other words, many people with mental illness can achieve “recovery.” These advocates soon coalesced into a recovery movement that, over time, succeeded in achieving a paradigm shift with mental health systems of care around the world at all levels “by challenging mental health providers, administrators, policy makers, funders, workers, and the people who experience mental health problems and their families to look at how negative or limiting assumptions are driving approaches to services, to funding, to treatment, to policies, and ultimately to the course of everyday lives” (Pennsylvania Office of Mental Health and Substance Abuse Services, 2005, p. 6).

“Recovery” should not be equated with “cure,” although many individuals with mental illness do experience what might be termed a cure, in that their symptoms—with or without treatment—recede and in that they do not have any subsequent episodes of illness. For example, about a third of individuals who experience an episode of psychotic illness that looks like schizophrenia have only one episode, get well, and never get sick again (Torrey, 2006). Today, we no longer call such illness schizophrenia; rather, the diagnosis is schizophreniform disorder. Someone who has schizophreniform disorder recovers in the complete sense of the word, in that they remain well with no reoccurrence of psychotic symptoms. For most people with serious mental illness, however, “recovery” means achieving a fulfilling life while living with and managing symptoms that may wax and wane over time.

But how is recovery defined exactly, and where does hope fit in? As an example, in November 2004, the Pennsylvania Recovery Workgroup developed a definition of recovery that was subsequently endorsed by the Pennsylvania Office of Mental Health Substance Abuse Services (POMHSA) as the definition to be used to guide transformation of the state’s mental health system. This definition is very similar to the general definitions of recovery used by other states and in other countries (see, for example, O’Hagan, 2001). Embracing recovery is not just an American phenomenon; it is a worldwide paradigm shift: “Recovery is [defined as] a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, choices and opportunities that promote people reaching their full potential as individuals and community members” (POMHSA, 2004, p. 7).

One of the most important aspects in an individual’s journey of recovery is achieving and maintaining hope. But what is hope, exactly? Hope is generally defined as the desire for something, accompanied by the expectation of obtaining it. We still don’t know much about hope’s determinants or biological correlates, or why some individuals can have hope in the most dire of circumstances while others in similar positions cannot achieve or maintain it. What we do know is that lack of hope, or hopelessness, is often very detrimental to mental health and is often the key component in negative psychosocial outcomes, such as completed suicides. Thus, the development and maintenance of hope is important for mental health.

In 2004, the Substance Abuse and Mental Health Services Administration (SAMSHA) released a consensus statement on mental health recovery, and it identified hope as one of the ten components of successful recovery when someone has a mental illness. Recovery provides our clients with the message that by maintaining hope they can achieve a better future and can overcome the obstacles and barriers that arise during the course of living with mental illness. Although maintaining hope requires that hope be internalized...
within the client, the development of hope can be initially facilitated by the client’s peers, family, friends, and treatment providers, including social workers. As one consumer stated, “My social worker provides me with hope—she had faith in me when I didn’t have faith in myself. Now, today, I feel I have achieved recovery and I have a decent life.” In other words, hope is the catalyst of the recovery process (SAMSHA, 2004).

In all areas of mental health care, it is critical to hear and respect the voices of those who receive services, particularly consumers and family members. Recovery and the maintenance of hope is a personal journey, and that journey differs for each individual; however, common threads cut across individual experiences. Hope is important for clients, it is important for families, and it is important for us as social workers.

The following quotes from the National Alliance on Mental Illness website (www.nami.org) illustrate what it means for individual consumers to have hope in recovery as expressed in their own words (retrieved March 18, 2009):

“Recovery does NOT mean I will be rid of my mental illness. It means I can learn how to manage my symptoms better and better all the time. I will still have occasional set-backs, but my mental health is in the process of recovery.”

“Recovery means properly managing my illness instead of my illness controlling me.”

“Recovery means learning to live your life successfully with a mental illness. It is a journey, not a destination.”

Social workers can facilitate hope with their clients by giving them the message of recovery and delivering services using a recovery orientation. This does not mean engendering false hope and unrealistic expectations; rather, it means supporting by helping them to set realistic and feasible self-determined goals, to learn how to overcome obstacles, and to self-advocate for what they want in life. This approach supports empowerment and engenders real hope in recovery.

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DSM-5 — the fifth edition of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* — is here. This is an exciting time for clinicians. The DSM-5 revision process created an opportunity for open discussion of the nature of our patients’ problems and how best to conceptualize them. This resulted in controversies that became so heated that some critics went so far as to suggest that the DSM should be abandoned altogether in favor of the World Health Organization’s diagnostic manual, the International Classification of Disease (ICD), from which the DSM’s diagnostic codes are taken but which lacks the DSM’s detailed diagnostic criteria.

The disputes — about proposed changes to diagnosis of depression, substance abuse, ADHD, autism, and many other categories, plus concerns about the addition of many new categories from hoarding disorder to binge eating disorder — were of such general interest that they garnered unprecedented media coverage. As a personal example, to my astonishment, a scientific review paper I coauthored with Michael First that criticized the DSM-5’s proposal to eliminate the major depression bereavement exclusion made the front page of the New York Times. The public at large seemed at once fascinated and disturbed by the vehemence of the DSM-5 skirmishes and what they revealed about the state of knowledge in the mental health professions. On the other hand, even some sympathetic observers see the changes as relatively modest and wonder whether the incremental progress was worth the effort.

Clinicians must now confront the challenge of digesting and adapting to the new criteria and categories from their own clinical perspectives. So, it is a good time to ask: What is new in the DSM-5, why was it changed, and why are the changes controversial?

Why all the controversy? The DSM-5 Task Force’s aspirations were high and suggested there would a paradigm change (e.g., focus on etiology, use of laboratory tests, reducing NOS diagnoses in favor of specific categories, dimensional diagnosis rather than categories, separating impairment from disorder diagnosis, continuous severity scales). However, the initial goals were largely unrealistic and unachievable, so naturally there was disappointment despite many constructive changes of detail that were made.

The most basic reason for controversy, however, was the claimed expansiveness of psychiatric diagnosis, both in terms of new categories and in terms of loosening the criteria for diagnosis of existing categories. The DSM-5 Task Force was very responsive to clinicians’ concerns about being able to diagnostically label individuals coming for consultation, but seemed to be tone deaf to broader validity concerns of overlabeling normal distress as mental disorders. The excessive secretiveness of the Task Force process added to a situation of frustration for many critics. Because psychiatry is in the grips of a biomedical brain-physiology ideology about mental disorder, the perceived classification of normal conditions as disorders triggered the additional concern that a raft of new conditions would become targets of drug development, and our already highly medicated society would become even more overmedicated.

To get a taste of the objections, here is a sample. Allen Frances, the Editor of DSM-IV and the most vehement and articulate critic of DSM-5, argued in an op-ed that the DSM-5 is transforming normality into disorder. Frances summarized:

“DSM-5 will turn temper tantrums into a mental disorder….Normal grief will become Major Depressive Disorder….The everyday forgetting characteristic of old age will now be misdiagnosed… creating a huge false positive population of people…. Excessive eating 12 times in 3 months is no longer just a manifestation of gluttony and the easy availability of really great tasting food. DSM-5 has instead turned it into a psychiatric illness…DSM-5 has created a slippery slope by introducing the concept of Behavioral Addictions that eventually can spread to make a mental disorder of everything we like to do a lot…DSM-5 obscures the already fuzzy boundary been Generalized Anxiety Disorder and the worries of everyday life…. Many millions of people with normal grief, gluttony, distractibility, worries, reactions to stress, the temper tantrums of childhood, the forgetting of old age, and ‘behavioral addictions’ will soon be mislabeled as psychiatrically sick.” (Frances, 2012)

Does DSM-5 represent diagnostic progress, or has DSM-5 in fact gone overboard in pathologizing normal human distress? You can judge for yourself as you review the major changes, surveyed below and in forthcoming parts 2 and 3 of this three-part review. I start by outlining the structural and organizational changes to the Manual. I then list the headline news about new disorder categories and major changes in diagnostic criteria sets, of necessity covering only the most
notable or controversial changes. In part 2, I will complete the survey of changes to disorders and criteria. In part 3, I offer a more detailed look at one chapter – depressive disorders — that includes some of the most far-reaching and incendiary changes.

**CHANGES TO THE DSM’S METASTRUCTURE**

Why is it DSM-5, not DSM-V? Roman numerals are traditional, but DSM-5 is slated to be the first DSM that is a “living document” that can be changed piecemeal online as new evidence emerges. (Some supplementary scales and other materials are being posted online immediately.) The change to Arabic numerals allows the labeling of later online revisions as DSM-5.1, 5.2, and so on. So, publication does not necessarily mean that the DSM controversies described below are at an end.

When you open the DSM-5, some immediate differences from DSM-IV leap out at you. Most obviously, the organization is different. First, the Manual is divided into three sections. Second, there are different chapter headings, and the disorders are regrouped and may be in different chapters. Third, the multiaxial system is gone. Fourth, each disorder seems to have two codes rather than one.

**ORGANIZATIONAL CHANGES AND DUAL ICD-9/ICD-10 CODING**

The DSM-5’s three sections are as follows:

- **Section 1** gives an introduction to DSM-5 with information on how to use the Manual, the definition of mental disorder, and other general information.
- **Section 2** presents the categories of disorder, with a revised chapter organization. The “V Codes” for nondisordered conditions often the target of treatment are also here.
- **Section 3** contains proposed diagnostic criteria for conditions requiring further study, an alternative trait dimensional system for personality disorder diagnosis, and additional materials such as a cultural interview. Note that section 3’s categories for further study can be diagnosed under section 2’s “other specified” categories.

In section 2, each disorder category has 2 codes. For example, generalized anxiety disorder is coded as 300.02 (F41.1). The first code is the currently legally mandated alphanumeric ICD-9-CM code used by the DSM, familiar from DSM-IV. This is the code to use for now. The ICD-9-CM, the only official coding system in the U.S., is required by Medicaid, Medicare, and most insurance companies in order to receive payment. These codes are to be used until the currently projected change-over date of October 1, 2014, when the U.S. healthcare system will switch to ICD-10-CM codes, represented by the second code in the parentheses that begins with a letter. All health care professionals will be required to use ICD-10-CM codes at that point. The parenthetical codes will become the only correct codes, and DSM-5 printings after October 2014 will no longer include the ICD-9-CM codes. So, for example, generalized anxiety disorder continues to be coded 300.02 until October 2014, when it becomes F41.1.

**CHAPTER CHANGES**

The new chapter organization represents an attempt to rethink how disorders relate to each other and thus how they should be grouped together to represent their likely underlying etiologies.

The DSM-5 disorder chapters are as follows: Neurodevelopmental Disorders; Schizophrenia Spectrum and Other Psychotic Disorders; Bipolar and Related Disorders; Depressive Disorders; Anxiety Disorders; Obsessive-Compulsive and Related Disorders; Trauma- and Stressor-Related Disorders; Dissociative Disorders; Somatic Symptom Disorders; Feeding and Eating Disorders; Elimination Disorders; Sleep-Wake Disorders; Sexual Dysfunctions; Gender Dysphoria; Disruptive, Impulse Control and Conduct Disorders; Substance Use and Addictive Disorders; Neurocognitive Disorders; Personality Disorders; Paraphilic Disorders; and Other Disorders.

The new organization means that your target of treatment are also here.

Some chapters have been eliminated and their disorders moved elsewhere:

- The “factitious disorders” are incorporated under “Somatic Symptom Disorders.”
- The “adjustment disorders” are incorporated under “Trauma- and Stress-Related Disorders,” and reconceptualized as stress-response syndromes to either traumatic or non-traumatic stressors rather than a residual category.

Many conditions formerly listed in the child and adolescent disorders chapter have been moved into later chapters for a more natural grouping based on etiology:

- Selective mutism and separation anxiety disorder are moved to “Anxiety Disorders.”
- Eliminative disorders of childhood are moved into their own chapter.
- Conduct disorder and oppositional-defiant disorder are moved to the “Disruptive, Impulse Control and Conduct Disorders” chapter.
- Childhood eating disorders are moved to the “Feeding and Eating Disorders.”

Reactive attachment disorder has been moved to the new “Trauma- and Stressor-Related Disorders” chapter. Its two subtypes, emotionally withdrawn/inhibited and indiscriminately social/disinhibited, have been separated into two distinct disorders.

Several DSM-IV chapters have been divided into multiple DSM-5 chapters:

- The former “Mood Disorders” chapter is now divided into two chapters, “Bipolar Disorders” and “Depressive Disorders.”
- The former “Anxiety Disorders” chapter is now divided into three chapters representing different etiological subgroups: “Anxiety Disorders,” “Obsessive-Compulsive and Related Disorders,” and “Trauma- and Stressor-Related Disorders.” The view that obsessive disorders are attempts to control anxiety is set aside as unproven.
- The former “Sexual and Gender Identity Disorders” has been divided into three chapters: sexual dysfunctions, paraphilic disorders, and gender dysphoria.

Some major features of the regroupings are as follows: “Neurodevelopmental Disorders” replaces the former chapter of disorders first diagnosed in childhood and adolescence, renamed to emphasize growing knowledge of brain development as an underpinning for child and adolescent research and treatment. Several categories (e.g., ADHD, separation anxiety disorder) have revised criteria or examples to allow easier diagnosis of adults as well as children.
ELIMINATION OF THE MULTIAXIAL SYSTEM

The most dramatic structural change in DSM-5 is the elimination of the multiaxial system. However, this change is not quite as impactful as it might seem at first.

Axis 2’s personality disorders are moved to the main disorders section and listed alongside other diagnoses. There is some hope that moving personality disorders to axis 1 might make it harder for insurance companies to deny coverage.

Axis 3’s general medical disorders are now simply listed as additional diagnoses.

Axis 4’s environmental stressor list is eliminated. However, these contextual factors are now found in a much-expanded list of “V Code diagnoses” (“Z Codes” once ICD-10 comes online) that are to be listed as additional diagnoses, whether they are targets of treatment or contextual factors influencing the course or treatment of the target disorder. This change appears to be a plus for contextualizing diagnosis.

Axis 5’s Global Assessment of Functioning (GAF) scale is eliminated. To assess adaptive functioning, DSM-5 recommends the World Health Organization Disability Assessment Schedule (WHODAS), a comprehensive inventory that, unlike the GAF, is purely about adaptive functioning and does not depend on symptom levels. However, the WHODAS is designed for general medical practice and asks about longer-term problems such as making friends and joining in community activities, so it may be less suitable than the GAF for psychiatric disability evaluations. It remains unclear how insurance reimbursers who now require the GAF will react to this DSM-5 recommendation.

Why was the multiaxial system eliminated? The primary reasons are the emphasis on making psychiatry more like general medicine and the need to coordinate with the ICD. General medicine does not use a formal multiaxial system, so psychiatry seemed divergent in this regard. The DSM has always indicated that axes 1-3 are the “real” diagnosis, consistent with what would be placed in a chart in a general medical diagnosis, and the other 2 axes are ancillary. Nor does he ICD have a multiaxial system, although ancillary systems are available for contextualizing ICD diagnosis. In fact, ICD developers explicitly attempt to separate contextual factors from disorder diagnosis to avoid individuals’ failures to meet cultural demands being misconstrued as disorders.

NEW CATEGORIES AND CHANGES IN DIAGNOSTIC CRITERIA

I now turn to the substance of DSM-5 changes in disorder categories and diagnostic criteria, proceeding in the order of the chapters in which they appear. Of necessity I am highly selective. Depressive disorders will be covered separately in part 3.

Neurodevelopmental disorders

The new autism spectrum disorder encompasses DSM-IV autistic, Asperger’s, and childhood disintegrative disorders. Based on the theory that Asperger’s is a mild form of autism, diagnosis requires deficits in social communication and repetitive behavioral patterns rated along a dimension of severity. In addition, a new social (pragmatic) communication disorder allows diagnosis of verbal and nonverbal communication difficulties without repetitive behaviors.

The change to autism spectrum disorder and the combining of Asperger’s with autism was highly controversial. Some feared that classifying milder “Aspies” as autistic spectrum would increase stigma. However, the major concern was that the lower end of the diagnostic spectrum was too high and that some DSM-IV Asperger’s and autism cases would not qualify for diagnosis. While some welcomed what they saw as an overdue correction to a category in which normal eccentricity and social ineptness may have become pathologized, others were concerned that special education support might be withdrawn from those who need it but no longer qualify for diagnosis. In a bizarre twist in diagnostic logic, the DSM-5 resolved the special-education problem simply by “grandfathering in” everyone receiving treatment by adding a clause specifying that anyone diagnosed under DSM-IV still falls under the category even if not satisfying DSM-5 criteria.

Attention-deficit/hyperactivity disorder (ADHD) criteria and examples have been altered to allow for the growing diagnosis of ADHD in adulthood. Onset of symptoms must now occur by age 12 rather than 7, and the diagnostic threshold for adults has been lowered to 5 symptoms from the usual 6. Critics charge that if ADHD is a neurodevelopmental disorder, then symptoms should be apparent in childhood, and that the lowering of diagnostic standards will only amplify an adult-ADHD diagnosis fad. This change comes as we learn from CDC data that one in five high school boys and 11% of all U.S. school children have been diagnosed with ADHD, and as evidence strongly suggests that a substantial proportion of those diagnoses are false-positive diagnoses of normal developmental immaturity.

A specific learning disorder category newly combines and replaces all the DSM-IV learning-disorder diagnoses, using specifiers to indicate specific problem areas. This change reflects the fact that these disorders often occur together. An additional shift was prompted by changing federal regulations that specify that the diagnosis of learning disorders cannot depend only on a difference between disorder-specific learning and overall IQ, because this approach disadvantages groups that score lower on IQ tests. Thus a variety of possible baselines other than IQ for evaluating subject-specific performance are provided. While well-intentioned, critics argue that this change makes the meaningfulness and validity of a learning disorder diagnosis more questionable.

Schizophrenia Spectrum and Other Psychotic Disorders

The “schizophrenia spectrum” chapter now reflects the idea that several psychotic disorders share a genetic basis but reflect different degrees of expression of that common basis. Schizophrenia spectrum includes schizotypal personality disorder, which appears both here and in the personality disorders section.

A major change in terms of clinical tradition is that the subtypes of schizophrenia – including, for example, paranoid schizophrenia – have been eliminated based on research suggesting they are not stable and reliable classifications. A dimensional approach to schizophrenia assessment is provided in section 3. Although the catatonic schizophrenia subtype is eliminated, catatonia is added as specifier across disorders.

The new category of attenuated psychosis syndrome is added to section 3’s conditions for further study. This disorder requires that the individual has intact reality testing but has experienced
mild versions of cognitive symptoms (delusions, hallucinations, or disorganized speech). The initial proposal was to add “psychotic risk syndrome” to psychotic disorders with the goal of identifying individuals in the “prodromal” phase who are developing but do not yet have psychotic disorders to allow early treatment in hopes of preventing the disorder or lessening its severity. Critics objected that this confuses risk of disorder with actual disorder. Moreover, it turns out that forms of eccentric and odd thinking satisfying the criteria are common in the general population, and only a small percentage (e.g., about 20% in one study) of those who meet criteria actually go on to develop a psychotic disorder, so diagnosis would involve many false positives who needlessly get antipsychotic medication and are stigmatized. Rather than abandoning this idea, the DSM-5 relabeled and reconceptualized the condition as a mild disorder in its own right rather than a risk of disorder, and included it in section 3.

Bipolar and Related Disorders
Diagnostic criteria for mania and hypomania now require a change in activity or energy during the manic episode, in addition to mood shifts. The goal is to avoid false positive diagnoses that occur due to, for example, misconstrual as mania of patients’ reports of periods of irritability which are in fact contextually normal, an error found to be responsible for very high false-positive rates for mania in epidemiologic studies. The “other specified bipolar and related conditions” now allows diagnosis of hypomania when duration or number of symptoms is less than is standardly required (e.g., 2 or 3 days instead of 4). End of Part 1. To be continued in Part 2.

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Author’s note: The views expressed here regarding DSM-5 are those of the author and do not represent the official views of the NASW. This article contains a revised version of material that appeared in the Clinical Social Work Journal (June 2013), which can be consulted for detailed references, not included here; I thank the Editor, Carol Tosone, and Springer for permission to excerpt this material.

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In our nation’s urban centers, too many students of color fare poorly in education, employment, health, housing, high school graduation, and college attendance rates (Noguera, 2008). These students are subjected to gangs, drugs, poor education, unemployment, crime, violence, and death. They are disproportionately represented in our nation’s criminal justice and penitentiary system (Alexander, 2010; Noguera, 2008). This article examines how school social workers play a role in improving the educational outcomes of students of color.

The racial achievement gap in education is one of the most difficult issues confronting public school K–12 education (Boykin, 2011). The role of the school social worker is integral to students’ academic achievement. A great challenge for school social workers is ensuring that children of highly diverse racial, ethnic, and multiracial backgrounds are accepted, supported, and educated. The inability of children to acquire advanced skills in reading, writing, mathematics, and science hinders their development.

In Massachusetts, where I reside, the official name for a school social worker is School Social Worker/School Adjustment Counselor. Far too often, the adjustment occurs only in identifying problematic behaviors or challenges with students. The adjustment needs to be expanded to look at the overall school environment: the school culture; relationship patterns among faculty, staff, and administrators with students; culturally sensitive and culturally responsive curriculum; and a rigorous curriculum that moves beyond traditional teaching practices to incorporate innovative teaching/learning activities. A school social worker can play an instrumental role in collaborating with educational staff to ensure learning and achievement for all students. One concrete way that school social workers can influence student achievement is to offer counseling groups in schools, which provides a group experience that encourages students to discuss specific problems in order to receive support, gain insights, find solutions, and increase their self-image. School social workers can encourage students to reach their academic potential by identifying, preventing, and helping them eliminate, overcome, or reduce obstacles to successful academic, social, and cultural learning. School social workers may be able to get buy-in for the group from school administrators as an alternative to the high number of internal and external suspensions and verbal and physical confrontations that occur in the classroom, lunchroom, hallways, busses, and school grounds before and after school. The group will be able to help students learn and practice effective conflict-resolution, decision-making, problem-solving, and coping skills.

The data used to devise the groups can be based on the high level of out-of-school suspensions and internal suspensions for disruptive school and classroom behaviors. The administrative team along with the school social worker can decide to utilize multiple counseling groups as a way to prevent internal and external suspensions and to help students become more receptive to learning. There can be a range of groups offered:

- **Grief support group for students**—available to any student who has experienced a loss;
- **Support group for students who are at risk for dropping out**—homogeneous male and female groups for students who have demonstrated a pattern of truancy, poor or sporadic academic performance, and/or behavioral issues;
- **Support group for students dealing with substance abuse/alcohol problems in the family**;
- **Anger management group**—homogeneous male and female groups for students to practice safe ways of expressing and dealing with anger; and
- **Support group for students who are separated from their family of origin**—students who are in foster care, living with grandparents/other relatives.
The topics of the groups can be instituted as a result of needs assessment surveys of teachers, parents, students, and school staff to ascertain common areas of concern. Candidates are screened and selected based on a common need and a willingness to actively participate and abide by the group rules. The students selected are referred by teachers, parents, administrators, themselves, and the school social worker.

The group can be a supportive environment for students of color who have exhibited inadequate academic, behavioral, and social performance in school. The group can focus on life skills, character building, and career exploration and can also provide academic, social, and real-world support for at-risk students.

In the group setting, it is important to discuss the value of education and to provide a safe space for students of color to discuss such issues as low teacher expectations or negative peer pressure, both of which can sabotage their potential and success. Ford and colleagues (2008) examine negative peer pressures on gifted African American students and the perceptions of “acting white” and “acting black” as it relates to their identity. These authors discuss the term “acting white,” which refers to behaviors of students of color being studious, participating in class, and obtaining a good report card (Ford et al., 2008). Some examples of “acting black” include dismissing education and using slang (Ford et al., 2008).

Group counseling sessions provide many long-term benefits. The students in the group, as opposed to individual counseling, will have an opportunity to learn and grow from each other, learn and practice new behaviors and skills, gain confidence while working collaboratively with others, and identify and remove barriers that may impede achievement. Most important, students will be motivated to overcome life’s challenges, excel academically, and improve the quality of their lives in the future.

In conclusion, school social workers can play a crucial role in helping students of color reach academic success. Through the use of groups, school social workers can utilize their expertise in providing support and helping students overcome obstacles that may interfere with academic proficiency. Additionally, as a result of group-based work with students of color, school social workers can also give voice to student concerns and advocate for changing aspects of school practices that are detrimental to students of color.

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Presently, our country is in the midst of another extended reflection upon what it is to be an American. More specifically, our leaders in Congress are reexamining our national policies with regard to immigration, and the Supreme Court is deliberating on the civil rights of the LGBT (lesbian, gay, bisexual, and transgender) community. As the national dialogue continues, professional social workers have a duty to engage in this discussion, which has many implications for our clients, our organizations, and our communities (NASW, 2009).

I am an associate professor at a comprehensive public university in northern California that largely serves a rural geographic region. One of my academic duties is teaching general education courses as well as major specific courses to undergraduate and graduate students enrolled in our BSW and MSW programs, respectively. In my classroom, I strive to create a safe space for students to engage in sometimes heated, but nevertheless civil, discussions as we address various concepts. One morning I came to my university office and found my door had been defaced overnight with three messages. Prominent among these messages were a powerful symbol and a phrase: a swastika and the words “white power.”

Hate crime has a long history in American society, with the first federal laws initially defining the dimensions of hate crime in the Civil Rights Act of the 1960s. Since then, this definition has been modified several times at both the federal and state levels to include additional categories of victims (Freeman & Kaminer, 1994). Today the California Penal Code defines a hate crime as “a criminal act committed in whole or in part because of one or more of the following actual or perceived characteristics of the victim: disability, gender, nationality, race or ethnicity, religion, sexual orientation, association with a person or group with one or more of these actual or perceived characteristics” (California Penal Code section 422.53).

In the days and weeks that followed, I came to two conclusions: (1) I was dissatisfied with the slow, partial, and inadequate response of the university police department to this hateful act; and (2) I wanted to ensure that in the future no member of the university community would have to struggle with the lethargy and indifference of a bureaucratic system. Ultimately, I turned to my public employees union—to determine whether my experience represented an isolated act and to fashion in collaboration with colleagues a response that could facilitate both a public discussion and a public response. A two-part study of secondary and primary data was initiated. It focused on the largest public university system in California and the United States once clearances to gather California State University system wide survey data were provided by the Institutional Review Board of my home campus.

In 1986 the Commission on Racial Ethnic Religious and Minority Violence (CRERMV) found that on campuses across the state, hate crimes and hate incidents were being committed, but there was no way to determine either their nature or their extent. Since that time, California law has been amended to require local law enforcement agencies to submit monthly copies of hate crime reports to the Department of Justice in compliance with the California Penal Code. In turn, these statistics are published annually by the California Attorney General Civil Rights Section and include a count of hate crime for each campus and year. All campuses must also report hate crime statistics in their respective annual security reports as a requirement of the Jeanne Clery Disclosure of Campus Security Policy and Campus Crimes Statistics Act, named after a woman who was raped and murdered in her dorm room at Lehigh University in 1986 (Sloan & Fisher, 2010). Today this annual report is known more commonly as simply a Clery Report. Another requirement of the Clery Act is to report to the U.S. Department of Education (DOE) annually, for inclusion in online statistics available at the DOE’s Office of Postsecondary Education (OPE). Both Clery Reports and the OPE database include descriptions of types of crime and bias within the count of hate crimes. In conducting this initial study of secondary data, it was determined that relatively few Clery Reports are accessible online with statistics prior to 2008, although the OPE does provide data from 2001 through 2008.
Both public university systems in California—the California State University (CSU) system and the University of California (UC) system—also collect these data from their respective campuses and publish them in an annual report. These reports were available and date back to 2005, thus providing data for a total of 33 CSU and UC campuses. The secondary data for 2008 through 2010 were entered into the Statistical Package for the Social Sciences for analysis.

The California Attorney General officially reported during the selected time frame the greatest number of hate crimes, approximately 120. By contrast, the DOE’s Office of Postsecondary Education campus security reports indicate 117 hate crimes. These statistics are much higher than the sum total of 100 hate crimes as noted in the Clery Reports for these two public university systems. Less than one-third of all campuses, irrespective of university system, had the same number of hate crimes officially reported across all three sources. Eight of the universities did not officially report any hate crimes, including my own campus during this time period—even though my office door’s defacing was reported to university police (Ornelas, Cox, & King, 2012).

During the period studied, “destruction” was the most frequently officially reported type of hate crime across both university systems. In the UC system, the next most frequent types of officially reported hate crimes were “intimidation” and “simple assault;” in the CSU system, the next most frequent types of officially reported hate crimes were “larceny” and “aggravated assault.” With regard to hate crimes based on bias, the officially reported crimes are most frequently based on perceived or actual sexual orientation and race in the CSU system; hate crimes based on perceived or actual religion and race tend to be officially reported most commonly in the UC system.

Efforts to combat hate and prejudice on campus have been initiated and supported at the national, regional, and local levels. It is important for social workers to be involved in these efforts directly. Universities and colleges across the nation are responsible for providing the formal education for aspiring social workers. The struggle to ensure our campuses are safe for all members of the community, regardless of their actual or perceived characteristics, is essential.

Portions of this article have been presented to the California Faculty Association and the American Association of University Professors. This article is the first in a three-part series that will address the issue of hate crime on college campuses.

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What caused the United States to start focusing on bullying? I wish I could say my own interest in this subject began in adulthood, as a concerned social worker, but the reality is that I, like many of you, was bullied in my youth. During the past decade, hardly a week has gone by when I haven’t read or heard of a violent tragedy befalling a family in America. I can recall exactly where I was more than 10 years ago, on April 20, 1999—I was talking with a colleague in her office in the juvenile division of the family court—when I heard the radio announcer report on the events unfolding in Columbine, Colorado. Investigators eventually learned that Eric Harris and Dylan Klebold—the two high school students who went on the shooting spree that killed 12 classmates, a teacher, and then themselves—endured years of bullying. They had left suicide notes that called their actions a “revenge killing” to get back at those who had bullied them for years. As an adult, I am most concerned about how the nature and methods of bullying have intensified. The rise of the Internet and electronic communications laid the groundwork for epidemic levels of hurtful rumor. Access to weapons added fuel to the fire. I am struck by what has—and has not—changed about youth violence in more than 10 years. Before I sat down to review and edit this article, I opened the newspaper, as I do every morning, to find headlines once again related to our American violence trifecta: bullying, mental health, and gun safety.

Immediately after Columbine, many people in our country started to view youth bullying more critically. Sadly, only a decade later, the suicide of Tyler Clementi on September 22, 2010, once again revealed the horrendous consequences of bullying. In September 2010 alone, at least six youth—all of whom identified as lesbian, gay, bisexual, and transgender (LGBT)—endured a relentless stream of taunts and ended their own lives. Tyler’s suicide galvanized a nation to put bullying at the center of attention. In New Jersey, it was Tyler’s suicide that prompted new legislation, the New Jersey Anti-Bullying Bill of Rights (P.L. 2010, c.122), which ended up receiving near unanimous support of the entire legislature (NJSA, 2010).

New Jersey’s existing gun laws and anti-bullying law are among the strictest in the nation. Senator Loretta Weinberg (D-NJ) told reporters that 22 new bills have been introduced to the state legislature following the 2012 Newtown, Connecticut, incident to “close some loopholes” (Fallon, 2013). The spotlight on childhood bullying has shed light on other kinds as well. Several states have begun proposing legislation for workers to be able to sue for harassment on the job. Parents are realizing that many of their bully classmates grew up to be their coworkers (Hananel, 2013). Upon in-depth review of the anti-bullying law, I see some unaddressed areas in the legislation: there is neither a structure of corrective sanctions requiring rehabilitative efforts with the bully in place nor any guaranteed funding source to provide counseling support for the targeted youth.

New Jersey’s Anti-Bullying Bill of Rights is the product of intense research by Garden State Equality and others who worked with many leading anti-bullying and child welfare experts. Highlights include strengthening of the existing cyber-bullying law, extending it to apply to bullying off school grounds that then carries into schools, and another section applies to the state’s public universities and colleges. The Anti-Bullying Bill of Rights protects all students bullied for any reason. The legislation maintains the language of New Jersey’s existing anti-bullying law, originally enacted in 2002, which enumerates protection of students based on their actual or perceived race, color, religion, ancestry, national origin, disability, gender, sexual orientation, gender identity, or expression, and has clear language protecting students bullied for any other reason. Dr. Dan Olweus of Norway is one of the world’s best-known expert of school bullying. He began to study and research student bullying and victimization back in the 1970s; by the late 1980s and early 1990s, the research spread to Japan, England, the Netherlands, Australia, Canada, and the United States. Olweus defines bullying as having three key
components: when a person is (1) exposed repeatedly to negative acts, that are (2) intended to harm the victim, and where there is (3) an imbalance of power between the victim and the bully (US-DHHS, 2012). Attention to bullying, and school/youth violence is also not new to the National Association of Social Workers (NASW). A succinct review of our literature shows nearly 20 years of anti-violence and anti-bullying messages (NASW, 2002, 2003, 2009–2012). How we apply these is apparent in daily practice and is reflected in our Code of Ethics, best practices, and policy statements.

Bullying behavior is not a normal part of childhood or youth development; it is a form of victimization that involves disparity of power. Bullying still involves physical assaults (that is, punching, kicking, tripping, throwing things) and verbal abuse (such as ethnic slurs and comments on appearance, weight, and assumed sexual orientation). And there are newer forms of bullying, too, such as cyber-bullying (that is, vicious texts and emails, Facebook smear campaigns, unflattering photos and videos going viral) and relational bullying (such as manipulation, silent treatment, gossiping, exclusion, and abandonment).

Cyber-bullying is particularly hazardous because it allows real or perceived anonymity through a false identity, screen name, e-mail address, and so forth. Harassing and insulting comments can “go viral,” turning an immature statement into a social disaster for the victim. In our Twitter-happy culture, openly identifying as LGBT is particularly laden with peril (Peckham & O’Keefe, 2010). Thanks to social media, a youth’s sexual orientation can become very public very rapidly. LGBT students are more likely than other students to think about, plan, or attempt suicide—almost half of them have seriously considered suicide, compared with just over one in five non-LGBT students (47% vs. 19%).

A disproportionate number of LGBT teens are represented in the nation’s juvenile justice system, possibly making up as much as 15 percent of the total juvenile justice population in the United States, according to Aisha Moodie-Mills, an LGBT policy and racial justice advisor at the Center for American Progress. The findings were presented by the National Council on Crime & Delinquency. While LGBT youth represent about 5 to 7 percent of the total youth population, estimates show they make up 13 to 15 percent of the population of young people involved with the nation’s juvenile justice system. However, sexual orientation aside, all youth are at risk. According to the American Foundation for Suicide Prevention, suicide is the third leading cause of death for young people between the ages of 15 and 24. The Centers for Disease Control identifies suicide as the second leading cause of death on college campuses.

According to the National Center on Addiction and Substance Abuse, bullied youth are at a greater risk of distress from depression and other mental health problems. Those young persons who have been traumatized learn to defend themselves by shutting down. Warning signs that a child may be being bullied includeclusion (such as coming home from school and locking themselves in their room), cancelling plans with friends, being quick to cry and/or easily triggered by negligible conflicts at home, neglecting hygiene, swiftly gaining or losing weight, sleeping more or less, or refusing to attend school. An astounding number—more than 140,000—of students refuse to go to school because of bullying. Our children’s mental health is at stake. Kids who have been bullied are more likely to suffer from depression in both the short and long term, have unbearable anxiety symptoms and well as eating or substance disorders, struggle with long-term relationship problems, drop out of school, and engage in suicidal ideation and suicide attempts (Peckham & Trestan, 2010).

What can social workers do to help? Educate parents. Because the effects of bullying can last a lifetime, making a referral to a social worker is recommended—sooner not later. In most cases, educators and lawmakers have not taken a sufficiently proactive stance toward intervention in bullying situations. Many maintain the belief that youth who have been targeted should “fight back” or “ignore” the bully and his or her behavior. Stan Davis, a social worker with expertise in bullying, advocates for using strengths-based approaches to help youth victims steer clear of internalizing harmful messages that can contribute to or exacerbate mental health conditions (Malamud, 2011).

Parents and social workers can forge a strong collaborative front in their efforts to stop bullying. Social workers are an instrumental source to affect change and influence positive outcome for families, schools, and communities. As the “grown-ups,” we must model kind, respectful behavior and become unified in teaching our children. Adults should guide kids in their evolution from bystanders to “up-standers” and contribute to more tolerant, accepting communities. Moms, dads, and teachers should reflect acceptance toward minorities, LGBT kids, children with special needs, and others, and help children through open discussions about interpersonal issues. Adults should never downplay bullying, whether their child is the perpetrator or the victim, and must get their children counseling— in either case, it is the appropriate parent/guardian “respond-ability” (NASW, 2002, 2003, 2009–2012).

I see examples of bullying and violence in my current private practice experience almost weekly. For the past several years, I have been working with the highest-conflict separated/divorced parents. Many have been engaged in waging “emotional and financial war” with their ex-spouse for nearly a decade. Actual circumstances or allegations often include child abuse, addiction, mental health problems, parental alienation, withholding children or child support, filing (false) police reports, vandalism, harassment, and domestic violence—all are commonplace “psychological ammunition” and adult forms of “he said/she said” bullying. As a court-appointed neutral party, I am charged to assist parents with ending the chaos and stress. It is no wonder that children engage in bullying: they are often mimicking the behavior their parents modeled for them.

According to the Centers for Disease Control, homicides and suicides by guns are correlated with states with fewer laws. States with the most gun control laws had 42 percent lower gun-related death rates than others. Former Representative Gabrielle Giffords spoke fewer than 20 words in her emotional call for gun control measures: “Be bold. Be courageous. Please support background checks,” she said (AP, 2013). “Can our elected officials summon the political courage to defy the gun lobby and protect our communities?” (Melady, 2013).
Although controversy still exists over the best way to address the problem, everyone agrees that bullying and violence are major issues facing families and communities today. Decades of research and tragedy underscore the need to establish stronger preventive, intervention, and rehabilitative measures for our youth nationwide. In addition to the efforts to help victims and to put an end to bullying, these measures should include mental health examinations to accompany annual school physicals and background checks for gun purchasers. Our society’s growing concern with ending bullying provides an opportunity for social workers to accelerate the development of comprehensive, multifaceted, and cohesive systems of support (CMHS at UCLA, 2011). When I sat down to finalize this article, I opened the newspaper—as I do every morning—to read headlines, once again, related to our American violence trifecta: bullying, mental health, and gun safety. Stand up for others.

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RESOURCES

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