Social workers practice in a variety of settings: schools, psychiatric and medical hospitals, mental health clinics, and other community-based social service programs. In each of these settings, social workers establish collaborative roles with their colleagues and interdisciplinary and multidisciplinary teams.

Social workers must continue to be committed to fostering a partnership with clients, physicians, and psychiatrists regarding their clients' course of psychopharmacological treatment. It is essential to gather information about the client's history of compliance or noncompliance with medications.

For decades, a growing literature, largely conceptual in nature, has argued for the expansion of social work roles regarding psychiatric medication as well as psychopharmacology in social work education. In October 2005, Bentley, Walsh, and Farmer's quantitative study showed variability in the types of roles carried out by social workers with regard to psychiatric medication. The perceptions of competence and appropriateness tended to be positively associated with frequency of role performed, and the results suggested that achieving greater competence with regard to psychiatric medications may be best met by increasing social workers' knowledge about medications, increasing their use of specific intervention skills, and increasing the frequency of professional contact between the clinical social worker and the prescribing physicians. Collaboration is the foundation of bridging our clinical services and advocating for our clients.
My role in supporting patients with their psychiatric medication started in 1970 and continues today. I took an active role in gaining skills in evaluation, and I partnered and collaborated with my clients, their families, their physicians, and psychiatrists.

To provide clinical psychotherapy services and psychiatric medication support and psycho-education services, I begin by gathering a comprehensive psychosocial assessment of the presenting problem, the client’s mental health history, a history of their psychiatric medications, and a list of who in their support system knows about the medication. My assessments and reassessments of a client’s psychiatric medications, the history of their medications, and their experiences with them are recorded in detail on the intake assessment application.

As a private practitioner, I obtain consent from my patients to work with their psychiatrist. They are informed that I am a licensed clinical social worker and not a physician. I learned early on in my private practice career that it is necessary to be connected with a psychiatrist who focuses on medication management and evaluation. Over the years, I developed a tracking support system to help me in assisting my patients with their psychiatric medication management.

PATIENT MEDICATION EMPOWERMENT LEARNING LOG
A patient medication empowerment learning log includes clients’ detailed experiences with their psychiatric medication. It provides clients with opportunities to report their symptoms, their thoughts about their medication, its effectiveness, and information about their social supports or those who are not supporters.

Clients need to talk about medication fears, including what they do not know and what they feel uncomfortable inquiring about. Recently several of my patients reported reservations about continuing their medication after listening to reports in the media. Psycho-education can be helpful to building and sustaining a collaborative and partnership exchange with the client. It supports the information provided to the client by the prescribing psychiatrist and enhances an ongoing awareness and respect for each other’s role. In my practice, each client is given a medication log as part of the intake package; the log is completed and reviewed monthly. Clients are encouraged to report their concerns. Any fears about medications are recorded. The reporting is done jointly, but only if the client agrees. My clients generally welcome this collaborative intervention.

It is clinically necessary to gather information about how clients respond to their psychiatric medications, the history of their medications, and their experiences with them are recorded in detail on the intake assessment application.

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There is controversy in the field of social work about describing disordered eating as an “addiction.” Although addiction to certain foods is not a recognized criteria in respect to eating disorders within the DSM-IV, there are interesting parallels between the eating patterns of some individuals and the DSM-IV criteria for psychoactive substance dependence: (a) the substance is often consumed in larger amounts or over a longer period of time than the individual intended; (b) the individual continues to use the substance despite persistent or recurrent social, psychological, or physical problems caused or exacerbated by the use of the substance; (c) withdrawal symptoms occur; and (d) the substance is often taken to relieve or avoid withdrawal symptoms. Regardless of the current debate on the addictive quality of refined foods, some practitioners advocate plans that address refined foods. For example, the Kay Sheppard recovery food plan (Sheppard, n.d.) is a comprehensive guide for persons with any kind of eating disorders and provides details of structured food plans, a list of trigger foods to avoid, portion sizes, and advice on how to implement the plan. Its goals are: (a) eliminate addictive substances; (b) balance proteins and carbohydrates; (c) manage volume; (d) provide good nutrition; and (e) distribute nutrients throughout the day.

The Department of Social Work and Communication Sciences and Disorders College of Education & Human Services at Lakewood University in Virginia conducted an online survey designed to investigate problems that individuals have with their consumption of food and drink. The type of measure used was self-completed, multiple choice and fill-in-the blank. There were a total of 300 email invitations. The sample consisted primarily of women. There were a total of
150 responses received. The response rate was 50 percent. The survey was used to assess the efficacy of using a structured meal approach as part of a treatment for eating disorders. Respondents (n=356) were female, predominantly white, and typically between the ages of 41 and 60. Of them, 38.5 percent reported that they had been formally diagnosed with an eating disorder. When asked whether they identify themselves as food addicts, 96.9 percent replied affirmatively. More than half of the total respondents indicated that they were currently implementing the plan always or most of the time with 80.3 percent indicating it was a lot of help/ completely helpful. Therefore, a structured meal approach may be beneficial in individuals with eating disorders.

In addition, 39 percent (n=139) reported an allergy to sugar, flour, and wheat. This allergy often causes a craving that requires more food, resulting in bingeing. Of the respondents, 80.6 percent (n=287) reported attending for their addiction to sugar, flour, and wheat. The most common was a 12-step program (82.2 percent) (Table 3). In terms of the type of meeting involved, 151 respondents (52.6 percent) reported attending a face-to-face meeting, whereas online and telephone meetings constituted only 4.5 percent and 2.1 percent, respectively. However, 40.8 percent of respondents indicated that they used a combination of these three types of meetings. In terms of specific organizations reported, Kay Sheppard’s own organization (the Loop) was the most common (26.5 percent), followed by Overeaters Anonymous (11.6 percent), and Food Addicts in Recovery (7.3 percent) (Table 4).

Although slightly more than a third of the sample was formally diagnosed with one or more eating disorder, practically all respondents identified themselves as food addicts, and there was little distinction between whether the addiction was about the food they ate or the rituals surrounding the food. Addiction to food is still a controversial topic. A case has been made that compulsive overeating is an addiction disorder, and perhaps, conceptually, Binge Eating Disorder (BED) is the closest eating disorder that fits the model; however, it is refined foods, particularly those rich in sugar and fat, that may lie at the basis of these addictions.

The survey results show whether food allergies could be a confounding factor in assessment of food addiction, and some evidence was found that women with a formal diagnosis of an eating disorder had a higher self-reported prevalence of a food allergy compared to women who did not have a formal diagnosis of an eating disorder. However, based on a reading of individual comments, it is likely that some respondents confused allergy with food addiction. Since there are clinical social workers with clients under the umbrella of an addiction paradigm, perhaps the profession of social work can start viewing eating problems as “food addiction” for some— but not all— clients.

Kristen McAleavey Nugent, PhD, BSW, is an associate professor in the department of social work and communication sciences and disorders at Longwood University, Virginia. She can be contacted at mcaleaveyk@longwood.edu.
### Table 8. Univariate analysis: tests of between subjects effects. Dependent variable: helpfulness of Kay Sheppard food plan.

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<th>Source</th>
<th>Type III Sum of Squares</th>
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<th>P</th>
<th>Partial Eta Squared</th>
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*R² = 0.525 (Adjusted R² = 0.508)  †Computed using alpha = 0.05

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