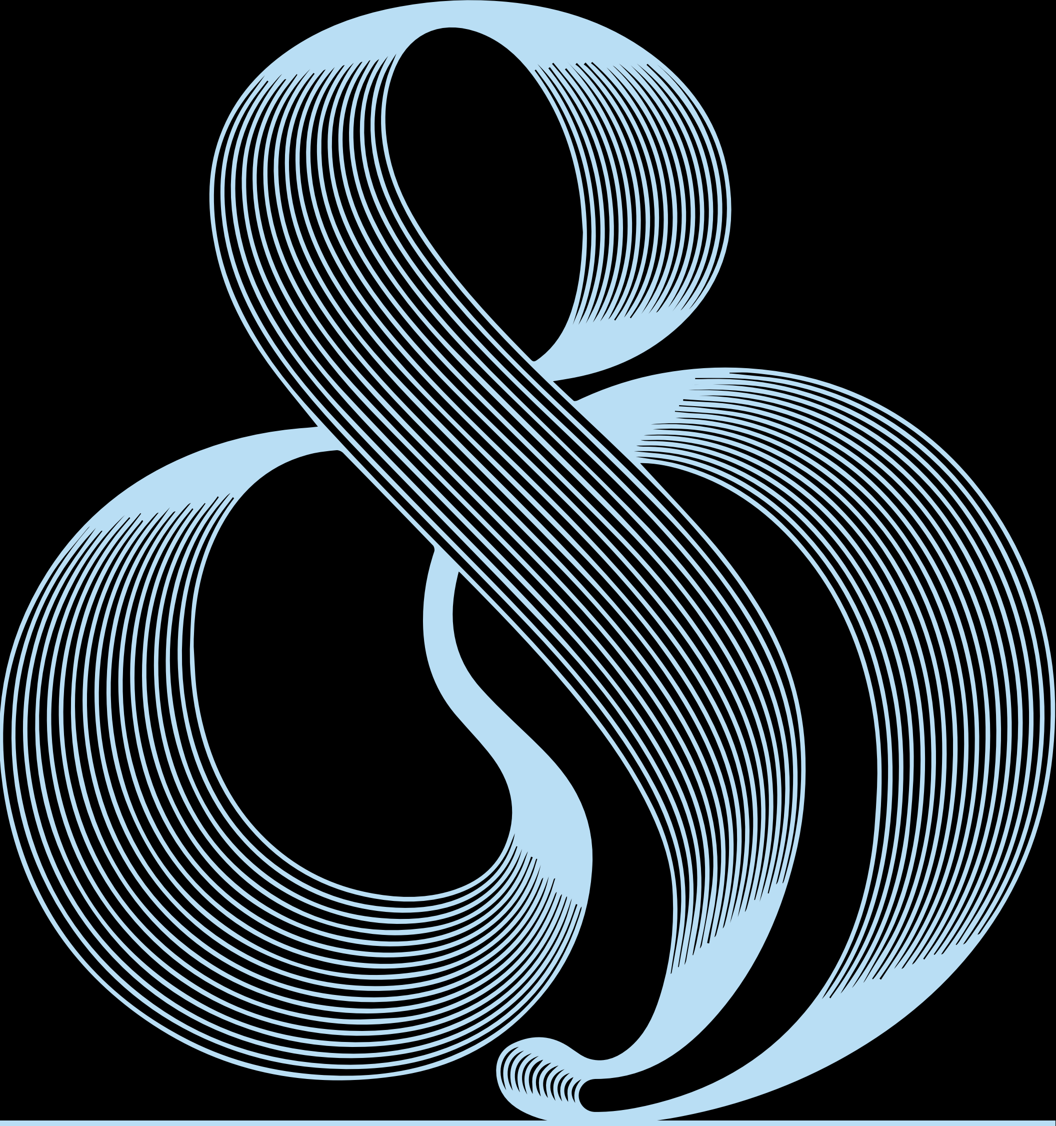

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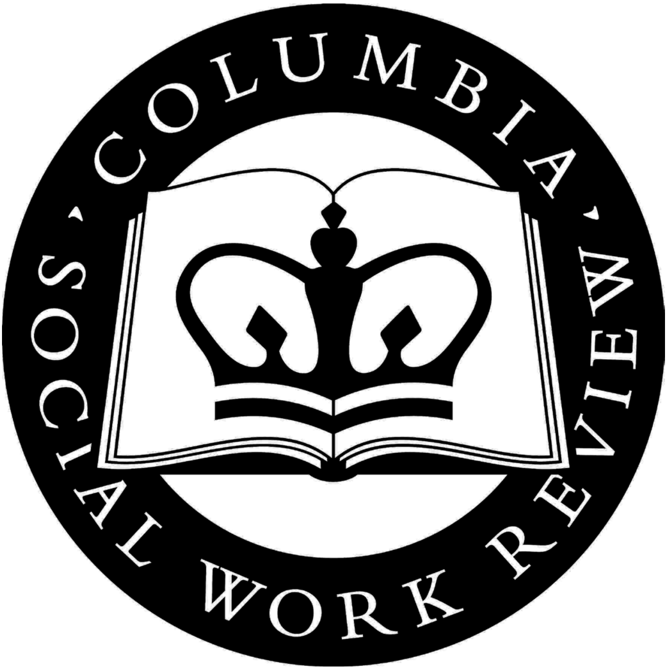
COLUMBIA SOCIAL WORK REVIEW

The mission of the *Columbia Social Work Review* is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. Founded by students at Columbia University School of Social Work in 2003 as the *Columbia University Journal of Student Social Work*, this academic journal provides an opportunity for students and scholars in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.



Spring 2023

Journal Statement

The *Columbia Social Work Review (CSWR)* is a peer-reviewed, academic journal that highlights the contributions of students and alumni from the Columbia University School of Social Work. We are dedicated to providing a forum for authors who have been historically overlooked in academic settings, including those early in their career, those from underrepresented groups, and those with diverse viewpoints. The *CSWR* is committed to social justice and to the project of dismantling systems of power, race, oppression, and privilege. Each publication features a variety of issues that affect a wide breadth of communities. Our editing staff, in addition to representing diverse identities and lived experiences, has met exceptionally high standards for social work ethics and practice.

Social workers are needed more today than ever before. In the past year we have witnessed an ongoing, and as-of-yet insufficient, national reckoning with systemic racism, an amplified attack on transgender communities across the country, the overturning of *Roe v. Wade* and the deprivation of essential healthcare access to millions of birthing people, a continued global failing to meet the moment demanded by the Climate Crisis, unfettered gun violence that has now become the leading killer of America's youth, escalations of Russian and Israeli aggression in Ukraine and Palestine, and protests for basic human rights in Iran. These are just some of the challenges we face in 2023. They also collectively embody our "why." As social workers we are regularly tasked with finding solutions to the seemingly insurmountable. But our ambitious visions for a greater future often crumble before the corrupt and unchangeable status quo. We then face an impossible choice: change the system from within or challenge the system from outside. In this *Journal* we ask, "why not both?" We hope that the articles included in this year's publication may offer hope and solutions amidst the systemic failings and recurrent tragedies that plague our country and our world. We are proud to present these fresh ideas with an eye towards the impact they will have on the profession.

> **WE THEN FACE AN IMPOSSIBLE CHOICE: CHANGE THE SYSTEM FROM WITHIN OR CHALLENGE THE SYSTEM FROM OUTSIDE. IN THIS *JOURNAL* WE ASK, "WHY NOT BOTH?"**

Table of Contents

ACKNOWLEDGEMENTS

This Journal would not be possible without the support of so many. The Editorial Board faced unprecedented challenges this year but continually showed up and put in the work necessary to create the polished product you are currently reading. Most of our editing team was new to the *Columbia Social Work Review* – their ability to quickly learn and apply newfound editing skills was essential to our operational successes. Our Managing Editors not only amplified the standing of our blog-style platform, *The Amsterdam*, but lead the movement to redesign our website. Our Associate and Executive Editors approached their work with tenderness, care, and expertise while fostering a welcoming environment for our authors. Speaking of which, we will be publishing many “firsts” in the *Journal* this year because of the novel approaches and unique ideas presented by all ten of our authors. Thank you all for your time, effort, and engagement with the material and with each other. We *literally* could not have done this without you.

We would also like to extend a special thanks to Dr. Susan Witte, who continues to be the *Columbia Social Work Review*’s dutiful faculty advisor. The Editors-in-Chiefs relied heavily on Dr. Witte for help in navigating the aforementioned challenges with dignity and grace. We thank Dr. Witte for her patience and wisdom. Adam Pellegrini (Director of The Writing Center), the *Columbia Social Work Review*’s Advisory Board, Sarah Griffis (our copy editor), Savannah Brogan (our design and layout specialist), and Village Copier (our printer) all continue to support the *Journal* and should take some pride in this collaborative effort.

Erika Lopez deserves to be singled out here for her work as our unofficial social media coordinator. She went above and beyond to freely offer her services to overhaul and helm out social media accounts. We look forward to Erika joining the Board in an official capacity next year.

EDITORIAL BOARD

Letter from the Editors

DEAR READER,

When we accepted the position of Editors-in-Chief, we could not have possibly foreseen the litany of challenges we would face. We also could not have foreseen the fulfillment and reward that would come from working with the *Columbia Social Work Review*.

This year's issue contains many firsts. The new and unique ideas brought to us by our authors resulted in us publishing the first IRB reviewed paper in *CSWR* history. We additionally present innovative takes on social work including mythology analysis and the role of feminism in the digital age. Our team regularly adapted to unprecedented obstacles with patience and resolve. We are so grateful to those editors who displayed flexibility in light of this and either changed roles mid-semester or worked short-handed to complete their tasks adequately and efficiently. We would also like to highlight the work done by our Managing Editors to overhaul our website and underscore the publications on our blog-style forum, *The Amsterdam*. Erika's dedication to our social media platforms additionally amplified the voice of the *Review*. We are eternally grateful for the tireless work of this year's Editorial Board as we have created an incredible 21st issue of the *Journal*.

The issues tackled this year demonstrate the commitment to bettering the field of social work, challenging systemic oppression, and enhancing social work literature. Whether you are holding a physical copy of our journal, reading it online, or finding it years from now in our university library, we sincerely hope that you find our colleagues' work as captivating as we do.

We are so proud to present the 21st annual issue of the *Columbia Social Work Review* to you.

Happy reading,

Dget Downey and Demetrios Kavadas
Editors-in-Chief, 2022-2023

New York's Directive for Mental Health Involuntary Removals:

The Intersectional Risk for Unhoused New Yorkers with a Serious Mental Illness

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LANYA SNYDER

ABSTRACT

Behavioral health care, more commonly known as psychiatric care, has been a longstanding and complex issue, especially for marginalized New Yorkers. Healthcare policy addressing and caring for people diagnosed with a serious mental illness is fundamental to basic human rights; at the same time, it is a nuanced matter. Policies surrounding economic issues of poverty and housing instability are inextricably linked to social issues of mental and physical healthcare.

Healthcare policy and the experience of homelessness are closely linked for two reasons: first, the high cost of healthcare contributes to poverty for many Americans; and second, the poor and the aging are the most likely to suffer from illness and high medical expenses (Martin, 2015). This paper will consider the intersectional risk for unhoused New York City residents with a serious mental illness in light of Mayor Eric Adams’ recent directive for Mental Health Involuntary Removals. This new directive enables authorities to forcibly transport unhoused New Yorkers to hospitals to remove them from public areas. Although the current mayoral administration frames this as a moral obligation to act on behalf of New Yorkers with a serious mental illness, it is far from an effort to ensure that everyone has housing and receives basic healthcare. Adams’ misguided policy is a veiled attempt to make the city appear safer while doing little to assist those who are suffering and fails to address interventions for the real issue at hand: housing.

On the morning of January 15, 2022, Michelle Go, a 40-year-old Chinese-American, was fatally pushed onto the subway tracks at Times Square. Martial Simon, the individual who committed this unprovoked act, emigrated to New York from Haiti in his teens and had been experiencing homelessness for the past 18 years. He also has a longstanding history of schizophrenia, including approximately 20 prior hospitalizations. Go's death is sadly not the first of its kind. New York has struggled to enact effective legislation governing the treatment of individuals with a chronic serious mental illness (SMI) and, as a result, thousands of New Yorkers like Simon elude treatment (Diven, 2022). A SMI is defined by the National Institute for Mental Health (NIMH) as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (Mental Illness, n.d.).

The timing of this violence impacted the political response. This tragedy occurred when hate crimes targeting Asian Americans were on the rise, and although police concluded that this particular incident was not racially motivated and there was no known prior connection between Go and Simon, the larger sociopolitical context may have fueled the administration's need to respond, in order to ensure public support. This particular incident happened following a slew of incidents in which people were pushed onto subway tracks, though none of the previous had been fatal. As of mid-March 2022, transit crime was up 80.3% compared with the same period in 2021, though this number may be skewed because of decreased subway ridership during the first year of the Covid-19 pandemic (Gelinas, 2022). It also occurred during Eric Adams' first week as mayor. This timing amplified issues of racially driven hate crimes, random acts of violence, and a perceived surge in subway crime, and it provided linkage to the deep-seated issues of unhoused New Yorkers with mental illness, specifically those with persistent and often treatment-resistant SMI.

Leaders in the public and private sectors have worked for decades to propose policies for those who struggle with homelessness and mental illness. Hospitalization rates for New Yorkers living with a SMI are consistently higher than the national average (Heun-Johnson et al., 2018). While the percentage of people with a SMI is a much smaller subset than those living with any mental illness, New York City has a disproportionately higher number of its population diagnosed with a SMI compared to the national average and fewer resources to treat those needing inpatient psychiatric care.

Go's death garnered widespread media attention and was the catalyst for The Subway Safety Plan, a reaction outlined by the Adams administration the month after the incident. This was followed by the Mental Health Involuntary Removal (MHIR) policy directive, announced later in 2022.

Multifaceted sociopolitical issues in which mental health is just one dimension enable politicians to cite mental health as an oversimplified justification while omitting other contributing factors that are not as politically compelling. Adams' MHIR response to the issues at the forefront, who it affects, and how it will be implemented amount to nothing more than compassionate window dressing in an effort to appear tough on crime. Using public safety as justification, it points the finger at unhoused individuals who may have an untreated mental illness. If, as Adams says, preventing unhoused New Yorkers from living on city streets or in subway stations and "helping them heal" is the city's objective, forcibly transporting them to an Emergency Department (ED) does little to solve the issue of housing (Adams, 2022, 16:45).

MENTAL HEALTH INVOLUNTARY REMOVALS (MHIR)

Racial and ethnic minorities and immigrant populations in New York City have significantly less access to stable housing, livable wages, and physical and mental health resources compared to majority groups, putting them at a higher risk for adverse mental health consequences in the wake of traumatic experiences (Rudenstine et al., 2020). On

November 28, 2022, Adams announced his directive to remove unhoused individuals from the street and treat their SMI. What was omitted in both Adams' speech and the policy is that not all unhoused individuals have a SMI and there are often co-occurring determinants that negatively impact the population of individuals with SMI: racial discrimination, employment status, familial or community support systems, comorbidities, co-occurring psychological disorders, and a person's health insurance or lack thereof. These are in addition to housing, the social determinant most closely linked to the MHIR policy directive.

For context, one must first understand the existing New York State Mental Hygiene Laws. Article 9 of the Mental Hygiene Law (MHL) is legislation from the New York State Senate (2021) that sets forth standards and procedures for patients who require inpatient hospitalization for a mental illness. The policy outlines emergency assessment for immediate observation, care, and treatment, powers of certain peace officers and police officers, transport for evaluation, and powers of approved mobile crisis outreach teams (Mental Health Involuntary Removals [MHIR], 2022).

The directive for MHIRs augments Article 9 of the MHL by outlining roles and responsibilities for involuntary removals. According to the Office of Mental Health's (OMH) directive, sections 9.41 and 9.59 of the MHL authorize the removal of a person who appears to be mentally ill and displays an inability to meet their basic living needs (MHIR, 2022). The relaxed language of the MHIR authorizes the removal of a person by force and involuntary transport to the closest hospital for a psychiatric evaluation, "even when no recent dangerous act has been observed" (MHIR, 2022, p. 1). The five-page MHIR policy ends after outlining vague protocols for involuntary hospital transfers with respect to different agencies tasked with enforcing this directive. The scant guidelines are expressed with over-simplified language compared to what has always been standard ED or Comprehensive Psychiatric Emergency Program (CPEP) procedure for receiving healthcare facilities: take responsibility for the individual in the hospital, obtain collateral information, complete a comprehensive psychiatric evaluation for the removed individual, and a psychiatrist evaluates the individual for admission (MHIR, 2022).

There is no outline in the MHIR for how a person, once removed from public areas and taken to a hospital, would receive long-term treatment for an ongoing SMI or related social determinants. Nor is there any guidance or resources if they are not admitted to the hospital and return to the streets. For individuals who meet the criteria to receive treatment through inpatient hospitalization, the MHIR fails to address what happens once a person is discharged. The crisis of care—as in the case of Mr. Simon, who, according to Kaufman (2023), received five months of inpatient treatment at the Bronx Psychiatric Center before discharge in July of 2021— is not an issue of whether New York hospital systems can compassionately treat someone experiencing a SMI. Medical facilities can and do stabilize hundreds of psychiatric patients every day. The gaping hole is an omission of policy that should but does not address the continuum of care, including effective housing solutions for New Yorkers with a SMI.

INSTITUTIONS AFFECTED BY THE MHIR DIRECTIVE

Hospital-based emergency care is the only medical treatment to which Americans have a legal right regardless of their ability to pay (Barish et al., 2012). Whether a particular hospital operates under public or private auspices is of critical importance in determining who receives psychiatric services and how those services are financed. Hospitalization rates for New Yorkers living with a SMI are consistently higher than the national average (Heun-Johnson et al., 2018). It is widely accepted that psychiatric units generate less revenue for healthcare systems compared to surgical units; thus, in consideration of financial pressures, private hospitals divert psychiatric patients to city public hospitals (Mueller, 2017). Unhoused New Yorkers are more likely to receive treatment through the city's public hospital systems.

OTHER RELEVANT PUBLIC POLICIES

THE SUBWAY SAFETY PLAN

The MHIR is an extension of the memorandum published on February 18, 2022 by the OMH known as the Subway Safety Plan. This was the first directive from the Adams administration for police and other officials to remove any person with a mental illness or any person who appears to be mentally ill, even when there is no recent dangerous act, and transport them to a hospital for a psychiatric evaluation. This lengthier policy qualifies the rationale for enforcement, stating that “homelessness in NYC has reached the highest levels since the Great Depression” (Office of Mental Health [OMH] et al., 2022, p. 2). What is conspicuous is the city’s rationale for why this population is at risk: “chronically homeless individuals with SMI often have symptoms and cognitive difficulties that contribute to difficulties accessing treatment and housing resources” (OMH et al., 2022, p. 2). Furthermore, the alternative agenda here is hiding in plain sight. Adams justified this aggressive language to augment existing sections of the MHL under the guise of a moral obligation to help unhoused New Yorkers in need of mental healthcare, while simultaneously using it to quell public safety concerns about crime on the street and in the subway system.

MHL SECTION 9.60, KNOWN AS KENDRA’S LAW

After Go’s death, Adams pointed to New York MHL section 9.60, better known as Kendra’s Law, which assertively connects New Yorkers experiencing a mental health emergency to medical treatment. Section 9.60 was named after Kendra Webdale, who died in January 1999 when she was pushed in front of a NYC subway train by a person with untreated schizophrenia (Pataki et al., 2005). Similar to Go’s case, the man who pushed Webdale had just been released from a psychiatric hospital, and his actions resulted from medication non-compliance (Diven, 2022). Soon thereafter, in 1999, New York passed legislation to provide court-mandated Assisted Outpatient Treatment (AOT). This is a more humane and less restrictive alternative to inpatient commitment for those who are unlikely to survive safely in the community without court-mandated supervision (Pataki et al., 2005). Per the U.S. Department of Justice (2022), AOT programs are also responsible for the oversight and monitoring of service providers, including case management services or Assertive Community Treatment (ACT) team services. Case managers and ACT team members follow an AOT recipient's level of compliance and delivery of services by other providers pursuant to the court order (U.S. Department of Justice [DOJ], 2020).

ASSISTED OUTPATIENT TREATMENT (AOT) EVALUATION

More than two decades have passed since the enactment of section 9.60 under New York's MHL. Critics of AOT argue that court mandated medical compliance infringes on civil liberties and disproportionately targets people of color. Others have studied the results and praised its effectiveness in reducing harm to individuals and communities. Appelbaum (2005) reviewed more than 10,000 New Yorkers who were referred to AOT during the five-year span after it was first enacted. Of the referrals, 93% of cases were granted court-ordered AOT. In evaluating participation, Appelbaum's (2005) study examined the history of the individuals granted AOT for three years prior to their court-ordered AOT. It found that 97% had been previously hospitalized, 30% were arrested, 23% were incarcerated, and 19% were unhoused. Even more encouraging were outcomes assessed over five years after mandated treatment, which showed a 44% decrease in general harmful behaviors, including a 47% decrease in physical harm to others (Appelbaum, 2005). Furthermore, arrests, incarceration, psychiatric hospitalization, and homelessness collectively dropped by 74 to 87% (Appelbaum, 2005).

AOT CRITICISM

Kaufman (2023) notes that when Simon left the hospital in July of 2021, social workers escorted him to a supportive housing apartment building in the Bronx, where he could live with on-site services. They left him with a 30-day supply of medication and a next-day appointment with a psychiatrist. Mr. Simon never showed up to his outpatient psychiatry appointment and is believed to have spent no more than two hours in his new home where he left only a trace of his presence: a brown paper bag stuffed with the supply of medications (Kaufman, 2023). AOT is not a life sentence; court orders can lapse after six months. The most frequently cited reason for non-renewal of court orders, according to the NYS-OMH, is that the individual has improved and is no longer in need of court-ordered services. The paradox is that people likely improved because they were mandated to comply with medication, as was the case for Simon. According to Simon's sister, treatment and medicine kept him going, and once he no longer posed a threat to himself or others, the court no longer required him to take his medicine (Diven, 2022). Left to his own devices, he stopped taking his medication and his delusions resumed.

Racial disparities pervade New York's AOT program, with Black and Hispanic people disproportionately subjected to its court orders. Because of this, AOT programs have arguably further marginalized and discriminated against New Yorkers of color (Rodríguez-Roldán, 2020). During Adams' 2022 announcement, he called to make it easier to enforce Kendra's Law as a means to improve ongoing mental health outpatient treatment compliance for those who cannot meet their needs outside of institutions. New York MHL 9.60, outlined by Jaffe (2019), stipulates that once a patient meets the threshold for AOT eligibility, almost any person associated with that individual can petition for court-ordered treatment. While hospital providers can and do apply for AOT, Adams' statement is misleading, as it suggests Kendra's Law can only be mandated through hospitalization. In fact, the petition can be initiated by any mental health providers, directors of community programs, supportive housing directors, parole or probation officers, or any social service designee working with the individual. Furthermore, AOT is not an under-utilized resource as Adams also infers. According to Rascoe and Lewis (2022), as of October, there was an 800-person waiting list for those eligible for AOT. Without additional funding for this supportive service, forcing AOT creates a bottleneck for outpatient behavioral healthcare supportive services in the community.

While Kendra's Law can be beneficial for those who do receive AOT, Diven (2022) outlines its pitfalls. It fails to address the population at large, because it does not account for those who are not a threat to themselves or others. Furthermore, the legal statute for obtaining a court order is based on prior acts demonstrating dangerousness and treatment non-compliance, which imposes a high burden of proof. A widespread misconception is that people who are hospitalized for psychiatric stabilization are simply discharged to the streets without shelter, follow-up outpatient care, medications, or other supportive services. According to a study of psychiatric inpatient discharge practices and aftercare appointments in New York State, Smith et al. (2017) concluded that hospital providers, including social workers, reported having scheduled appointments for ongoing follow-up treatment for 85% of patients prior to discharge. The percentage of those found not to have psychiatric outpatient services were patients associated with having a co-occurring substance use disorder or other comorbid condition that took priority. This does not account for other social services secured for these patients in discharge planning. This study examined associations between routine discharge planning practices and time to treatment follow-up after discharge, finding that 45% of adults did not attend an initial aftercare appointment within 30 days of discharge (Smith et al., 2017). The data illustrates a void in the continuum of care needed for outpatient support, such as intensive case management and services through ACT teams, during the transition from the inpatient setting to supportive housing.

STAKEHOLDERS

For the MIHR directive, stakeholders include community members, law enforcement officials, healthcare workers and administrators, lawmakers, and New York City residents. New Yorkers with a SMI are primary stakeholders, considering this policy directly affects their social welfare. At present, it is estimated that 250,000 adults have a SMI, or 3% of the total population in New York City. Among the unhoused population, which totals about 60,000 living in city shelters or on the streets, the NIMH's New York chapter estimates that one in five to one in six people live with a SMI (Kaufman, 2023). While the percentage of people with a SMI is significantly smaller than those living with other mental illnesses, New Yorkers with a SMI are disproportionately visible in the community given the longstanding systemic failures and lack of continuity in care.

SOCIAL DETERMINANTS FOR PRIMARY STAKEHOLDERS

In addition to the linkage between poverty and housing insecurities, it should also be noted that much of the population in need of urgent psychiatric care already face racial stigma, injustice, and other oppressive systemic forces. This population may suffer for years without being treated, and then often do not have affordable follow-up care or access to costly prescriptions. Many unhoused patients with a SMI also suffer from comorbidities such as substance abuse, which is to say that even if medication and therapeutic treatments are to stabilize the mental illness, these New Yorkers still face afflicting headwinds. Longstanding failures to address oppressive social determinants are why people often end up back in the ED or CPEPs mere days after discharge from inpatient care. The lack of funding and resources for the continuum of care including housing—that is not predicated on drug testing, curfews, or a lapse in mental health care—exacerbates the syndemics of homelessness and mental illness.

THE PROBLEM: NEW YORK CITY'S CURRENT MAYORAL STANCE

New York City is facing a crisis as those in power are using people experiencing homelessness, more specifically those with a SMI or, now, even a perceived mental illness, as a means to ensure public safety. Politicians like Adams, a former NYPD Captain, turn to policing as a means to remove the unhoused from the streets. Friedman (2022) argues that politicians conflate issues of homelessness and the need for public safety, utilizing law enforcement to unfairly target people who are unhoused to ensure public safety. He points to how laws, particularly those in urban areas that wrest the "out of sight, out of mind" mantra, lessen public concerns for safety. There is an exhaustive list of legislation to keep those experiencing homelessness out of sight, including laws against living in public spaces, camping in cities, vagrancy and loitering, begging and panhandling, and sleeping in public.

In the policy's original version, Adams claimed people with mental illness were largely responsible for an increase in subway crime, despite data suggesting most crimes were not committed by unhoused or mentally ill New Yorkers (Fitzsimmons & Newman, 2022). The only qualification for removal, according to the MHIR directive, is that the person in question cannot meet their basic needs, a judgment entirely subjective and in the hands of those tasked with the person's removal.

CRITIQUES AND CONSIDERATIONS

The MHIR is an attempt to outstrip laws that already exist for people experiencing a psychiatric emergency in public, through its directive that police and emergency responders simply remove individuals from the streets and transport them to a hospital, whether or not the individual poses a danger to themselves or to others. Superficially, this implies that all people without permanent housing must suffer from an untreated mental illness and are violent individuals. In addition to this flawed presumption, politicians such as Adams cite morality and responsibility to disguise policing as a means of confronting longstanding problems, instead of addressing the root causes of homelessness through substantive policy changes. The New York City Civil Liberties Union (NYCLU) has been a vocal critic of MHIR and believes this directive violates fundamental legal rights for people living with any mental illness. The National Alliance on Mental Health (NAMI) has been critical, too, suggesting involuntary detention does not solve the issue of supportive housing for those with any mental health crisis. Adams points to court ordered AOT as a successful law that should be enforced, yet is misleading regarding how this essential component of a functional public mental health system can be implemented and to whom it applies (Subway Safety Plan, 2022).

Admittedly, the 2019 NYS-OMH data for all inpatient New York City psychiatric facilities show that one in five (20%) patients were readmitted within 30 days, and nearly one in three (33%) were readmitted within 90 days. At five city hospitals, the 90-day psychiatric readmission rates were significantly higher, ranging from 53% to 64%. Similar rates exist for those presenting to EDs departments for psychiatric symptoms soon after inpatient discharge. On the surface, it is easy for politicians to point the finger at healthcare systems, when in actuality the data points to a system that relies on short-term treatment of psychiatric symptoms rather than adequately addressing long-term supportive care and social determinants for people with a SMI (Nortz, 2021). There is no formal healthcare policy, much less detailed plans or proposed guidance for actual treatment in the MHIR other than a psychiatric evaluation. This policy does not acknowledge, let alone propose, solutions that largely contribute to why unhoused people do not have access to healthcare. And for those who do receive some inpatient treatment through hospitalization, there are inadequate resources for the post-discharge continuum of care, which is essential for sustaining remission from chronic illness.

Opponents of the mayor’s MHIR policy say not enough attention is directed towards accessible and affordable housing and healthcare. For decades, unhoused New Yorkers have been brought to EDs by NYPD and EMS every night. In response to Adams’ plan, many psychiatrists say this will not come close to solving the problem of untreated mental illness among those living on society’s margins (Goldstein, 2022). Hospitals are not a place to forcibly transport and offload people simply to remove them from the streets. Adams fails to acknowledge the long-term resources needed to address the interconnected medical and housing issues this policy directive purports to solve. When treating someone with a SMI there is a disproportionate emphasis on symptom reduction using drug therapies and psychotherapy and not enough attention and resources for the continuum of care that is practical and affordable. The mental health crisis cited by politicians is not strictly medical; the path to healing also involves interventions to address the social determinants. Without ongoing follow-up appointments, supportive care, and rehabilitative services including housing, several days or even a few weeks of psychiatric hospitalization do little to break the cycle of chronic homelessness and SMI.

SOLUTION: HOUSING REFORM

The solution to the issue at the core of this crisis is to reform housing policies. Social workers join other providers and advocates in lamenting the lack of service integration and the scarcity of resources available for adults who are experiencing comorbidities of homelessness and mental illness (Padgett et al., 2006). However, studies have consistently found that only about 25%–30% of unhoused people have a SMI (Padgett, 2020). In just a handful of days, if a person receives proper nutrition, sleep regulation, social support, and consistent medication, their behavior changes and psychiatric symptoms diminish. During the public announcement for the Subway Safety Plan, Adams said, "It is cruel and inhumane to allow unhoused people to live on the subway, and unfair to paying passengers and transit workers who deserve a clean, orderly, and safe environment" (2022, February 18). If the mayor believes this, then the administration should consider redirecting resources toward policies that connect people with community-based systems such as ACT teams and adopt Housing First (HF) policies.

New York City relies on an overcrowded shelter system and a treatment-first approach, which requires unhoused individuals with a SMI to complete a sequence of steps to demonstrate readiness for supportive housing. HF is a departure from this linear continuum of care model by providing immediate access to housing in independent apartments. This evidence-based housing policy offers tenants an array of services through interdisciplinary ACT teams consisting of social workers, psychiatrists, vocational trainers, and substance abuse counselors (Padgett et al., 2006). HF does not require people experiencing homelessness to address their behavioral health or substance use before providing housing. The policy is predicated on the philosophy that housing is the foundation on which people can recover. Additionally, studies have consistently shown access to housing generally results in cost savings for communities because housed people are less likely to use emergency services such as hospitals, jails, and emergency shelters (National Alliance to End Homelessness [NAEH], 2022). Waiting for individuals to receive and comply with medical treatment for a SMI, then rewarding them with housing, perpetuates the never-ending cycle of homelessness, institutionalization, and incarceration. In short, it solves neither the housing nor the mental health crisis.

During his MHIR address, Adams said his administration had a moral obligation to help [New Yorkers] who “cycle in and out of hospitals and jails, and New Yorkers rightly expect our city to help them and help them we will” (Adams, 2022, 1:47). Ironically, a mere three weeks before this speech, data was released showing that nearly 2,600 supportive housing apartments were vacant, which is enough to house the estimated 3,400 people living in streets or subways (Newman, 2022). According to Brand (2022), the city launched a new pilot program in early September of 2022, moving 80 formerly unhoused New Yorkers into vacant supportive housing units in single-room occupancy (SRO) buildings in Brooklyn and Manhattan. This pilot program, based on the HF model, enables residents to bypass the bureaucratic hurdles necessary to obtain supportive housing. While a start, the 80 units represent a paltry 3% of NYC’s empty units. Furthermore, the program is being run by the nonprofit volunteers, rather than by the city. If the Adams administration truly wanted to solve the issue of housing and provide compassionate care for those in need, it might consider adopting the evidence-based HF policies citywide in the other 97% of reportedly empty apartments.

CONCLUSION

Adams' MHIR policy takes a page out of the political playbook that conflates issues of public safety with those of mental health. If, as the MHIR directive states, the only qualification for removal from public areas is that a person cannot meet their basic needs, then perhaps a more compassionate and effective way to solve the problem at hand would be to pivot from "mental health" and reform current housing policies that enable individuals to meet these basic needs. Policing unhoused New Yorkers with a SMI and forcibly transporting them to overcrowded healthcare systems in NYC do little to reduce the intersectional risks for this population. Without reforming policies that address long-term care, namely social determinants and housing policies, forcibly hospitalizing unhoused New Yorkers in need of psychiatric treatment is not only ineffective, but perpetuates this cycle. Thus, it is reasonable to conclude that Adams' MHIR directive is largely symbolic—optics for being tough on crime—while doing little to implement policy that provides actual relief and support to New Yorkers who are unhoused and living with a chronic SMI.

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Digital Exclusion, Gender Oppression, and How Social Workers can Advocate for Digital Feminism in China

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ABSTRACT

For the past decade, the pace of China's digital and technological development has been rapidly increasing. While this growth creates economic opportunities, it has negative impacts for Chinese women who are marginalized at the intersections of gender, class, and geographic location. This paper adopts an intersectional feminist lens to examine how Chinese women experience digital exclusion and gender oppression in the digital era. To do so, it discusses (1) existing technologies that reflect and perpetuate gender stereotypes through gendered technology design, (2) digital spaces and media censorship that disenfranchise women, and (3) AI surveillance and unfair labor practices that oppress women.

This paper calls for social work practices in digital feminism at the micro, mezzo, and macro levels, specifically in promoting gender equality in training and design, leading feminist initiatives, and promoting digital accessibility and data protection.

Keywords: digital feminism, feminism, digital age, gender, social work, intersectionality

As new technologies, digital innovations, online platforms, and technology companies emerge in China, women face increasing challenges and exclusions, such as the digital divide, barriers to access, underrepresentation in tech-related fields, technology-enabled violence, and privacy concerns (UNESCO et al., 2022). Given that China is ranked 102 out of 146 countries in gender inequality (World Economic Forum, 2022), social workers who advocate for social and gender justice must take action to advocate for women in China who are excluded and oppressed in the digital age. This entails rethinking technologies and digital spaces and understanding patriarchy and other forces of oppression exacerbated by the digital age.

This paper applies an intersectional feminist lens to examine how women in China experience digital exclusion and social oppression in the digital era and proposes social work practice interventions. Legal theorist Kimberle Crenshaw first coined the term “intersectionality,” which explores discrimination based on race, gender, and other markers of identity. An intersectional framework acknowledges that people experience varying degrees of marginalization due to their multiple intersecting identities (Bowleg, 2021).

This paper will use numerous references to technical definitions. First, *digital exclusion* describes a lack of access to the information and communication technology required for full participation in society (Sanders, 2020), and it also refers to being marginalized by the design of technologies. Second, *feminism*, as defined by D’Ignazio and Klein, is a term for “the diverse and wide-ranging projects that name and challenge sexism and other forces of oppression, as well as those which seek to create more just, equitable, and livable futures” (2020, p. 6). Third, oppression includes “systematic mistreatment of certain groups of people by other groups” that occurs because of an unequal distribution of power wherein one group controls the institutions of “law, education, and culture, and uses its power to systematically exclude other groups” (D’Ignazio & Klein, 2020, p. 8).

The first part of this paper will describe the ways in which technology development in China has had negative effects on Chinese women, including a discussion on how technologies reflect, perpetuate, and create gender oppression. The second part of the paper advocates for *digital feminism*, which means applying feminism in the digital context to combat patriarchy and other forms of oppression. This part also delineates how to lead feminist actions in digital technologies and strive for gender equality and social inclusion and outlines ways in which social workers can help to empower women and challenge technological oppression.

HOW DO WOMEN EXPERIENCE GENDER OPPRESSION AND DIGITAL EXCLUSION?

Gender biases in new technologies are likely the result of the male-dominated technology design industry in China (UNESCO et al., 2019). The biases reflected in these technologies harm women by perpetuating gender norms. As one example, a proliferation of voice assistants (VAs) designed by Chinese technology companies such as Alibaba, Baidu, and Xiaomi have dominated Asian markets (Kinsella, 2019). VA speakers are designed for spoken interactions with users and mimic natural human speech on a day-to-day basis. Baidu and Xiaomi’s VAs, which are projected as female both in name and sound of voice, interact with users in a cooperative and submissive manner (UNESCO et al., 2019). The feminization of VAs is designed to cater to the needs of consumers who want to “be the bosses of it” and are therefore more likely to “opt for a female interface” (Hempel, 2015, para. 9). VAs further perpetuate discriminatory gender norms by sending a signal that women are “obliging, docile and eager-to-please helpers” and are “available at the touch of a button or with a blunt voice command like ‘hey’ or ‘OK’” (UNESCO et al., 2019, p. 106-107). This reinforces the cultural norm that women are tolerant of poor treatment and should be placed in a subordinated service position.

ONLINE SEXUAL HARASSMENT AND MEDIA CENSORSHIP DISENFRANCHISING WOMEN

In addition to technologies that perpetuate undesirable gender norms, online sexual harassment and media censorship greatly harm women. According to a 2017 survey with 1,277 Chinese college student respondents, about 33.2% experienced some form of online sexual harassment, such as sexualized messages or non-consensual pornographic images; among these sexual harassment survivors, about 71.0% identified as women, showing how the digital age increases the gendered risk of being sexually harassed (Ye et al., 2018). Additionally, the circulation of inappropriate content, such as AI-generated "deepfakes," has been used to threaten, blackmail, and abuse women, in addition to harming their careers (Lucas, 2022). Numerous sellers on online platforms like Baidu have developed e-commerce chains that offer personalized deepfakes by swapping the faces of female celebrities or private civilians in pornographic movies at affordable prices (Chen, 2019). Ninety-six percent of deepfake videos in the survey contained non-consensual pornographic images, and one hundred percent of these videos were of women (Ajder et al., 2019).

Remote employment and digital platforms for coworker interactions have also increased incidents of sexual harassment toward women (UNESCO et al., 2022). In a survey titled *Sexual Harassment Experienced by Female Journalists* (N=416), 83.7% of the women surveyed experienced gender-based harassment online, and 18.2% experienced it more than five times in the remote workplace (Ma, 2022).

AI MAKES WOMEN VULNERABLE IN THE WORKPLACE

The use of AI in the workplace contributes to a culture that does not consider workers' personal data as separate from their professional lives. Additionally, it stratifies employees and employers as the latter group uses AI to track workplace permanence and make decisions about wages, promotions, and dismissals (Bales & Stone, 2020). These employer-employee power dynamics further marginalize workers, and women in particular are the most vulnerable. Although the *Civil Code of the People*'*s Republic of China* requires employers to implement informed consent of the collection and processing of employees' personal data, workers hardly reject unfair labor practices for fear of retaliation (Tang, 2021). Retaliation from employers, which includes demotion or even termination from current work, further marginalizes vulnerable employees.

In these situations, women may have the most to lose by challenging their employers. As previously mentioned, Chinese women workers earn lower wages, receive less educational training, and are less likely to be promoted than men (World Economic Forum, 2022). This means women bear the devastating risks of retaliation more heavily and are more likely to accept unfair labor practices, including risks of personal data invasion. As a result of AI, women workers are especially vulnerable to the effects of stratification.

HOW DO SOCIAL WORKERS ADVOCATE FOR DIGITAL FEMINISM?

Although digital technologies can increase an individual's independence politically, socially, and financially, this can only happen when they are able to use technology autonomously (UNESCO et al., 2019). Unfortunately, technologies, media, digital devices, and innovations in the digital age, which are rooted in an oppressive social structure, widen the power divide between men and women, government and citizens, urban people and rural people, and employers and employees. As previously stated, women who are marginalized at the intersections of gender, class, and geographic location are the most vulnerable in the digital age. They are negatively impacted by stereotypical gender norms coded into technologies, online sexual harassment and media censorship, the urban-rural digital divide, and AI surveillance. In these conditions, digital development reinforces patriarchal norms and perpetuates power asymmetry.

According to the code of ethics for social workers in China, social workers accept responsibility for advancing social justice and protecting human rights (Zhu & Wen, 2006). Thus, social workers are encouraged to think from an intersectional feminist perspective in order to address the root causes of issues in the digital era: patriarchy and other oppressive forces created by culture, government, and society. Social work interventions call for schools, corporations, NGOs, and policy institutions in China to advocate for women's representation in all spaces and to develop social welfare programs (Fan, 2019; Lu & Bao, 2022). In the digital age, social workers should stand by women to challenge oppressive power and adopt digital feminist practices. Strategies for digital feminism inside and outside digital spaces include conducting gender equality training, promoting design justice in technologies, leading online initiatives, bridging the digital gap, and promoting personal data protection.

LIMITATIONS SOCIAL WORKERS MAY FACE IN CHALLENGING DIGITAL OPPRESSION

GOVERNMENT CENSORSHIP

Feminist activists in China have taken the initiative to challenge gender oppression through social media (Ma, 2022). For example, since 2018, Chinese women have engaged in the #MeToo Movement, a hashtag campaign to challenge sexual violence, patriarchy, rape culture, and male-dominated values (Han, 2018; Yin & Sun, 2021). The narratives of their experiences went viral on social media. In 2018, more than 36,000 online articles related to the #MeToo Movement were published on Chinese social media (Ma, 2022).

However, Chinese authorities silenced the voices of survivors and activists before the movement was able to reach a wider audience. Authorities became intolerant of the public outcry, which criticized their lack of effective response to sexual violence, and feared "social unrest" or that the public would question their legitimacy. Consequently, authorities retained tight control over the flow of information on social media platforms (Ma, 2022) by blocking and removing “MeToo” and “sexual assault” -related posts and closing activists’ social media accounts as a way to silence supporters (Fileborn & Loney-Howes, 2019). As a result, survivors and activists suffered from a lack of institutional and legal support (Yin & Sun, 2021).

THE URBAN-RURAL DIGITAL DIVIDE

The digital divide between urban and rural China has widened over the years, given that the rural population only represents 28% of Chinese Internet users (CNNIC, 2022). This divide is pronounced for rural Chinese women, who are more underprivileged and disenfranchised than urban middle-class women. In the digital age, rural women face increasingly more barriers to accessing information and communications technology due to poor infrastructure in technology, connection costs, increasing economic inequality, digital literacy issues, norms of perceived female inferiority, and a long history of rural-urban disparity (Yang & Du, 2021). The digital divide accelerates urban-rural gender inequality.

The “gendered digital divide” and digital exclusion, which varies substantially between urban and rural areas, prevent rural women from benefiting from digital innovations (Yang & Du, 2021, p. 2,520). China’s major digital payment services and innovations have supported millions of small businesses and entrepreneurs in China. Some examples include Ant Financial, a lender for small businesses that supports low-income earners, and Alipay, which offers a low-risk money account to provide investment for individuals (OECD, 2018). However, rural women without digital outlets are unable to access online loans and investments to support their businesses. Without digital access, rural women will not be able to access these services, and as a result, urban-rural gender inequality in resources, opportunity, and capability will continue to widen.

GENDER EQUALITY IN TRAINING AND DESIGN

This section suggests three digital feminist interventions to increase women's representation in STEM, AI, and coding/programming, which include (1) providing gender equality training that addresses gender stereotypes, (2) increasing women employees' skill sets and readiness for the AI field, and (3) enhancing women's roles in the technology field through recruitment, equal wage, and promotion opportunities.

MICRO PRACTICE INTERVENTIONS

GENDER EQUALITY EDUCATION

Gender norms suggesting that women are subordinate to men hinder women's participation in STEM fields. They lead people to believe that the STEM field opposes these gender roles (Tandrayen-Ragoobur & Gokulsing, 2021) and perpetuate the idea that women should find secure jobs with regular working hours rather than working in high-intensity environments that require advanced technical skills (Xu, 2020). Furthermore, Chinese higher education hardly provides courses addressing gender norms; these institutions overlook the importance of gender equality education, since the post-graduation employment rate is considered the de-facto indicator of a university's educational quality and outcome (Zhang, 2020).

School social workers must intervene by creating gender equality training and advocating for institutions to include this type of training, which would trickle into STEM fields. Gender equality training should not just be held in urban areas, but also in rural settings, given that gender norms are most detrimental in rural China (Li, Y., 2021). Research has shown that providing gender equality training is effective in changing students' attitudes toward STEM (Ikkatai et al., 2021). School social workers should also help school curriculum decision-makers and education departments understand how gender equality training can improve female students' competitiveness and interest in STEM professions and thus improve the schools' quality of education and prestige. The purpose of gender equality training is to help students have a better understanding of gender norms as well as the importance of education and careers for women. Additionally, conducting gender equality training for teachers can make teachers aware of their own subconscious biases and prevent them from perpetuating traditional gender stereotypes and sustaining the patriarchy.

While STEM education can increase students' readiness and competitiveness in AI fields (Ikkatai et al., 2021), exposure to STEM careers can grow interest in pursuing careers involving technology and engineering (Blotnicky et al., 2018). Therefore, social workers should advocate for increasing STEM educational resources in the form of coursework, teaching staff, and career counselors. This approach will inspire more women students to challenge patriarchy and increase their competitiveness and interest in entering the technology industry.

PROMOTING DESIGN JUSTICE

Social workers can disrupt the male-dominated technology market by promoting design justice in technologies. Design justice "rethinks design processes, centers people who are normally marginalized by design, and uses collaborative, creative practices to address the deepest challenges our communities face" (Design Justice Network, 2018, para. 2).

With a trained background in gender justice, data justice, and social inclusiveness, social workers can participate in software design. Desmond U. Patton (2019), a professor at Columbia

University School of Social Work, calls for bringing social work scholars to the AI table, and explains that AI designers need "community support and buy-in" (para. 5). Social work scholars can utilize knowledge learned from social work school, such as understanding a person within a community context and uncovering any biases members may have toward that community (Patton, 2019). Social workers should also encourage companies to re-examine the gender biases encoded in technologies. They could do this through workshops on specific topics such as “gender norms reinforced by technologies” or by promoting accessible, gender-friendly technologies for diverse and inclusive communities.

In addition to allowing social workers to participate in design, inviting women to the table is another form of digital feminism for enterprise social workers. Voices should be heard not only from female scholars, engineers, and designers, but also from women who come from underprivileged, low-resourced communities. Enterprise social workers collaborating with women helps empower and center the voices of women who have been directly impacted by the outcomes of the design process and helps them seek liberation from the oppressive patriarchal system (Costanza-Chock, 2018).

MEZZO PRACTICE INTERVENTIONS

AI TRAINING FOR WOMEN

Rapid digital development requires that employees be equipped with updated technical skills. Therefore, those who do not receive technical training are adversely affected. There is already a large gender gap in AI skills training (Li, J., 2021). On top of this, technology companies do not provide equal AI training for women, resulting in a gender gap in promotions, positions, and roles. Data from LinkedIn (2020) suggests that the AI skills penetration rate for women to men, which reflects the “prevalence of AI skills across occupations,” is about 0.85 to 1.02 in China (Zhang et al., 2021, p. 218). A study conducted in manufacturing companies in Shanghai, China discovered that the AI skills training per season for men to women is about 6.12 to 1.58, highlighting how firms indicate a gender preference in staff training (Li, J., 2021). Lack of training is a barrier for women, as fewer women trained in AI means fewer women are eligible for promotion in tech firms. This perpetuates male domination of the tech industry as women are underrepresented and continue to hold less vital roles (UNESCO et al., 2022).

Digital feminist practice includes intervening in the male-dominant industry by providing

the required training for women marginalized in the workplace and underemployed due to lack of training or formal education. Social workers from NGOs and NPOs can seek partnerships with educational institutions that have expertise as one solution. They can provide training in diverse subjects, such as AI, software skills, management, and human resources. They can also assist women in earning professional certifications in information technology and management, such as *System Architect, Information System Project Manager,* and *Project Management Professional*, to increase women's qualifications for vital roles in companies. This training can be provided "after hours" to meet the needs of domestic housewives or women who work during business hours.

INCREASE WOMEN'S REPRESENTATION IN THE AI JOB MARKET

Due to long-standing gender stereotypes in the male-dominant tech industry, increasing women's AI skills cannot promise gender-equal hiring outcomes. The top 10 Chinese Internet companies' public figures indicate that their ideal employees are as young, able-bodied males (Li, C., 2021). To increase women's representation in tech companies, social workers need to work in human resources to recruit women for senior roles and advocate for higher working conditions and opportunities for women.

Social workers can also help to correct gender bias during the hiring process, enhance implementation of anti-discrimination policies in the workplace, and advocate for increasing representation of female employees in areas of employment, leadership, management, and engineering. Social workers not only support women in recruitment, but also advocate for better wages, working conditions, and promotion opportunities as a way to promote gender equality and inclusiveness in the workplace.

FEMINIST ACTIVISM

MICRO PRACTICE INTERVENTIONS

Regardless of the #MeToo Movement being blocked on social media by the government, social workers can still lead strategic digital feminist initiatives to create and sustain a more equitable environment to end gender and power-based violence. They can do this through disrupting algorithms, online advocacy and prevention, and workplace innovation and regulation.

DISRUPTING THE ALGORITHM

Social workers are encouraged to come up with innovative ideas that allow more survivors of sexual abuse and activists' voices to be heard in the digital space. One method is to embolden supporters of the #MeToo Movement to disrupt the algorithm. Ma (2022) suggests ways to avoid government surveillance tools by rotating the images of certain censored #MeToo cases to trick online platforms' detection algorithms, putting censored content on a blockchain, and using open-source repository hosting services, like GitHub. These innovations were helpful in circumventing censorship and thus supporting feminist movements (Ma, 2022).

ONLINE ADVOCACY AND PREVENTION

Social workers should especially reach out to sexual violence survivors who lack access to digital outlets due to media censorship. Social workers can support these survivors by creating advocacy projects that challenge forms of patriarchal and institutional oppression. They can also provide online service options such as virtual crisis and mental health counseling,

intervention programs, support groups, and legal assistance. Additionally, social workers should train survivor advocates and volunteer peer educators to respond to individuals who are experiencing sexual, intimate partner, and gender-based violence. Trained advocates will then assist survivors by safeguarding their rights and exploring various options to identify their unique needs. These trained advocates can also accompany individuals to report to law enforcement and guide them through the legal process.

In addition, social workers can play a role in digital harm reduction. Social workers and trained staff can host virtual sexual violence response prevention programs, such as sexual assault awareness and relationship violence awareness events, prevention-focused training, and education workshops. The purpose of these programs would be to help resist the power of abuse and educate the community about healthy relationships and sexual health in an honest and judgment-free way (Columbia Health). Social workers should also educate women about different forms of sexual violence in order to help break the social stigma around rape culture.

MEZZO PRACTICE INTERVENTIONS

WORKPLACE INNOVATION AND REGULATION

As previously discussed, increasing remote work exposes women to higher risks of online sexual harassment. This is further exacerbated by the lack of actions and policies against online sexual harassment in Chinese companies (Ma, 2022).

Enterprise social workers are needed to develop digital innovations and write policies addressing the new risks of online sexual harassment. Enterprise social workers can encourage companies to adopt AI systems that detect and track abusive, harassing language in company documents, emails, chats, texts, and comments. Referring to practices from other countries, such as Brazil-based *Think Eva*, an AI and human interaction combination that was designed to monitor and address harassment, and Canada-based *Botler* AI, which utilizes deep learning to provide free and accessible support to survivors, could be helpful for Chinese companies in selecting an AI system to combat harassment (Das, 2020). Enterprise social workers can also encourage companies to develop apps such as Callisto and AllVoice, which allow employees to report harassment (Das, 2020).

MACRO PRACTICE INTERVENTIONS

POLICIES AND PROCEDURES FOR GRIEVANCES

Enterprise social workers can write new policies and procedures, including reporting and grievance mechanisms, in order to support employees to take appropriate action, reassure survivors, accuse and punish perpetrators, and help prevent future online harassment.

DIGITAL ACCESSIBILITY AND DATA PROTECTION

MICRO PRACTICE INTERVENTIONS

CONNECTING LOCAL COMMUNITIES TO DIGITAL RESOURCES

Community social workers should connect low-income communities and individuals to local libraries which can expand electronic check-out services and technology learning courses. Supporting individuals through technology training will help social workers engage with these populations. Gibson et al. (2020) suggest that people will be more willing to use new technologies if they receive some type of formal training.

DIGITAL LITERACY WORKSHOP AND INTERNET SAFETY TRAINING FOR WOMEN

Community social workers should hold digital literacy workshops in community centers to teach women and other vulnerable groups how to navigate digital devices and use social media platforms. In addition, social workers must teach individuals how to protect their privacy and ensure their safety both online and offline. One example of this type of training material is called *The Empowering Internet Safety Guide for Women*, produced by vpnMentor, which lists multiple ways to protect one's privacy and safety while navigating social media platforms, online dating sites, and ride-sharing apps (Levavi-Eilat, 2018).

MACRO PRACTICE INTERVENTIONS

Social work scholars should advocate for high-speed, low-cost internet and accessible technological devices in rural areas for digitally excluded communities. NGOs and NPOs should collaborate with large technology companies to provide discounted technology devices to rural women. Research has shown that Internet use has a significant impact on accessing employment opportunities and reducing poverty in rural China (Yang et al., 2021).

DATA PROTECTION

Policy social workers and enterprise social workers should protect workers’ personal data through regulation and education in the labor market. Policy social workers and social work scholars should refer to the case of *Bărbulescu v. Romania* (2016), a milestone in the pursuit of protection for employees’ privacy, which established that an individual has a “reasonable expectation of privacy.” As another example, the U.S. Constitution guarantees workers’ rights to the protection of intimate, private, and family life (Article 26) as well as private correspondence (Article 28). While employers have the right to monitor how employees complete professional tasks, employers have a responsibility to guarantee the confidentiality of employees’ personal data. Personal data may only be processed “if the person concerned consented to it and it sets out a list of exceptions when consent is not necessary” (*Bărbulescu v. Romania*, 2016, para.16). Advocates should refer to these countries’ policies regarding workers' personal data protection as a guide to promoting inclusive and safe laws in Chinese institutions.

POLICY ADVOCACY FOR DATA PROTECTION

Meanwhile, enterprise social workers should play an important role in regulating AI usage and data protection in workplaces. Enterprise social workers can do this by setting up ethical guidelines for employers who use employees’ social media data, supervising companies’ data collection process and dissemination efforts, and affirming workers' reasonable expectations of privacy in the workplace.

In addition to regulation, enterprise social workers need to educate both employers and employees about the importance of ethical usage of employees' data monitoring. Employees need to understand the importance of informed consent, the negative impact of personal data being misused or abused, and whether their companies have a legitimate reason to monitor their activities.

CONCLUSION

Women marginalized at the intersections of gender, class, and geographic locations are the most vulnerable to digital exclusion and gender oppression in the digital age. Even though social workers face barriers in addressing digital exclusion and gender oppression issues in the patriarchal and political contexts in China, they can still advocate for human rights and digital feminism in creative ways. Through promoting gender equality in training and design, leading feminist initiatives, and promoting digital accessibility and data protection, social workers can advocate for a more gender-equal and gender-inclusive society in China.

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"Small Victories of Survival in a Deeply Homophobic World":

Current Realities and Paths Forward for Substance Use in the LGBTQIA+ Community

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KATE ORCHARD

ABSTRACT

According to the National Institute on Drug Abuse, members of the LGBTQIA+ community are disproportionately impacted by problematic substance use (National Institute on Drug Abuse, 2020). Despite this well-documented reality, there is still limited funding and access to substance use treatment for queer and trans people. This exploratory paper surveys the literature on the prevalence of substance use in the LGBTQIA+ community in the United States (US), highlighting the historical and cultural realities leading to this trend within the context of the minority stress model. The article then outlines a path forward, suggesting the best treatment models for social workers in the field. Suggestions include integrated healthcare, trauma-informed, LGBTQIA+-specific treatment models, cognitive behavioral therapy focusing on co-occurring Post-Traumatic Stress Disorder (PTSD) and substance use disorder, harm reduction, and crisis intervention outside of policing.

Keywords: substance use treatment, LGBTQIA+, trans-affirming healthcare, minority stress model, integrated behavioral healthcare, crisis intervention

In a YouTube video by Brujas World (2019), a New York-based feminist street collective and streetwear brand, a group of young people of color stand watching a soccer game, passing around a joint. Meanwhile, a New York City Police Department watch tower looms overhead. What starts as an everyday scene of friends hanging out and playing soccer suddenly morphs into a public health announcement. A powerful voice informs viewers that "deaths due to opioid-related overdoses nearly tripled in 2015" (Brujas World, 2019, 0:40). The voice continues: "This s*** continues to keep Black people, poor people, gay people, sick people, to keep us, punished for our need" (Brujas World, 2019, 0:44). A player on the soccer field suddenly looks dizzy, and their friends run over to help. The voice reminds viewers: "Call your friends if you're using it alone. Carry fentanyl strips with you. Give them to your loved ones. Help them use them. When you're out there, check to see that someone on the subway or sidewalk is breathing" (Brujas World, 2019, 1:01).

According to the National Institute on Drug Abuse (2020), LGBTQIA+ individuals are more likely to suffer from substance use disorders than the cisgender, heterosexual population. This paper explores the prevalence of substance use in the LGBTQIA+ community, barriers to treatment, and suggested paths forward through the lens of the minority stress model. The marginalization of queer and trans populations leads to minority stress, which is a theoretical concept defined by Meyer (2003) as occurring when “stigma, prejudice, and discrimination create a hostile and stressful social environment that causes mental health problems,” thus increasing the likelihood of substance use and its potential associated risks (p. 674). This model thus posits that minority stress increases the likelihood of substance use, as well as its potential associated risks.

Given the insufficient research and lack of appropriate services for LGBTQIA+ individuals struggling with substance use, this paper argues that treatment approaches must evolve. Suggested approaches include integrated behavioral healthcare, trauma-informed LGBTQIA+-specific treatment models, strategies that address co-occurring Post-Traumatic Stress Disorder (PTSD) and substance use disorder (SUD), harm reduction methods, and non-police crisis intervention. Approaches with these considerations would better support the needs and well-being of LGBTQIA+ individuals and foster more inclusive and equitable care.

METHODS & LIMITATIONS

Research for this article includes meta-analysis and thematic analysis of various sources from databases including Columbia University Library Online and PubMed. The following search terms were used: “substance use,” “substance use disorder,” “trans-affirming healthcare,” “integrated behavioral healthcare,” “substance use treatment,” “crisis intervention,” “LGBTQIA+ people of color,” “harm reduction,” and “minority stress model.” Sources include five observational studies, four meta-analyses, one pilot study, six surveys, one sample study, one systematic review, 2 pieces of advocacy-oriented content, four creative pieces, and one educational training video. Publication dates range from 2003 to 2023, with most from 2014 forward.

With the intent of surveying the literature, this article analyzes 20 peer-reviewed studies with evidence from 13 additional sources, such as prominent LGBTQIA+ advocacy centers, healthcare facilities, harm reduction centers, news organizations, and companies. The available sources exhibit noticeable disparities in their demographic and topical foci. Among the 20 peer-reviewed articles, 14 discussed substance use, while others explored topics such as minority stress, social services, and the health and mental health issues of these populations. Fourteen articles broadly focused on the LGBTQIA+ community, three on LGBTQIA+ youth, three on the trans population, 2 on the LGB population, and one on the LGBTQIA+ homeless population. Concerning racial demographics, 9 sources on people of color are referenced, including 3 on the Black population and 1 on the Latinx population. Two sources pertain to substance use among people of color more broadly. Finally, 8 articles discuss substance use in the LGBTQIA+ population, with 1 focusing on youth within that category and 1 solely on trans substance users.

Limitations include a lack of research on substance use treatment in LGBTQIA+ communities (Glynn & van den Berg, 2017). Alarmingly, the National Survey on Drug Use and Health does not even include sexual orientation or gender identity in demographic surveys (Glynn & van den Berg, 2019). Specifically, data about trans individuals, especially trans men and trans women of color, is practically nonexistent. In addition, there is a huge gap in research on older adults in the community (Crath et al., 2021; Vareed & Mendoza, 2019).

LGBTQIA+ HISTORY, CULTURE, AND REALITIES CONCERNING SUBSTANCE USE

In a Youtube video from an event called "HaHa Harm Reduction," Del Castillo (2017) describes an experiment in which a rat was locked in a cage and provided a water bowl containing heroin. Quickly, the rat became addicted to heroin. When the scientists took the rat out of the cage, they gave it a jungle gym to climb on, lots of space to run, food, and water, and added other rats to the area. Some rats tried heroin but remained disinterested in it; none of the rats in the second cage became addicted to heroin. In the words of Del Castillo, "Is the problem the substance, or is it the cage?" (Del Castillo, 2017, 09:30).

Del Castillo (2017) elaborates that for many LGBTQIA+ individuals, substance use is not so much about the high, but instead about "the safe haven from a hostile world that would not otherwise embrace the rainbow," a statement that illustrates an experience of the minority stress model (04:17). Del Castillo (2017) explains that when healthcare providers are aware of their patients' gender identity or sexual orientation, the patients are more likely to build rapport with their providers and disclose health information, and the providers, in turn, are more likely to screen for and monitor health issues. But for many queer and trans people, that is a luxury. While healthcare spaces have not always provided a safe space for the LGBTQIA+ community, bars and clubs have always been a central part of the history of the LGBTQIA+ movement (Vareed & Mendoza, 2019). So much of queer culture centers around relationships, connection, community, and chosen family. While bars and clubs can be a liberating source of joy, spaces centered around drugs and alcohol can also come with risks, especially for those with preexisting challenges related to substance use (Vareed & Mendoza, 2019). An example of this is the use of party and play (PNP), which is a term describing the use of party drugs, such as crystal meth and ecstasy, during sex among men who have sex with men (Mallon, 2018).

Additionally, Mallon (2018) finds that lesbians may be particularly at risk for developing substance use disorders. On this topic Mallon (2018) states, "The role of oppression, being part of a marginalized population, and the importance women place on relationships are integral to understanding addiction among lesbian women" (p. 71). This suggests that lesbians may use substances as a way to relate to one another. Therefore, Mallon (2018) argues treatment interventions for people who identify as lesbians should focus on relationship development and “expression of the true self, examining both external and internal homophobia, including addressing shame or a lack of self-acceptance" (p. 71). While Mallon's explanation contains tinges of sexism and stereotyping of women, community building and building authentic connections are time-honored pieces of LGBTQIA+ culture.

Unfortunately, in addition to high rates of substance use in the community, another epidemic, HIV/AIDS, has made a significant mark on LGBTQIA+ history. Much work has been done around the trans population, for example, in the context of HIV risk due to the high prevalence of risk in that group, focusing on HIV/AIDS and substance use within a syndemic framework (Glynn & van den Berg, 2017). The AIDS epidemic points not only to another collective trauma but also to co-occurring illnesses with the potential to be treated together. For example, a summary of 12 studies on LGB youth informs readers that the most common risk factors for substance use include experiences of victimization, stress, and housing insecurity (Goldbach et al., 2014). Risk factors such as these, in addition to cultural and historical influences on LGBTQIA+ substance users, point toward the necessity for increased research, improved access to care, and treatment for this group.

THE PREVALENCE OF SUBSTANCE USE IN LGBTQIA+ COMMUNITIES

Surveys from the NIDA (2020) confirm substance use is an issue that disproportionately impacts the queer and trans communities. However, the organization elaborates that it is impossible to establish long-term trends on this topic because surveys only recently began to include gender identity and sexuality. Much research on the topic orients this stratification within the minority stress model, which postulates that exposure to discrimination over time by people in marginalized groups leads to higher rates of mental health and substance use challenges (Glynn & van den Berg, 2017). Studies have shown that discrimination and substance use are correlated (Glynn & van den Berg, 2017). Social stigma and discrimination increase the likelihood of harassment and violence. These sources of added stress expose the community to a greater risk of behavioral health vulnerabilities (NIDA, 2020). To compound matters, a disproportionate number of LGBTQIA+ young people go without housing each year in the U.S. LGBTQIA+ youth without housing have excessive rates of substance use issues and mental health challenges, higher rates of suicidal behavior and HIV risk, and are more likely to be victims of violence (Keuroghlian et al., 2014).

Similarly, substance use is comparatively high within the trans community. Among transgender individuals, there are higher rates of use for alcohol, illicit drugs, and non-medical prescription drugs compared with the cisgender population (Glynn & van den Berg, 2017). Reasons for the higher prevalence of substance use among trans people include the prevalence of intimate partner violence, low-income status, housing instability, PTSD, and participation in sex work (Keuroghlian et al., 2014). In fact, 35% of trans people who have experienced verbal harassment in school, physical or sexual assault, or have been expelled from school report using substances as a coping mechanism for these gender-related traumas (Keuroghlian et al., 2014). Furthermore, the psychological stress of disparities in healthcare access that trans people experience is another trauma that worsens mental health and increases the likelihood of substance use. This stress also leads to decreased healthcare utilization, which puts the trans population at increased risk under the minority stress model (Keuroghlian et al., 2014).

FURTHER DISPARITIES WITHIN LGBTQIA+ SUBSTANCE USE RESEARCH

Despite well-documented disparities, research on the mental health outcomes of LGBTQIA+ people of color lacks nuance and heterogeneity, with many studies grouping people of color into one singular group or looking only at Black and Hispanic populations (Allen & Leslie, 2020; Eisenburg et al., 2022). However, people of color in the LGBTQIA+ community require due diligence and nuance regarding research. For example, Drazdowski et al.'s (2020) study surveyed 200 LGBTQIA+ people of color about their experiences with racism, LGBTQIA+ discrimination, and substance use. The study found that being both a person of color and LGBTQIA+ puts one at a higher likelihood of using all researched types of "illicit drugs," disaggregating data based on experiences of internalized racism, homophobia, and discrimination based on both identity groups (Drazdowski et al., 2020).

Eisenburg et al.'s (2022) study displays that Latinx and Black trans youth are the group with the highest prevalence of substance misuse of their age group. The experiences of multiple marginalizations and minority stress, including racism from within the LGBTQIA+ community, are likely to impact the prevalence of service utilization and completion (Cyrus, 2017). Therefore, a more thorough analysis of varied racial groups' substance use trends, treatment access, and treatment outcomes may help improve health outcomes for those from diverse cultures and experiences. While advocacy groups like the Trevor Project and aforementioned researchers are working toward expanding the research and data on this topic, the absence of earlier research suggests there is still a long way to go (2022 National Survey on LGBTQ Youth Mental Health, 2022.; “*Substance Use and Suicide Risk Among LGBTQ Youth*,” 2022).

ACCESS TO SUBSTANCE USE TREATMENT IN THE LGBTQIA+ COMMUNITY

The reasons canvassed above prove the necessity of using trauma-informed, community-based, holistic, person-in-environment centered treatment modalities for substance use in LGBTQIA+ populations. However, only 17% of substance-use treatment centers provide queer and trans-specific programming (Williams & Fish, 2020). Plus, it can be even more difficult outside of large metropolitan areas such as those in New York and California to find such programs (Senreich, 2010). Despite the clear need for these services, culturally competent substance use treatment remains scarce (Williams & Fish, 2020).

Data is lacking on whether access to queer and trans-specific treatment modalities has improved treatment outcomes compared to programming that is not specific for the LGBTQIA+ population (Senreich, 2010). One exception is a study which examined the outcomes of participants in an Austin, Texas-based recovery housing facility for men who have sex with men (Mericle et al., 2020). The study displayed that relief from minority stress factors while in a queer-specific treatment facility led to positive outcomes according to qualitative analysis, suggesting that replicas of such models might be beneficial. Additional evidence shows that LGBTQIA+ individuals have lower completion and abstinence rates on average in substance use treatment than their cisgender, heterosexual peers, due to a lack of affirmation of their sexual orientation in treatment (Senreich, 2009). Various aspects of the queer and trans experience complicate the potential for success in traditional substance use-related services. Twelve-step programs, such as Alcoholics Anonymous (AA), have higher success rates among those who identify as part of the group and believe in a higher power (Vareed & Mendoza, 2019). Since

LGBTQIA+ people might be more uncomfortable with the religious aspect of 12-step programs due to the fear of certain religious groups displaying homophobia or transphobia (Vareed & Mendoza, 2019), healthcare providers should encourage seeking out LGBTQIA+ specific groups.

In a first-person account, Jain (2019) describes their experience in a Queer People of Color AA meeting in the San Francisco Bay Area: "AA is not the only model that responds to alcoholism. Scholars of the history of the Alcoholics Anonymous program have pointed out that the program often eclipses harm reduction approaches. Even as I dream of the abundance of those options," Jain adds, "I believe in that meeting. In the embodied warmth of the church room in Oakland, in the happy babbling of children, and in the clasped hands of queer people choosing to save each other" (para. 21). A study in British Columbia reflected the sentiment, finding that queer and trans men thought that even existing harm reduction services in their area were usually inaccessible, unsafe, and a space where they experienced judgment from providers (Goodyear et al., 2021). Many participants feared they would face drug charges due to using services. For example, young queer and trans men sometimes chose not to use drug-checking services, which screen for the presence of risky substances, including fentanyl, because of the concern that the police would stop them (Goodyear et al., 2021). Since queer and trans people have had a long history of struggle with police harassment, drug criminalization is a massive issue for the LGBTQIA+ population, especially for people of color, who are even more at risk of police harassment and violence (Goodyear et al., 2021). Professionals in the field should consider these facts when striving to create more accessible substance-use services.

BEST TREATMENT PRACTICES

The following section presents a case for five models of care that have been shown to improve treatment utilization and outcomes by considering statistical differences in substance use among the LGBTQIA+ population, historical and cultural themes of the people, and treatment access trends. Several models are discussed, including implementing integrated behavioral healthcare to improve access and utilization of care, implementing treatment models tailored for the trans population to address disparities, and providing treatment for co-occurring PTSD and SUD. As these disorders are prevalent among queer and trans people, adopting harm reduction strategies that account for cultural realities within the LGBTQIA+ community and putting into action means of crisis de-escalation outside of policing systems are required actions.

BEHAVIORAL HEALTH INTEGRATION

According to the Integration Academy, "Integrated behavioral health care blends care in one setting for medical conditions and related behavioral health factors that affect health and well-being" (“What is Integrated Behavioral Health? [WIBH?],” n.d., para. 2). When working within an integrated care model, providers must recognize that physical and behavioral health are interrelated and that clinicians working on both sides of the healthcare sphere must work together to treat patients and help them meet their health goals (“WIBH?”). This convenience makes it easier for patients to access behavioral healthcare treatment, which is significant given challenges with access in the trans community. However, most healthcare professionals have not received training to work in that system (“WIBH?”). In the highest level of integrated care, there is complete collaboration between providers in a merged practice within the same building (Keuroghlian, n.d.). Advocating for more training and services in LGBTQIA+-specific integrated behavioral healthcare is imperative in order to reduce the disproportionate risk of substance use. Fenway Health, a Boston-based LGBTQIA+-focused healthcare center, is a leader in this field. Fenway Health psychiatrist Dr. Keuroghlian (n.d.), explains that Fenway’s integrative behavioral healthcare improves the patient experience because its holistic approach reduces stigma around substance use and mental health while simultaneously improving access to treatment and reducing healthcare costs. In addition, Keuroghlian affirms that treating opioid use and psychiatric disorders simultaneously has positively impacted outcomes.

TRAUMA-INFORMED, LGBTQIA+-SPECIFIC TREATMENT MODELS

The literature broadly suggests a person-in-environment model that is holistic and also trauma-informed is the best course of action. Due to the disproportionate rates of substance use and lack of access among trans individuals, this section will focus on treatment models for trans substance users. As a treatment model, Behavioral Health Integration for this population should take place in an environment tailored for the LGBTQIA+ community specifically (Keuroghlian, n.d.). Clinicians need to be aware of the minority stress model and implement a trauma-informed framework that centers on the realities faced by people impacted by minority stress and that highlights the strengths of the LGBTQIA+ community (Keuroghlian et al., 2014). Given that queer and trans individuals are more susceptible to having a background of trauma associated with violence compared to the cisgender, heterosexual population, adopting trauma-informed practices is critical in mitigating the likelihood of substance use relapse (Vareed & Mendoza, 2019). Hence, interventions should celebrate identity.

TREATMENT OF CO-OCCURRING PTSD AND SUBSTANCE USE: THE SEEKING SAFETY STUDY

Like in Dr. Del Castillo's (2017) story about the lonely rat in the cage, fostering relationships and community while acknowledging and mitigating the impacts of the societal "cage" of transphobia and homophobia can be essential factors in preventing substance misuse. Supporting individuals impacted by minority stress also requires being trauma-informed. Integrated treatment for people who have suffer from both substance use disorders and PTSD is impactful in improving both diagnoses (Keuroghlian, n.d.). A 2017 study called Seeking Safety sought to address substance use through a holistic model (Empson et al., 2017). Seeking Safety is a treatment program that uses cognitive behavioral therapy for co-occurring PTSD and substance use disorder. It was tested in 12 sessions with a group of women of trans experience who are HIV positive. The study improved all three outcome measures: PTSD symptoms, alcoholism, and substance use (Empson et al., 2017). This study shows the importance of confronting substance use in the trans community holistically, in line with the concept of integrated behavioral healthcare (Empson et al., 2017).

HARM REDUCTION

Harm Reduction International defines harm reduction as "policies, programmes, and practices that aim to minimize negative health, social and legal impacts associated with drug use, drug policies and drug laws" (“What is Harm Reduction?” para. 1). Harm reduction is a rights-based approach that focuses on support without discrimination. This philosophy implies that models which do not prescribe harm-reduction strategies may involve discrimination, which explains why marginalized communities have historically led efforts toward harm-reduction. Ripley Soprano, one of the producers of the Brujas World video, does this well with his production of harm reduction kits, which include practical tools for safer sex and drug use as well as more artistic items, such as a sticker that says "suck d***, carry Narcan" (Kuwabara Blanchard, 2020, para. 6). According to Soprano, "so much of harm reduction practices and theories came out of sex working communities, people who are chemically dependent, sick and disabled people, and communities of care made up of gay men of color and trans women of color" (Kuwabara Blanchard, 2020, para. 5). Soprano expands by asking, "What if the whole kit was super-vibrant and didn't look so clinical? What if it was both a piece of utility and a piece of political propaganda?" (Kuwabara Blanchard, 2020, para. 5). Such creative approaches to harm reduction may reduce stigma and increase service utilization.

Another group which focuses on harm reduction education is Queer Appalachia (Worlley, n.d.). Their website explains that "with the disheartening and exponentially increasing rate of opioid use in Appalachia, there is nobody in the region who doesn't play a role" (Worlley, n.d., para. 2). On queerness, they state, "As if being queer in rural regions isn't isolating and ostracizing enough, the addition of trying to recover only further exacerbates these experiences" (Worlley, n.d., para. 2). For queer communities, the government has been unsuccessful in providing impactful and accessible services when it comes to substance abuse treatment, especially if the intersection of race is considered (Dradzowski et al., 2022). For this reason, communities have turned to harm reduction and mutual aid practices to support their loved ones and community members in a way that does not rely on government support.

CRISIS INTERVENTION OUTSIDE OF POLICING

The criminalization of substance use is intrinsically linked to the history of racism in the U.S., with disproportionate negative impacts on people of color. Plus, as previously discussed, there is a collective trauma associated with police violence in the LGBTQIA+ community. Hence, building methods of crisis intervention that exist outside of the policing and carceral systems is another critical next step in supporting LGBTQIA+ people who use substances (Alang et al., 2017; Atlas, 2021; Bor et al., 2018; Goodyear & Knight, 2021). For example, implementation of crisis intervention models outside of policing has proven impactful among the general population in Portland, Oregon through the Crisis Intervention Helping out on the Streets program, which proved successful not only in de-escalating crises, but also reducing costs and leading to only a 1% need to obtain police backup ("Cahoots Media Guide," 2020). In addition, implementing this model in communities could increase access to care by drawing a direct line between communities and behavioral health providers, instead of a line between substance users and the carceral system.

CONCLUSION

There is still limited government funding for LGBTQIA+ affirmative substance use-related services and higher substance user rates, help-seeking behaviors, and treatment completion rates (Vareed & Mendoza, 2019). From literature assessment, historical and cultural factors, and statistics, this paper concludes that while more research and funding are certainly needed to support this vital issue, service models must additionally be rethought to best support LGBTQIA+ communities. Effective models which may reduce the detrimental effects of minority stress on those in the LGBTQIA+ community who use drugs include integrated healthcare, trauma-informed, LGBTQIA+ specific treatment models, cognitive behavioral therapy focusing on co-occurring PTSD and substance use disorder, harm reduction, and crisis intervention outside of policing. In the words of Jain (2019):

> What might it look like to build models of care for alcohol abuse that, instead of just including queer people, begin with us in mind? Models that recognize the interconnectedness of social marginalization and alcohol abuse instead of pathologizing alcoholism? That commemorate the small victories of survival in a deeply homophobic world? That to accept and even celebrate that sometimes, you have to hide parts of yourself? (para. 15)

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Enhanced Cognitive Behavioral Therapy (CBT-E) as an Intervention for BIPOC Adolescent Girls with Eating Disorders

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ABSTRACT

Eating disorders (ED) have some of the highest mortality rates of any mental health condition due to medical complications and high rates of suicidality. Black, Indigenous, and People of Color (BIPOC) adolescent girls and women are at especially high risk for developing EDs, which can have numerous negative mental and physical health consequences. Enhanced Cognitive Behavior Therapy (CBT-E) is a transdiagnostic cognitive behavioral treatment for EDs that, although originally designed to work with adults, has been shown to be effective with adolescents. Despite CBT-E's proven efficacy across age populations, there is limited research on its effectiveness with BIPOC individuals. We argue that with culturally informed, competent, and sensitive clinicians, CBT-E can be used to treat underdiagnosed and undertreated BIPOC adolescent girls, whose EDs have been unjustly overlooked.

Eating disorders (EDs) are serious mental health diagnoses within the United States, warranting the attention of social workers and clinicians due to their high mortality rates (Arcelus et al., 2011; Johnson et al., 2002; National Institute of Mental Health, 2021; Striegel-Moore & Bulik, 2007). Many EDs begin in adolescence and can have negative consequences on mental and physical health (Micali et al., 2014; Verschueren et al., 2020). Women and adolescent girls are especially at risk due to societal pressure to conform to the "thin ideal" (Striegel-Moore & Bulik, 2007). Black, Indigenous, and People of Color (BIPOC) women and girls are even more vulnerable because the existence of EDs among them has been ignored by researchers and practitioners alike, leading to a general lack of research and treatment (Gilbert, 2003; Rodgers et al., 2017; Sonneville & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015).

It is vital that social workers have an adequate, evidenced based intervention to address the gap in treatment for BIPOC adolescent girls. This paper proposes Enhanced Cognitive Behavioral Therapy (CBT-E) as an effective intervention for treating BIPOC adolescents with EDs, as it is highly adaptable and has been shown to be effective with adolescents (Fairburn, 2008; Cooper & Grave, 2017). Although there is little research on CBT-E's effectiveness with BIPOC individuals, we argue that the inclusion of culturally competent care will allow for accessible and effective treatment.

EATING DISORDERS

Eating disorders (EDs) are a serious mental health concern globally and within the United States. About nine percent of all Americans will be diagnosed with an ED at some point in their life, and more than a quarter of individuals with an ED will attempt suicide (Arcelus et al., 2011; Deloitte Access Economics, 2020). EDs are more prevalent among women than men, mostly due to societal pressures placed on them.

Although men are also faced with pressure to conform to an ideal body type, women face constant exposure to society’s “thin ideal,” or the notion that worth and beauty are dependent upon body size and shape (Striegel-Moore & Bulik, 2007). This pressure can cause women mental distress about their current weight and body shape, which can lead to the development of extreme and unhealthy attitudes or behaviors around food and eating habits. There are multiple types of EDs, the three most common being binge eating disorder, anorexia nervosa, and bulimia nervosa (National Institute of Mental Health, n.d.).

EATING DISORDER TYPES

Of the multiple ED diagnoses in the DSM-5, anorexia nervosa and bulimia nervosa are most likely to begin in adolescence (Striegel-Moore & Bulik, 2007). Anorexia nervosa, which has the highest mortality rate of all EDs, is commonly characterized by extremely restrictive eating and food avoidance, an obsession with one’s weight, and a significantly low body weight (Arcelus et al., 2011; Johnson et al., 2002; National Institute of Mental Health, 2021; Striegel-Moore & Bulik, 2007). There are two subcategories of anorexia nervosa: restrictive type, which is described above, and binge-eating/purging type, which includes episodes of binging—consumption of a large amount of food in a short amount of time—and purging through vomiting, laxatives, or diuretic use (National Institute of Mental Health, 2021). Bulimia nervosa is characterized by episodes of eating large amounts of food in a short period of time followed by purging through vomiting or use of laxatives or diuretics, fasting, or excessive exercise. Binge eating disorder, which is the most common ED in the United States, is characterized by an individual losing control and eating a large amount of food in an unusually short time, without any form of purging, fasting, or excessive exercising afterwards.

ADOLESCENTS

ED symptoms often begin to present in adolescence (Micali et al., 2014; Verschueren et al., 2020). Adolescent girls experience the dual stressors of societal pressure to ascribe to the “thin ideal” and a natural increase in weight as they transition through puberty, which may lead to discontent with their body shape (Verschueren et al., 2020). Thus, ED symptoms such as body dissatisfaction, restrictive eating, and purging begin to appear. Adolescents are particularly at risk if they suffer from perfectionism or low self-esteem, which can increase the likelihood of internalizing the “thin ideal” due to an increased reliance on the opinions of others (Keel & Forney, 2013). Social media exposure and peer influences, namely through the selection of peers with shared insecurities about weight and body shape, also work to perpetuate EDs by reinforcing these insecurities.

The onset of EDs in adolescence can have numerous negative consequences on an individual’s mental health (Micali et al., 2014; Johnson et al., 2002; Verschueren et al., 2020). For example, EDs are closely correlated with anxiety and depression in what appears to be a cyclical relationship, wherein one perpetuates the other (Verschueren et al., 2020). Adolescents with EDs are also more likely to have difficulty regulating their own behavior, as well as having a dysfunctional self-evaluation caused by placing too much value on their body weight and shape. EDs are also related to feelings of being a burden to one’s family and can negatively impact one’s social relationships (Micali et al., 2014). Finally, EDs are associated with higher levels of suicidality and mortality (Johnson et al., 2002).

BIPOC CONSIDERATIONS

Historically, researchers have falsely believed that EDs are most common among White, upper-class women (Striegel-Moore & Bulik, 2007). This belief is in part because ED symptoms can differ by race or ethnicity; some researchers argue that this perceived difference in the prevalence of EDs between White women and BIPOC women may be due to cultural differences in beauty standards and ideal body types, with White cultures placing more value on the “thin ideal,” resulting in differences in body dissatisfaction and ideal body weight (Gilbert, 2003; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). Symptoms may therefore manifest differently for BIPOC women than they do for

White women (Talleyrand, 2015). However, many experts posit that globalization and the spread of Western culture will cause the thin ideal to become more prevalent, thereby diminishing cultural differences in rates of EDs (Striegel-Moore & Bulik, 2007).

The false belief that EDs exist only among White women has led to a lack of research on EDs in the BIPOC community (Striegel-Moore & Bulik, 2007). BIPOC women and girls are also less likely to seek or receive treatment for an ED for a variety of reasons, including clinician stereotyping or bias, limited resources, and mistrust of the health and mental health systems (Gilbert, 2003; Sonneville & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). In addition, Black and Latinx adults and children have the highest rates of obesity in the US and are therefore less likely to be diagnosed with EDs, as clinicians working with overweight women often focus on weight loss and therefore fail to recognize symptoms of EDs among this population (Stierman et al., 2021).

Despite the fact that BIPOC women have comparable rates of EDs to White women, many risk factors are specific to BIPOC women (Talleyrand, 2015). These include level of acculturation, low levels of racial or ethnic identity, and experiences with racial oppression. High levels of acculturation appear to be a risk factor for Latina women, for example, because their culture of origin may place less value on thinness than mainstream White American culture, while the opposite appears to be true for Asian American women (Gilbert, 2003; Talleyrand, 2015). High levels of racial and ethnic identity, on the other hand, may protect women from mainstream White beauty standards, while experiences of oppression can create feelings of powerlessness that may result in the development of EDs as a coping mechanism (Talleyrand, 2015). Thus, the presentation of EDs for BIPOC women may differ from the current clinical understanding, which centers the experiences of White, upper-class women. More research is needed to understand the complexities of EDs and best treatments for BIPOC women.

RESEARCH LIMITATIONS

There is little research available regarding EDs among BIPOC adolescent girls. Rodgers et al. (2017) studied the prevalence and expression of EDs among overweight adolescent girls and found that overweight Asian American girls, compared to Black, Latina, and White girls, had the highest risk of overeating; White overweight girls had the second highest risk. Black overweight girls were most at risk for partaking in unhealthy behaviors such as fasting, purging, and food restriction to control their weight, and Latina and White overweight girls had the highest rates of dieting. Interestingly, the findings suggest that Black girls may be at greater risk for binge eating in early adolescence, while risk among White girls increases with age.

Overall, it appears that BIPOC women and adolescent girls experience EDs at similar rates to their White counterparts. Despite an increase in the number of studies that are beginning to demonstrate this fact, BIPOC women are still underdiagnosed and undertreated, due to a variety of factors (Gilbert, 2003; Sonneville & Lipson, 2018; Striegel-Moore & Bulik, 2007; Talleyrand, 2015). It is vital to understand the different ways EDs develop and present based on an individual's culture, race, or ethnicity in order to more effectively treat the diverse women and girls who experience EDs. This is especially important for adolescent girls, who are in a highly vulnerable developmental period at the age that EDs often begin (Micali et al., 2013; Verschueren et al., 2020). Studies suggest that adolescent girls are at equal, if not higher, risk for developing such disorders compared with adult women (Rodgers et al., 2017).

ENHANCED COGNITIVE BEHAVIORAL THERAPY (CBT-E)

Enhanced Cognitive Behavior Therapy (CBT-E) is a leading empirically supported transdiagnostic cognitive behavioral treatment for EDs (Fairburn, 2008). The transdiagnostic theory of EDs is based on the finding that the primary maintaining processes for each ED diagnosis largely overlap (Atwood & Friedman, 2020). Because of this, CBT-E was developed to address the psychopathology of EDs as a whole. It is a treatment for all forms of EDs, including anorexia nervosa, bulimia nervosa, and binge eating disorder (Fairburn, 2008). CBT-E also allows patients with EDs to learn how their disorder functions, how it is maintained, and how to disrupt the self-reinforcing cycle of the ED (Murphy et al., 2010).

CBT-E was initially developed for individuals in outpatient treatment settings, but there are also guidelines for implementation as an intensive form of day treatment, inpatient treatment, or group therapy (Fairburn, 2008). According to the Centers for Disease Control and Prevention (CDC), adults 20 years old and older with a BMI under 18.5 kg/m2 are considered underweight (CDC, 2022). Individuals with a BMI of 17.5 kg/m2 or more, who are not significantly underweight (Murphy et al., 2010), are advised to attend twenty therapy sessions over twenty weeks. For individuals with a BMI between 15.0 and 17.5 kg/m2, who are significantly underweight and are subject to marked physical and psychosocial effects (Fairburn, 2008), weight restoration is the main treatment aim, and forty sessions over forty weeks are advised. Similar to other evidence-based CBT treatments, CBT-E is highly individualized, which requires patients and clinicians to work together to develop a personalized treatment plan based on an individual's symptoms, core pathology, and triggers. The psychoeducation component of CBT-E addresses the distorted beliefs that contribute to patients' EDs.

TREATMENT STEPS OF CBT-E

According to Fairburn (2008), CBT-E usually starts with a one-and-a-half to two-hour evaluation session, followed by twenty fifty-minute therapy sessions over the course of twenty weeks. The first eight sessions, including the evaluation session, are held twice a week, followed by ten weekly sessions and three final sessions every other week.

There are four stages associated with CBT-E (Fairburn, 2008). Stage one is the intensive initial stage, called "starting well." During this stage, patients meet clinicians twice a week for four weeks. They spend the first few weeks of the treatment gathering information about the disorders and carefully considering the reasons for and against change. Then an individualized treatment plan is developed, and patients are informed of its utility, structure, and homework. Research on EDs has shown the magnitude of change in the first few weeks of treatment is a strong predictor of treatment outcomes, so these initial weeks are especially crucial.

Sessions in stage one include weekly weigh-ins to help patients understand natural fluctuations in weight; this data is plotted on a graph to give individuals a better understanding of weight trends. Patients may not weigh themselves outside of these sessions (Fairburn, 2008). Homework between sessions includes self-monitoring forms to record everything consumed, cognitions and emotions while eating, any excessive eating or drinking, use of laxatives or diuretics, bouts of purging, and any compensatory actions in response to eating. Self-monitoring forms not only increase patients' self-awareness around eating behaviors, but also provide a structured log for practicing skills so they can address any barriers. Clinicians also introduce regular eating to patients, which entails eating three meals and three snacks per day in regular intervals, not exceeding four hours without eating.

Stage two of the treatment, the transitional stage, is called "taking stock" (Fairburn, 2008). In these sessions, clinicians review progress and help patients identify and address any barriers they encountered between sessions, such as resistance to change, not prioritizing the treatment, depression, poor planning, and low self-esteem. Then, clinicians and patients review and modify the initial formulation of the disorder based on the information collected over several weeks of self-monitoring. For example, if patients are not able to follow their dietary plan when they are angry or anxious, they would need to add mood changes as a trigger for binge eating to their existing formulation.

After modifying the initial formulation, clinicians and patients must decide whether to use a broad or focused version of CBT-E for the remainder of the treatment (Fairburn, 2008). The focused version exclusively addresses ED psychopathology, while the broad version is only recommended if one or more external mechanisms, such as clinical perfectionism, core low self-esteem, or marked interpersonal difficulties, are identified to be maintaining the disorder and preventing change (Cooper & Grave, 2017). Normally, the focused form is the default because it is more effective and easier to implement; it is used with most patients who can be safely managed as outpatients. Once clinicians and patients determine which mechanisms to address and in what order, based on the patient's needs and presentation, they develop a treatment plan (Fairburn, 2008).

In stage three, the intensive treatment stage which comprises eight weekly sessions, clinicians and patients address key mechanisms that maintain the ED: body image; dietary restraint; and events, moods, and eating (Fairburn, 2008). The clinician addresses patients' overvaluation of body shape and weight by providing psychoeducation about overvaluation and its consequences. This helps to develop formerly ignored domains of self-evaluation; reduce unhelpful body checking and avoidance (e.g., mirror checking and comparing bodies); relabel unhelpful thoughts (e.g., feeling fat); examine the origins of the overvaluation; and learn to identify and modify the mindset surrounding the ED (Cooper & Grave, 2017). Additionally, clinicians help patients change rigid dietary rules into flexible guidelines for eating, introduce previously avoided foods, and develop problem-solving and mood-regulation skills. If clinicians decide to use the broad version mentioned in stage two of the treatment, they address the external mechanism in addition to the general psychopathology.

Stage four, called "ending well," is the final stage of CBT-E (Fairburn, 2008). It consists of three sessions that take place every other week. During the final part of stage three and in stage four, the emphasis shifts from treating the existing problem to looking toward the future. In this stage, patients work with clinicians to address their reactions and concerns about ending treatment and find ways to maintain progress. The goal is for patients to be able to apply learned skills independently, so as to handle setbacks and maintain the changes that have already been made in order to minimize the risk of relapse. Together they devise a short-term maintenance plan for patients to utilize until their review appointment, which occurs twenty weeks after the final session.

In stage four, clinicians help patients phase out treatment procedures and homework (Fairburn, 2008). For example, patients stop self-monitoring records and in-session weighing in week eighteen. Patients learn to be aware of what they eat, what happens throughout the day, and their urges to engage in ED behaviors without the aid of self-monitoring forms. Patients also start to weigh themselves at home with an open mind about their weight and identify strategies to prevent relapse, including listening to joyful music, reaching out to friends and family for support, exercising (CBT-E, n.d.), and engaging in relaxation techniques, such as deep breathing and mindfulness practices. They may also identify helpful preventive strategies such as avoiding certain people, places, or stimuli when they experience urges to binge eat. Finally, during this final stage, clinicians educate patients about realistic expectations for recovery, devise a long-term maintenance plan to deal with setbacks, and encourage patients to seek help from professionals to address these issues (Fairburn, 2008).

Twenty weeks after the conclusion of treatment, patients are asked to return for a post-treatment review session (Cooper & Grave, 2017). A questionnaire is used to assess the present state of the ED and whether daily function is impaired by the ED (Fairburn & Beglin, 1994; Bohn & Fairburn, 2008). In addition to the assessment, the review also includes a recap of patients’ progress throughout the entire treatment, a short-term plan for how patients can continue to address the remaining symptoms, and strategies to handle setbacks. Clinicians also review the long-term maintenance plan with patients to see if any necessary changes are needed (Fairburn, 2008).

EVALUATION AND MEASUREMENT IN CBT-E

In CBT-E, patient outcomes are observed through pre- and post-assessments as well as session-by-session symptom measurements. These measures include the Eating Disorder Examination (EDE), with versions available for both children and adults (Cooper & Fairburn, 1987; Hilbert et al., 2013); the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn, 2008); the Clinical Impairment Assessment (CIA; Bohn & Fairburn, 2008); the Clinical Perfectionism Questionnaire (CPQ; Fairburn et al., 2003); the Eating Problem Checklist (EPCL; Dalle Grave et al., 2019); and the Starvation Symptoms Inventory (SSI; Calugi et al., 2017).

CBT-E WITH ADOLESCENTS

The content of CBT-E for adolescents is similar to that of adults, although it tends to be shorter because adolescents are typically capable of changing their behaviors faster than adults (Cooper & Grave, 2017). For example, underweight adolescent patients may only need thirty sessions to complete the treatment, instead of the typical forty sessions. A major modification of the treatment for adolescents is parental involvement. Because a significant number of adolescents receiving treatment are younger than eighteen, parental involvement is necessary. In the first two weeks of the treatment, the clinician has assessment sessions alone with the parents. Afterward, fifteen- to twenty-minute joint sessions with the adolescent and parents are conducted throughout the course of treatment to update parents on treatment progress. The joint sessions also educate parents about the nature of their child's ED, the rationale of treatment interventions, and how they can help their child during the treatment process. The number and frequency of these joint sessions depend on each patient's situation.

EFFECTIVENESS AND LIMITATIONS OF CBT-E

There are many reasons CBT-E is useful in both clinical and social work practice: it can be used in both inpatient and outpatient settings, has a fixed length, and uses specified strategies and procedures to address ED psychopathology through four well-defined stages (Fairburn, 2008). Additionally, it encourages the establishment of "therapeutic momentum" that is needed early in treatment to make inroads in addressing the ED, helps ensure clinicians and patients keep working to achieve change, and increases the likelihood that treatment will have a formal ending.

Additionally, although there is limited research on the effectiveness of CBT-E among younger patients, many considerations support the proposal that CBT-E might be especially suitable for them (Cooper & Grave, 2017). CBT-E is designed to increase patients' self-control, which can benefit most adolescents, and enhance motivation, a goal that is particularly relevant for underweight adolescent patients. CBT-E also adopts a flexible and individualized approach that is easily adaptable to the needs of adolescents' cognitive development; moreover, it promotes autonomy, which is particularly relevant to adolescents, who respond favorably to collaborative treatment. Finally, CBT-E has been adapted for adolescents in a way that takes their physical health into account because the prevalence of medical complications associated with EDs is particularly severe for adolescents. As a result, there is a lower frequency of hospital admissions among adolescents in CBT-E treatment.

Studies on CBT-E with adolescents have shown a significant improvement in the BMI in adolescent participants with anorexia nervosa, as well as decreases in their clinical impairment scores, ED psychopathology, and general psychopathology scores (Dalle Grave et al., 2013; Dalle Grave et al., 2020; de Jong et al., 2020). They have also demonstrated that patients are able to maintain improvements even after treatment is completed (Signorini et al., 2018). Although this research is primarily focused on anorexia nervosa, the transdiagnostic feature of CBT-E suggests its effectiveness with all EDs.

Even with the many benefits of CBT-E, some limitations need to be addressed through additional research. Despite a low remission rate for individuals who participate in CBT-E, it does not work for everyone. Around 50% of individuals do not fully recover using CBT-E, with some showing no improvements at all (Linardon et al., 2018). Similarly, around 25% of individuals drop out of treatment prematurely due to dissatisfaction. The current research does not specifically address multiple comorbidities that individuals with EDs may experience and does not address other relevant factors to the disorder, such as shame or trauma. More importantly, there is a lack of evidence that CBT-E treatment works across ethnic, racial, and socioeconomic groups.

Despite the lack of research on the effectiveness of CBT-E with BIPOC individuals, we argue that the individualized and cooperative nature of the treatment allows clinicians to assist individuals in constructing culturally appropriate treatments. As such, we suggest adding a component during the initial planning stage that addresses patients' culture and beliefs around mental health and EDs. This addition would allow patients to bring up any culturally specific concerns, barriers, or accommodations they would like to include in their treatment. In the case of BIPOC adolescents, this component would involve parent and caregiver input as well. It is also vital for all clinicians working with BIPOC individuals to receive cultural competency training and speak the same language as those they are working with, preferably the client's first language, to maximize effectiveness.

CONCLUSION

Evidence-based treatments such as CBT-E are crucial for addressing EDs and their symptoms, which can lead to fatal consequences. We argue that CBT-E is efficacious in treating adolescents because it is highly individualized and promotes engagement in order to produce change. We believe our recommendations would aid in improving the quality of care for BIPOC adolescent girls and ultimately reduce further negative outcomes. However, due to a lack of evidence on the effectiveness of CBT-E for BIPOC adolescent girls in particular, further research is needed to examine the efficacy of the treatment and to develop CBT-E to be more culturally competent.

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Choosing a Frame:

How Medusa Tells the Story of Trauma and Life After Trauma

EZRA YURMAN-WHYDE

ABSTRACT

This paper names the elements of the Medusa myth that make it an uncanny allegory for trauma and examines the role of choice—both having choice and offering choice—in the treatment of trauma. It considers two perspectives on the myth: (1) Medusa as a captive object to the hero in the myth and (2) Medusa as an autobiographer, the narrator of her own story, and a subject working to establish more control over her own experience. This myth translates to the social work space. When a clinical social worker acts as the listener/observer and a patient as narrator/autobiographer, the social worker is uniquely positioned to support the patient in reclaiming life after trauma.

Keywords: Medusa, trauma, autobiography, Freud, Herman, Cavarero

The Gorgons turned men who looked into their living, venomous, snake-encrusted faces to stone. I wonder what might have happened if those men had known how to politely greet the dreadful chthonic ones (Haraway, 2016, p. 54).

To narrate is to edit and revise, to decide and imbue meaning. The narrator is the voice we hear, the voice which crafts our beginnings and endings and directs the process of mythmaking. The challenge of capturing one central myth of Medusa, sometimes called the Gorgon or Gorgo, lies in the transience of myth, with its various versions compiled through written and oral histories, each with details slightly adjusted to create a new myth. Each new myth has a different moral or ethical alignment and narrative.

Medusa's name refers originally to her role as a mindful ruler and guardian (Gordon, 2014). Her myth, captured by such classical authors as Homer, Hesiod, Ovid, and Lucan, likely originates from the classical Greek period of 500 BCE-336 BCE (Silverman, 2016). It is the story of a beautiful, mortal woman who is raped and turned into a monster. Medusa, said to be even more attractive than Aphrodite, draws the attention of Poseidon, the god of the sea, who rapes Medusa in the temple of Athena. The virginal, asexual goddess Athena, offended that her temple has been desecrated, punishes Medusa by transforming her countenance from beauty to horror, giving her a head of snakes. It is said that anyone who dares look at Medusa will be petrified in stone. But the brave and cunning Perseus, the hero of the story, uses a mirror to show Medusa her own reflection. By using her power against her, he turns her to stone and is able to decapitate her. Perseus takes the head of Medusa and wields it as a weapon along his journey, eventually gifting Medusa's head to Athena and saving a princess. The story ends happily in marriage between our hero Perseus and the princess, Andromeda.

The clinical social worker benefits from reconsidering the hero's perspective, particularly when approaching treatment with survivors of trauma. The clinical social worker may be tempted, consciously or unconsciously, to identify with the hero's narrative: Perseus, who set out to conquer the Gorgon, is a metaphor for the worker setting out to alleviate the psychopathology of trauma. The clinical social worker, no matter their good intentions, runs the risk of overexerting control in the treatment of trauma if the patient's sense of choice is not paramount. Attempts to optimize healing, alleviate pain, prioritize treatment protocols, or evade the trauma dismiss the painful, yet necessary, process of the patient grappling with the loss of control they once experienced. In the treatment of trauma, hope lies in the ability of the clinical social worker to see the patient with open eyes, to align with the patient, to revisit dichotomies of self vs. other, and to understand the reestablishment of commonality as the ability to recognize oneself in another, to commune, and to feel seen. By considering the perspective of Medusa, the clinical social worker comes closer to understanding the survivor's story, allowing the worker to become more adept at supporting the survivor in more fully stepping into their role as narrator of their own story, autobiographer charting their own narrative arc.

MEDUSA AS AN OBJECT IN PSYCHOANALYTIC THOUGHT

Medusa's long existence in the clinical imagination consists mostly of plucking her from context, creating an image on which to project meaning. For Sigmund Freud (1922/2003a), the Medusa myth is a means for illustrating the effects of the female body—particularly the mother's body—on the male subject. For the male onlooker, Freud claims that the phallic snakes resting atop Medusa's head are themselves "a mitigation of the horror, for they replace the penis, the absence of which is the cause of the horror" (Freud, 1922/2003a, pp. 84-85). Freud's framework positions Medusa as an object to be gazed upon, an object useful only for its effects on the male psyche, not herself a subject with an internal world.

Freud positions himself within a tradition of seeing Medusa as an object of horror. In tellings of the myth, Medusa's decapitated head is said to bring about the birth of Pegasus, the winged horse, and the blood that drips from her head is said to fall to the ground, transforming into snakes that now roam the desert of Libya (Hesiod, 700/2003). These iterations of the myth have historically taken up Medusa as a dead thing, not a person. Freud, too, is interested only in Medusa's detached head. Freud's male subject sees Medusa's head and is reminded of his own castration complex (i.e. "to decapitate = to castrate"; Freud, 1922/2003a, p. 84). As a locus for male psychosexual development, Medusa is made to symbolize an abject horror felt by a young boy seeing his mother's genitalia (Freud, 1922/2003).

Feminist thinker Sarah Kofman (1980/2003) categorizes Freud's account of Medusa's head symbolizing the embodiment of the mother's genitalia as fetishism, because the account deals primarily with the symbolic meaning of Medusa's parts rather than her whole role as a character in the myth. Not only does Freud (1922/2003a) deal primarily with Medusa's head cut from her body, "but the figure herself is cut away from, among other things, her relationship to her two sisters" (Gordon, 2014, p. 116). In his analysis of her parts, Freud names the various fragmented objects of Medusa "uncanny." He states that "severed heads" and female genitalia provoke the experience of the uncanny "double take," or an experience of seeing something so similar to something else, yet different, which causes unease—even horror—in the onlooker (Freud, 1919/2003b, pp. 150-151).

For the clinical social worker, Freud's reductive reading of Medusa serves as a warning. By adopting a schema that aligns with the hero's narrative, the clinician runs the risk of encouraging a framework which treats patients as clusters of symptoms (parts) and characterological traits to be overcome and changed (decapitated). Particularly in work with patients who have survived trauma, the popularity of trauma-informed manualized treatments and the mandate for efficacious progress to predicate reimbursability are at odds with the process of narrating: telling and retelling, reenacting, meandering and pausing, picking up at different places than where one left off, creating new directions of memory and thought that previously lay dormant or didn't previously exist. When the social worker ceases to see the patient as a human subject, instead favoring the proper operationalized intervention, the psychotherapeutic process becomes the actual uncanny thing—a forged replica, a capitalistic, hollowed endeavor that only hints at the original power of the therapeutic process that prioritizes connection.

MEDUSA AS A SUBJECT AND HER TRAUMATIC EXPERIENCE

Medusa does not have to exist solely as an object in clinical discourse; nor should she. I propose a clinical approach that, as psychologist and psychoanalyst Doris Silverman puts it, attempts to "find a liberating refuge in a symbolic figure with great and fierce power and freedom" (2016, p. 117). To grapple with Medusa as a subject is to see her as a person working through trauma. A reading of the myth that doesn't account for her surviving a brutal rape is, to say the least, limited. A close reading of Medusa's myth offers the opportunity to promote her subjectivity, agency, and choice–-an approach which can be applied in the clinical setting.

The frame with which the clinical social worker enters the therapeutic dyad tells its own narrative about the positionality of the worker and trauma survivor respectively. It is precisely the way of seeing self and other that has the capacity to empower and disempower and to promote commonality and separateness, connection and disconnection. The processes of telling one's own story, working it out, and inhabiting a self-other relationship in which one tells and one listens serve as reparative acts that reintegrate the survivor's sense of selfhood (subjectivity) within the larger context of their world. To offer a survivor the choice of determining their own narrative is one attempt the clinical social worker can make to imbue power and promote commonality in the therapeutic dyad, and by extension, support the survivor's reintegration into their everyday life.

In analyzing trauma, we can consider post-traumatic stress disorder as a culmination of uncanny experiences. The symptoms of PTSD include re-experiencing the trauma through flashbacks, somatic replication of the arousal state experienced during the trauma (hyperarousal), and reliving the event through nightmares. These symptoms are uncanny because of the unease they strike in their subject. By alluding to something familiar, the subject is forced to recollect the moment of the inciting traumatic event. Flashbacks are like memories, except they are disjointed relivings. Flashbacks are not integrated parts of self that serve the construction of a cohesive narrative; rather, they are fragmented and activating. They are involuntary jolts out of the present state. In Medusa's myth, the scenes that move the hero's narrative forward are predicated on men acting on Medusa: for example, Medusa's cave is entered without her permission by the men who attempt to conquer her.

Constriction, hyperarousal, and intrusion are the major post-traumatic symptoms that an individual may experience in the aftermath of trauma (Herman, 2015). Hyperarousal, or having an "extreme startle response" and "intense reaction" to otherwise benign stimuli, is a striking concept when contextualized in the Medusa myth, especially when it comes to the example of Medusa's decapitated head (Herman, 2015, p. 36). Her head, if we take Freud's view, is a horror, a frightening object that induces a startle response in the eyes of the onlooker. A defense mechanism first named by Melanie Klein, projective identification, is described as a two-step process: first, the patient projects a part of themself onto the other, and second, the other experiences "pressures" to feel and act in accordance to the cast off part (Issacharoff, A. & Hunt, W., 1994, p. 593). For Medusa, the act of looking is her act of projecting onto men the symptoms associated with trauma, notably the "intense startle response" of hyperarousal (Herman, 2015, p. 36). While projective identification is not characterized as a trauma response by Herman, she does detail the "involuntariness" of trauma responses, and notes that where there is involuntariness, there exist unconscious desires (Herman, 2015, p. 41). Hurt, isolated, and traumatized, Medusa develops a desperate, unconscious desire to rid herself of Athena's curse. She attempts to project her own fear and hyperarousal onto her onlookers in an attempt to free herself from reliving the traumatic experience.

Intrusion and its role in the lived experience of trauma appear when men visit Medusa's cave in an effort to tame and conquer her. Their attempts to enter Medusa's cave can be read as an allusion to the rape that begins the myth: as reenactments of her trauma. Intrusion and constriction characterize Medusa's responses to these men.[1] Medusa is cast as the embodiment of her intrusive thoughts, faced with reliving her trauma each time a man forces himself into her cave.

Intrusive thoughts and the compulsion to repeat behaviors assign the survivor the role of the repeater. The survivor plays out the trauma over and over again, just as Medusa involuntarily kills anyone attempting to conquer her. Their stone corpses strewn across her cave are reminders of every attempt to enter her. Here we glimpse constriction, or "paralysis of the mind": the "frozenness" of Medusa's destiny of destitution (Herman, 2015, pp. 35-45). Ovid (43-17/2004) highlights these monuments to Medusa's trauma when describing Perseus's entrance into the cave: "Across the fields and along the tracks he had seen the / statues / of men and of beasts transformed to stone at the sight of Medusa" (p. 170). She becomes a link in the chain of her own cycle of violence. Incapable of self-definition or voluntary action, she becomes unreachable, a woman whose gaze can never be met–-that is, paralyzed, stunted, and much like the petrified statues of men.

Herman notes that navigating the legal, familial, and social services systems in the aftermath of trauma can be retraumatizing if the survivor's sense of agency is not upheld. In the aftermath of Medusa's rape, she is punished by Athena, who attributes the trauma to Medusa's beauty. Once again, we see that Medusa, as the survivor, is considered only as an object and is blamed for the trauma forced

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[1] Intrusion deals with what Judith Herman calls the "indelible imprint" of, or fixation with, the traumatic moment (pp. 35-45). The phenomenon of constriction is defined by the "numbing response," or what Herman quotes Robert Jay Liston as naming a "paralysis of the mind" (pp. 35-45).

upon her. Medusa, in the aftermath of her trauma, is denied by Athena the opportunity to voice and define her rape on her own terms. In the absence of choice and connection, Medusa projects her trauma onto others: when Medusa turns her would-be conquerors to stone, she recreates a set of circumstances strikingly similar to her own. In one scene, Perseus displays Medusa's head to freeze his foe, Nileus, in battle:

> "To have such a hero as me for your killer / must surely console you amongst the voiceless shades." But / his final / words were cut off as he said them. To judge by his open / lips, / you'd suppose that he wanted to speak, but the sounds / couldn't find a way through. (Ovid, 43-17/2004, p. 185)

The head of Medusa freezes, stiffens, and silences. Perseus stops his foe from speaking mid-sentence, demonstrating the power of Medusa's gaze to take away others' agency through the act of silencing. Deprived of having the chance to speak for herself, she prevents others from speaking, even post-mortem.

Scholar of feminist narrative theory Teresa De Lauretis (1984/2003) explores subjecthood through the Medusa myth and posits that by inheriting the hero's narrative from classical mythology, we restrict our ways of seeing womanhood. De Lauretis (1984/2003) takes up Stephen Heath's assertion that seeing oneself through the other is a formula for subjecthood. Medusa is pursued as the horrific object par excellence, the thing to be slain. As men approach her, they hold a preconceived notion of what they will find. They are on edge, looking around every corner, expecting danger in their own state of hyperarousal. Hesiod (700/2003) goes as far as to describe Medusa as "unapproachable" (p.12). Upon noticing the presence of men, Medusa looks. She cannot see these others seeing her, for when she looks, she finds herself looking at stone, no one there to greet her gaze. Heath states, "If the woman looks, the spectacle provokes, castration is in the air, the Medusa's head is not far off; thus, she must not look, is absorbed by herself….” (as cited in De Lauretis, 1984/2003, p. 199).

Attached so closely to her trauma, Medusa is denied a life in which she is able to contextualize her traumatic experience within a broader understanding of her identity. Instead, she becomes defined by her trauma, caught and codified in her own myth. In this state, she is stripped of her agency, alone, unable to experience the subjectification born from seeing another see her. In framing Medusa as the monster and the men who come to tame her as the heroes, we are enabling a practice of limited perception and perpetuating the narrative of Medusa as a monster. That is, we are preserving her isolation, framing her as other and as the object of trauma personified.

Medusa’s is the canonical gaze that turns others to stone; it is therefore the gaze that cannot seem to see itself. If Medusa were to look at herself, would she not turn to stone? Without the capacity to gaze upon herself, she cannot offer herself a loving gaze, contemplate her own narrative, acknowledge her own fragility, or place herself within the context of the life she has lived. Without selfhood and the capacity to commune with her world, Medusa is a series of flashbacks, caughtness incarnate, repeatedly reliving her trauma.

Without the ability to see her whole self or to see herself through the eyes of another, Medusa is limited, if not completely inhibited, in her ability to gain self-awareness of her positionality in her world. Psychoanalyst Robert Bosnak (2007) writes of the necessity of narrative to contextualize and attach us to our own story: “Endless, stereotyped, fixed repetition is the exception, and such trauma will not reattach to the Renaissance patchwork of states, but will remain a body drifting in space” (p. 46). The ability to weave one’s experiences into the patchwork that is their life story is paramount for integration and healing from trauma.

Bosnak (2007) differentiates narrative memory from traumatic memory, which is the timeless, ahistorical, elusive, atypical flashback that the American Psychiatric Association (2013) names as a criterion in the diagnosis of Post-Traumatic Stress Disorder. He writes, “Flashback-type memory is completely different from the discursive, narrative memory of ordinary waking consciousness” (Bosnak, 2007, p. 46). He goes on to explain that the Greek word for revelation is apokalupsis (apocalypse). The earth-shattering *revelation* of meaning, Bosnak purports, is not found in the flashback. Instead, the startle, the uncanny, and the terror belong to the realm of the traumatic: the realm of Medusa. Herman (2015) takes up the notions of memory and time in her explication of the somatic aspects of trauma, describing the quality of traumatic memories as “frozen” in time (p. 37). She goes on to describe the uncanny, atemporal qualities of reenactments. Herman states that reenactments have feelings of “involuntariness,” that they are “driven, tenacious” in character, and that they fulfill a “repetition compulsion” and “death instinct” (2015, p. 41). Medusa’s reenactments and embodied traits of hyperarousal, constriction, and intrusion exemplify the “flashback-type” memories that Bosnak (2007) describes as not integrative, because there exists in them no revelation of meaning (p. 46). The act of gazing upon oneself to know oneself does not occur, because we do not see ourselves in a flashback; we see what happened to us. It is a repetitive stuckness: there is no going forward, no new knowledge, no mourning or grieving—only a reliving of what was.

GLIMPSING HEALING THROUGH NARRATIVE REINTEGRATION

A central complication of trauma is determining when something traumatic ceases to control the survivor and at what point the survivor is able to integrate their traumatic experience into the patchwork of their greater life experience. Symptoms of trauma look a lot like the healing of trauma—uncannily so. Herman (2015) posits the final stage of recovery for trauma survivors as reconnection. Empowerment is the core experience of recovery, and this stage of reconnection is characterized by a readiness to incorporate the lessons of one’s traumatic experience into their life. The importance of agency and choice is highlighted in Herman’s work concerning the stages of recovery for survivors of trauma, specifically “the choice to expose oneself to danger,” which, she states, can be understood as “another reenactment of trauma” (p. 197). The distinction between the stuckness of some reenactments and the freedom of this sort is the variable of choice: “an attempt to master the traumatic experience” that is “undertaken consciously” (Herman, 2015, p. 197). This conscious reenacting is a reclamation of one’s own life—reclaiming the traumatic and redefining it on one’s own terms—a process of finding alternate endings that are different from the traumatic moment itself. It is an ascription of new meaning between signifier and signified.

Particularly for clinical social work, a therapeutic narrative reclamation offers the patient the chance to reenter the role of narrator of their own life. The philosopher Adriana Cavarero (2000) establishes a methodology for narrative reclamation by illustrating how the act of silencing is the preluding act to one taking on the role of narrator, in which one must remain quiet for the other to speak, or that one must silence in order to be heard. With this perspective, we may question the involuntariness of Medusa’s repetition compulsions and cast them instead as intentional reenactments—attempts to regain her voice and narrative.

In attempting to define the subjective experience, two central questions arise: “*who* is speaking,” and “*who* is listening?” According to Cavarero, the act of autobiography serves to empower by offering the opportunity for the narrator (self) to practice self-determination through the crafting of their own story. Cavarero (2000) writes, “[T]o tell one’s own story is to distance oneself from oneself, to double oneself, to make oneself an other” (p. 84). This means seeing oneself in one’s memory and using recollection as a “separated mirror” (Cavarero, 2000, p. 84). We gaze upon ourselves to know ourselves. It is the distance from ourselves that allows us the space to see with clear eyes, not in fragmented parts, but as a whole. It is through the practice of autobiography that we are offered the opportunity to rewrite beliefs, ascribe new meanings, see ourselves without judgment, bear witness to our own fragility, and, in effect, to love ourselves:

> As the saying goes: Love is blind—not because it turns upon the invisible, but because it is without judgment with respect to that which others see. It experiences another type of gaze—a gaze that comes from the agonizing experience of finite being's appearance, in its constitutive fragility. (Cavarero, 2000, p. 112)

Cavarero defines the loving gaze as seeing in spite of or looking past judgment. There exists an intentionality to the loving gaze in choosing to see the other despite preconceived judgment. Medusa's myth holds potential for this kind of seeing. Precisely as Herman (2015) describes healing from trauma, awareness of reenactments is essential to healing. Intentional reenactments, when repeated over and over again, are small steps toward re-working and re-wiring ourselves into subjects who, through practice and time, come to acquire a certain command over our experience. We slowly and untidily become the narrators of our lives again. We can see the instance of the men's stupor as the moment that the role of narrator and protagonist transfers to Medusa. Medusa's intent to be seen and heard is what freezes the men. Medusa's act of being seen, turning her enemies to stone, and silencing them gives her a chance to reclaim the role of narrator and heroine.

We see Medusa's intentionality in the climax of her battle with her heroic counterpart. Perseus uses Medusa's own gaze against her to freeze and decapitate her. But there must be time between these two moments, freezing and decapitating, because as art critic and theorist Craig Owens asks, "how can Perseus cut off the head of a stone statue?" Owens (1984/2003) took up the Lacanian concept of *suture* and renamed it the "Medusa effect" (p. 207): the process of pseudo-identification in which two things are seen as one but are in fact separate (i.e., there is a difference between seeing something and the thing itself). Owens identifies the moment Medusa sees herself in the reflection of Perseus's mirrored shield as entirely different from the moment when she turns herself to stone. If Medusa is not in fact turned to stone upon seeing her reflection in Perseus's shield, she may have seen herself in the shields of her assailants all along. Through this reading, Medusa is imbued with a freedom, an agency, and a satisfaction in seeing herself. If she can see herself, her capacity for inhabiting the role of narrator lives on. She owns her willingness to be seen.

ANOTHER KIND OF GAZE

The Medusa effect allows the reader of the myth to glimpse intentionality: a decision is made when Medusa shows herself. If the act of seeing herself and of being seen are separate from that quintessential moment of stiffening, there exists a moment of time for a decision to be made—a moment for Medusa to make "the choice to expose [her]self," that is critical to her reentry into communing with the world (Herman, 2015, p. 197).

Medusa can be our heroine, pushing forward her own narrative. Gordon (2014) writes of Medusa as the "beautiful figure [who] can only wonder, quizzically…with a smile, at the frustrated men who would turn her beautiful hair into snakes, and her into a monster" (p. 123). Medusa stupefies only when she allows herself to be seen. Perhaps, in looking at her straight on, we glimpse Medusa looking at herself in a state of recollecting, as Cavarero (2000) suggests—distanced enough from herself, telling and retelling her own story. We glimpse a woman trying to put pieces together. Medusa is compelled by involuntary actions until the suture, or Medusa effect, is exposed and undone: until we shift our frame and see her with different eyes. And what of Medusa experiencing herself being seen through the eyes of another who is not afraid, not fetishizing her, but instead gazing upon her with "another kind of gaze," gentle, without judgment, and intent on preserving her sense of choice (Cavarero, 2000, p. 112)? A tender gaze that said *I'm here with you?* What if Medusa could experience this communion with another? She might be "as the drop of rain in the sea" (Herman, 2015, p. 236). What potentiality would exist for her then?

> Commonality with other people carries with it all the meanings of the word common… It means having a feeling of familiarity,

> of being known, of communion. It means taking part in the customary, the commonplace, the ordinary, and the everyday. (Herman, 2015, p. 236)

Herman (2015) emphasizes the necessity for survivors of trauma to focus on the development of desire and initiative, as well as commonality, in the process of reintegration. Telling one's story is itself an act of searching for common experience. Narrative is bridge-building, allowing one to escape the isolation of traumatic experience. There is potential for someone occupying the patient role to find hope in their own choice to decide when, how, and for whom they become vulnerable or show themself after trauma. Herman (2015) posits that healing is at least in part due to the individual's ability to acquire a multitude of experiences—some mundane—after a trauma, which serves to help recalibrate one's sense of an appropriate stress response to stimuli.

A clinical social worker who consciously or unconsciously emulates the decapitation of Medusa is one that promotes functioning in social and institutional systems founded on patriarchal power structures. The ramifications of containing the uncontainable in hopes of promoting acceptable modes of functioning for systems that are designed to oppress stifle self-definition and choice. It is Medusa's interlopers, and by extension, viewers who adopt the hero's narrative, who objectify and mitigate the anticipated horror they perceive in Medusa. It is Perseus' success in avoiding the act of facing Medusa head-on that enables him to decapitate her. To look head-on is something different. How then can the clinical social worker approach Medusa with clear eyes and a loving gaze rather than with the impulse to contain and manage?

Medusa's myth suggests that instead of being tempted to soothe all wounds, to rescue, and to make the trauma go away, the clinical social worker has a duty to see the patient as affected by their trauma but not defined by it, as someone whose actions may test, may push away, and may try to imbue those around them with feelings that are not their own. This is the patient working it out, finding their voice, calibrating, and learning to see themself and their world anew. As clinical social workers, we are alongside our patients, attempting to always expose the Medusa effect, continually moving toward the space in between the world and our understanding of it. It is in this space that the most important aspects of trauma treatment—choice, awareness, and intention—are seen.

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Disability and Self:

Critical Factors in Positive Adjustment After the Onset of Disability in Emerging Adulthood

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NATALIE CHRISTENSEN

ABSTRACT

Resiliency, self-efficacy, and social support are key factors influencing adjustment following the onset of chronic disability. The presence or absence of these factors influences the affected person’s perceptions of self, perceptions by others, and overall life satisfaction and confidence in their ability to achieve goals. This article assesses data collected from an open-ended interview with a single participant, D, organized by thematic analysis. It finds that D's resiliency, self-efficacy, and social support system significantly influenced her mindset and attitude toward life after being diagnosed with Multiple Sclerosis (MS). The author explores how these factors were influenced by the micro-, meso-, and macro-contexts in which D existed, focusing particularly on the context of her relationships with others. The paper concludes with recommendations for future research.

Over 1 billion people live with some form of disability and that number is increasing (World Health Organization, 2021). Some reports suggest that 15% of adults ages 60 and older report at least one functional limitation (Infurna & Wiest, 2016), while an estimated 5% of working Americans experience a short-term disability each year (Council for Disability Awareness, 2021). Research indicates the life stage in which one develops a disability may influence their developmental trajectory, since individuals face different responsibilities and priorities throughout the life course. As discussed by Lachman (2004), in emerging adulthood, individuals are generally healthy and therefore focused on milestones related to their career and personal life. Emerging adulthood is characterized as a time when young adults explore their newfound freedom and solidify their identities (Arnett, 2000). Developing a physical disability during emerging adulthood disrupts normative developmental trajectories and creates a stark contrast between life experiences gathered as an able-bodied person and life experiences following the onset of disability.

The development of a disability not only influences how a person views themselves, but also impacts their interactions with others and with society at large. Ableism is a tangible experience for many people with disabilities who may experience judgment and marginalization. Experiences of ableism can vary depending on the severity of symptoms, the individual's own attitudes and perceptions, and the visibility of an individual's disability. People with visible disability symptoms may be more likely to experience overt ableism, as their conditions are difficult or impossible to hide. Conditions characterized by recurring-remitting symptomatology, such as Multiple Sclerosis (MS), are unique in that they have a spectrum of symptom severity. MS is an incurable neurodegenerative disease in which the body's immune system attacks the myelin sheath, resulting in diverse and unpredictable manifestations of symptoms. An individual may be able to pass as able-bodied at times, depending on where they happen to be on the spectrum at that time. The choice to disclose or conceal disability can have practical and psychological consequences that influence a person’s daily experiences (Nario-Redmond, 2020).

Studies by Fong et al. (2006) and Dalmonte et al. (2004) found that a “positive outlook, maintenance of social relationships, and an ability to adapt to the environment are critical to maintaining well-being” (Ploughman et al., 2012, p. 7). The purpose of this study is to demonstrate how a person's resiliency, self-efficacy, and social support system influence both how they view themselves and their ability to thrive and achieve their goals after the onset of a physical disability.

LITERATURE REVIEW

ABLEISM

Ableism is defined as prejudice and discrimination based on physical and mental disability classification (Nario-Redmond, 2020). Nario-Redmond (2020) identifies ableism as affective emotions or attitudinal reactions, behavioral actions or practices, and cognitive beliefs and stereotypes that go beyond general negativity. There are nuances and degrees to which these three forms can manifest, and ableism exists at the internal, interpersonal, and institutional levels.

Internalized ableism incorporates ableist attitudes, beliefs, and practices in the minds of individuals who identify as disabled. This form of internalized oppression has been found to contribute to mental health concerns, including anxiety, depression, isolation, and feelings of inferiority (Jóhannsdóttir et al., 2022).

RESILIENCY AND MULTIPLE SCLEROSIS

After experiencing stress or trauma, some people adjust positively and establish a stable developmental trajectory; others respond maladaptively (Herrman et al., 2011). An individual’s ability to recover from stress can affect development and influence health outcomes. Ploughman et al. define resilience as “the ability to achieve, retain, or regain a level of physical or emotional health after illness or loss, which is associated with successful coping and ‘bouncing back’ in spite of substantial adversity" (2020, p. 2769). Studies on the ability to maintain independence, adaptive lifestyle habits, social participation, and overall health-related quality of life through symptom management suggest that resilience promotes healthy aging with MS (Ploughman et al., 2020).

Higher psychological resilience is associated with better physical function in people with MS and with fewer neurological symptoms (Jakimovksi et al., 2022). Studies report a lifetime prevalence of depression in people with MS of up to 50%, and the development of depression is closely linked to coping style, positive adjustment, and resilience factors (Ploughman et al., 2020). Social connection closely intertwines with the concept of resiliency: greater social support is associated with greater resiliency and more adaptive coping strategies in people with MS (Jakimovksi et al., 2022).

SELF-EFFICACY

Self-efficacy refers to an individual's sense of control over their achievements and their capacity to respond to challenges and meet goals. Disability self-efficacy is a person's belief that they can manage their disability to achieve their goals (Amtmann et al., 2012). There are several ways in which self-efficacy beliefs impact behavior, including the actions an individual chooses to take, as most opt for behaviors that result in feelings of competency and accomplishment. These beliefs also influence perseverance and perceived stress levels (Amtmann et al., 2012). Individuals with higher levels of self-efficacy often demonstrate lower levels of anxiety and depression, which can positively influence their outlook and adjustment to life following a diagnosis (Tan-Kristanto & Kiropoulos, 2015).

Additionally, an individual's locus of control influences how they perceive life events. People with an external locus of control attribute events and consequences to forces outside of themselves, such as others' actions, while those with an internal locus of control feel that their actions are the catalysts for events. A health locus of control (HLC) refers to the perception individuals have of their options for symptom management and disease control (Wilski et al., 2019). The degree to which an individual feels responsible for their disability can affect how they choose to cope with the limitations they experience.

SOCIAL SUPPORT

Social support is associated with better psychological well-being, reduced stress levels, and improved emotional well-being and perception of happiness and success (King et al., 2000). Jensen et al. (2014) found that perceived social support is associated with subjective well-being in people with physical disabilities. The corollary is that there is a strong association between lack of social support and depression. Individuals with physical disabilities are at a higher risk of lacking perceived social support, as their mobility may be impaired and, as a result, their ability to engage with a broader community is limited. The type of social support people receive, whether from friends, family, or significant others, has a differential impact on depression levels; friend support plays the largest role (Jensen et al., 2014). The importance of friend support indicates the influence of the broader social environment on perceptions of self and happiness, demonstrating how essential having a diverse support system is to positive adjustment after an adverse life event.

METHODS

D is a 56-year-old heterosexual, cisgender, white female from New York who developed MS at 24. This study aims to explore the influence that developing a disability in emerging adulthood has on an individual's perception of themselves and their ability to live a fully-realized life and achieve their goals. Having lived without this disability for a significant portion of her early life, as well as having experienced periods of remission and flare-ups, D has unique insight into the spectrum of MS. This research focuses on the influence of resiliency, social support, and self-efficacy on D's perception of her abilities before and after her diagnosis and into middle adulthood.

The student researcher arranged to interview D in person at her home. The student researcher made it clear before and throughout the interview that the participant could stop at any time and that D was under no obligation to answer questions with which she did not feel comfortable. The interview lasted approximately two hours and was recorded and transcribed via the Otter app on the researcher's phone. To protect D's confidentiality, these recordings were deleted upon completion of the research paper. She was informed of her rights and signed an informed consent document indicating that she understood the interview's context, requirements, and outcome. Quotes from the interview were organized using thematic analysis into topics related to self-perception, perception by others, resiliency, and social support. This study received IRB approval prior to publication.

RESULTS

IMPACT OF DISABILITY ON SOCIAL SUPPORT

Numerous protective factors were present in D's childhood, including a strong sense of community, growing up in a middle-class family, having access to quality education, and being white in a homogenous, conservative town. Concurrently, she experienced certain risk factors, particularly within her family dynamics. D shared that her role in the family, even as a child, was the peacemaker and "perfect child" who made her parents proud and helped to mitigate the consequences of her sibling's maladaptive behaviors. Growing up with a brother who struggled with substance abuse and undiagnosed bipolar disorder, she became familiar with the disabling effects of mental and physical illness.

When discussing her parents' devastation over her diagnosis, she expressed feelings of guilt: "I felt awful. I'm not the one that brings heartache into their life." She experienced a transition from being an independent emerging adult to an emerging adult who relied heavily on the support of others. This sense of guilt carried over to other important relationships in D's life, including that with her husband. She recalled her fears of becoming dependent on her husband at only 24, thinking at the time, "Oh no, he's going to have to take care of me, like I'm an old woman." Despite fears of being a burden, D shared that her husband and marriage adapted quickly to life after her diagnosis: “My husband became even more devoted. He looked out for every detail, every detail that would make my life better and easier.”

Relocating far from home as an emerging adult, D found herself away from family and friends. However, she quickly established connections through her husband’s work, finding a cohort of young adults in similar situations as transplants to the area.

> I had just gotten married here in New York and immediately moved out to Los Angeles. So I didn't have a whole group of good friends or any family. But everyone from my husband's company were kind of misfits being out there, having no family. So we had a good social support system.

She explained that her friends in California became skilled at adapting to her needs to the point that she experienced very few perceived limitations during that period. Her disability became integrated into the backdrop of her social relationships without defining her. This was made especially clear as she described how her friends responded to her new limitations.

> They're just like, oh, we'll carry you up the hill. Well, you know, there's no handicapped access here. I’ll throw you over my shoulder. So yeah, in that respect, it wasn't a stigma…They’d say don't worry. We'll get you there.

Despite acknowledging the crucial role social support played in D’s perception of her limitations, she was highly resistant to becoming involved with the broader MS/disability community. She explained that she felt the disability community represented a “pity party” she could not afford to get involved in. In her own words, “Out of sight, out of mind.” D expressed that she felt no need to be involved with the community because she could get any information about her condition from her doctor or online, without hearing about other people’s problems. Coming from a family that believed highly in taking responsibility for one's problems without outside help may have helped shape this attitude toward her disability.

SELF-PERCEPTION AND DISABILITY

D's priorities at different stages in her life evolved with how she perceived herself and her abilities, roles, and goals. Due to the relapsing-remitting nature of her MS, there were periods when she could live life essentially as an abled person and disconnect from her diagnosis. However, during symptom flare-ups, she could not ignore the very real limitations that she was experiencing. She was also frustrated with herself for not having the capacity to do everything she wanted. Initially, and for quite some time, flare-ups were characterized by spikes in internalized ableist thoughts; D felt she was being denied the full experience of emerging adulthood. However, these attitudes would shift as she developed adaptive coping mechanisms and began to accept life as it was. D expressed that as a young adult, she struggled with comparing her experiences with those of her peers. Watching her cohort advance their careers was difficult, especially in conjunction with her health challenges. When D lost her job due to her symptoms, it significantly impacted her self-perception: "I was incredibly disappointed with myself because I worked so hard to get where I was, and I had to leave it because of this stupid disease… I felt badly about myself because of that."

D expressed that she was also forced to confront the reality of her condition when her doctor presented an ultimatum: be a lawyer or be a mom. At this point, she had to reassess her goals and aspirations and recognize that she could not do everything. She cited this as another turning point in her acceptance that the real limitations imposed upon her by MS restricted some life paths. However, D took this as an opportunity to reevaluate her priorities and recognize that she valued starting a family over having a career. After the birth of her daughter, D had to again come to terms with her capabilities as she initially struggled to reconcile her new role as a mother with her physical limitations.

> There were things I couldn't do with my daughter when she was a baby. Like I could never give her a bath by myself. Those kinds of things…got to me, but then I hired a nurse to come and take her for a couple hours here and there. And she did all the things I couldn't do, and I just had to be okay with that because then I could do other things… So that made it not so bad. It was just part of how we lived.

The experience of aging also influences a person's perception of themselves. While D's chronological age is 56, it is important to consider her biological age when discussing her perception of self. As a neurodegenerative disease, MS strongly affects biological aging and physical deterioration, and D expressed concerns over both physical and cognitive decline as she ages and the disease progresses. When asked about considerations when planning for the future, she explained that she is much more practical about her capabilities now.

> Well, now I have to absolutely face that if I stay in the physical condition I am in right now, there are things I won't be able to do. For example, we are most likely taking the retirement cruise of our lifetime long before my husband is retiring…It's nothing we planned on doing, but you know what? I might not be able to do it next year. Or ever, right? So I'm just realistic about it.

These concerns have affected how D approaches life and perceives the opportunities afforded to her. Developing a pragmatic view of her situation has been an empowering coping mechanism from the onset of her MS.

SELF-EFFICACY

D's experiences and decisions since she developed MS are characterized by a strong sense of self-efficacy and an internal locus of control, which greatly influenced how she perceived herself and her opportunities. She expressed that she frequently faced the decision to either give into despair or forge ahead. D shared that after her mother received a cancer diagnosis, her mother essentially decided life was over.

> From the day they gave her her diagnosis, not a positive word passed her lips. Everything was miserable. Everything was terrible. Everything was awful. Even good things that happened…I never wanted that, and I thought, 'I got through all these years with the disease without becoming bitter.'

At a critical turning point in her life, D adopted a mindset that deliberately looked for the positive aspects of life because she viewed it as a decision within her control, demonstrating her strong sense of self-efficacy. This mindset of perseverance through adversity, modeled by her father as he managed her brother's struggles and family responsibilities, came to play a crucial role in how she tackled the challenges she faced as an emerging adult.

RESILIENCY AND DISABILITY

"I think that's probably the best thing you can do. Just make it a part of how you live." This simple statement by D reflects a profound strength and resiliency that characterizes her experience with MS from her diagnosis up to the present day. Throughout the interview, D made many comments about refusing to let her diagnosis "ruin [her] attitude."

> I saw when my mother was so depressed and negative, what it did to the people around her, and I never wanted to do that to my family and friends. And truthfully, it's better to have a good attitude, and people want to make themselves miserable by seeing only the negative.

D's experience watching her mother battle cancer strengthened her already existing resiliency. Some of D's response may be rooted in the interpersonal role that she took on within her family from a young age, that of the dependable child who rose to meet challenges head-on. When asked to identify her strengths, D reflected on some of the characteristics that informed her perspective on disability and adversity.

> I think I'm very pragmatic. And I think that helps a lot. You have to be practical. How can I make this better? You try it. Does it make it better? Maybe, maybe not. But you tried to make it better. And if it simply can't be done, you move on.

D’s resilience manifests through a strong sense of practicality. Her ability to bounce back after setbacks and challenges is integral to who she is, shaped in part by her self-determination.

HISTORICAL CHANGES AND SOCIAL INSTITUTIONS

D also reflected on the broader social changes she witnessed over the past three decades. When D was first diagnosed, there were limited treatment options for MS, and she jumped on the opportunity to be a “guinea pig” for experimental medications. While reflecting on disability accommodations and treatments for MS now, compared to when she was diagnosed, D expressed gratitude for the changes over the past decades.

> I think in the last 20 or 30 years it has been an amazing period of time for disabled people, with the ADA rules being enforced and people becoming more aware. So I think it's a better world than 30 years ago when I was first diagnosed…if I had been 25 and living in this kind of world, maybe I wouldn't have had to make that decision of ‘I'm disabled,’ or ‘I'm not disabled.’ So I think it's really wonderful.

It is evident that societal perceptions of people with disabilities have shifted positively since D’s diagnosis, as have the accommodations and opportunities afforded to them. The accessibility of public spaces was also identified as a way in which things have become “exponentially better” since her diagnosis. The increasing accommodations provided to her through her urban environment and the development of accessibility tools, such as her electronic gait stimulator and her portable wheelchair, have made it easier to maintain her current mobility and allow her more freedom.

EXPERIENCES WITH ABLEISM

The complex interactions between achievement and disability perception are reflected in D's thoughts on how others' opinions have influenced her life. People judge D as either abled or disabled based on the severity and visibility of her symptoms, meaning that at times she could "pass" as able-bodied even if it took a physical or mental toll to do so. Overall, D expressed that she is far less concerned with the perception of others than when she was younger and still coming to terms with her new reality. Having to constantly decide between disclosing her condition or maintaining an abled persona characterized much of D's early period with MS.

After her diagnosis, D continued working at a California law firm, hiding her diagnosis from her bosses and coworkers as she recognized there were potential repercussions to disclosing her disability status. D recounted how she was forced to share her diagnosis after deteriorating to the point that her symptoms became visible. When her MS caused her to require a cane and wear an eyepatch, she was asked to leave her position. In this instance, the ableist perception of others directly resulted in limited career opportunities.

D shared that as she has gotten older and her disease has progressed, she has noticed acute differences in interactions with acquaintances and strangers. D described feeling largely unbothered by the thought of how people see her, despite recognizing that others' perceptions influence how they interact with her. Now, the choice to disclose her condition is no longer an option; symptoms such as a persistent limp provide visual indicators. Responses to her disability are often characterized by ableist attitudes, whether they manifest as pity, discomfort, or dismissal. She emphasized how frustrating it can be when someone reduces her to her disability. D also reflected on how she responds to other people's reactions now compared to when she was younger.

> The younger me probably would have cared. But now, I don't care if someone says, 'Oh, what is that,' and they kind of push it, and

> I tell them, ‘Oh, you know, Multiple Sclerosis.’ It really doesn't matter to me what they say. What are you gonna do?

Rather than shying away from increasing visible indication of impairment over the years, D has embraced the realities of life with MS. Not only did she share her gratitude for mobility aids such as her walker and wheelchair, she also described her assortment of “fabulous canes, one for every outfit.” D reflected that while she cannot control whether people are aware of her disability, it is up to her to decide how she responds to them.

DISCUSSION

Study of the factors that contribute to positive adjustment after the onset of disability is a crucial area of research that is only becoming more relevant, as more and more people are experiencing disability and living with their conditions for many years. As people with MS age, their expectations and priorities evolve with the progression of the disease. According to Ploughman et al. (2012), many people diagnosed with MS feel that physical limitations influence their quality of life less than they affect social and emotional functioning. We can conclude that resiliency, self-efficacy, and social support all contribute to an individual’s sense of agency and control over their condition and promote positive adjustment.

D’s inner strength and belief in her ability to live a fully realized life helped her positively adjust to life with a disability and maintain an adaptive developmental trajectory. Informed by her parents' beliefs and behaviors and her loved ones' support, her mindset characterized her self-perception and her efforts to reach her goals. Throughout the interview, D expressed beliefs in resilience and resistance to despair. Without this sense of control over how she responded to adversity, D may have found it more difficult to cope with her diagnosis, particularly in the early stages. As Ploughman et al. (2012) proposed, D experienced a transition from denial to acceptance to self-advocacy. This transition was not always linear, as MS’s relapsing-remitting nature caused her to vacillate between denial and acceptance even as she learned to advocate for herself.

Individuals do not exist within a vacuum, and it is essential to look at the broader social contexts in which they exist. The development of disability affects an individual's life trajectory through the interdependent lives of that individual and the people with whom they have relationships. D's diagnosis of MS had a profound impact on herself and on dynamics with her parents, husband, and larger social network. D relied on the support of friends and family members while navigating life with MS. Social support positively influences one's selection of coping skills, social life, sense of empowerment, and reduction in loneliness (Forouzan et al., 2013). The importance of this support is underscored by the numerous references D made throughout the interview to the network of friends and family that emerged to help her manage MS.

D's experiences with MS were also influenced by the intersection of her identities and positionality. Multidisciplinary research has consistently indicated significant health disparities between whites and racial/ethnic minorities, with minority and socioeconomically disadvantaged populations up to three times as likely as other groups to experience disability at older ages (Schoeni et al., 2005). However, research has indicated that many of these differences are linked to disparities in income and education rather than biological distinctions (Fuller-Thomson et al., 2009). As a middle-class woman, D had access to early care. Although she experienced financial concerns relating to her inability to work, she was at a lower risk of falling into poverty. She was fortunate enough to understand the healthcare options available to her and to connect with pioneers in the MS field who facilitated her involvement with novel treatments as they became available.

LIMITATIONS

It must be noted that the data provided through this interview represent a single person's experience. The resulting interpretations may not accurately describe the experiences of other persons with disabilities, even those who also developed MS at a young age. Due to the subjective nature of disability, caution must be exercised when attempting to extrapolate one individual's experience to a broader population. There is a possibility that the phrasing of some questions may have led D in a particular direction, even though open-ended questions were used. Additionally, data analysis was carried out by a single individual without collaboration with others. However, every effort was made to ensure that conclusions regarding the roles of resiliency, self-efficacy, and social support in D's experience of disability were rooted in evidence drawn from relevant, peer-reviewed research.

FUTURE RESEARCH DIRECTIONS

Future research directions may explore the influence of different types of social support on an individual's experience, investigating whether there are differential effects based on the source of support. Additionally, researchers may be interested in studying how positive internal traits, such as resiliency and self-efficacy, can be cultivated through interventions. Developing programs that encourage the adoption of health-promoting attitudes and behaviors may allow healthcare professionals to provide important scaffolding for coping mechanisms moving forward. These interventions could significantly impact how people with MS view themselves, their capabilities, and their life trajectory.

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Where Were the Social Workers?

A Historical Overview of the Social Work Profession's Complicity in the Family Policing System

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JASMINE WALI

ABSTRACT

In recent years, segments of the social work profession have highlighted the ways that social workers are complicit with carceral systems, including the foster care system. Following the advocacy of impacted families and communities, social workers have increasingly called for the re-examination of standard social work practices such as mandated reporting. This paper seeks to strengthen the historical understanding of the social work profession's complicity in the creation of the modern family policing system, commonly known as the child welfare system. In particular, this paper explores the impacts of the anti-communist movements on social work advocacy and practice during crucial periods of racial and economic reckoning, with an emphasis on the profession's complicity with the 1960s-era criminalization of the Black family structure.

Understanding the confluence of social work's stances on child well-being, racial dynamics, poverty, and crime in the 1960s can strengthen the future of social work. The family policing system, commonly known as the child welfare system, disproportionately impacts Black families. The social work profession played an important role in perpetuating anti-Black beliefs about Black families that contributed to the construction of the modern family policing system. As the profession grapples with its role in the carceral apparatus, understanding can guide practice by informing social workers of the legacy of resistance, confronting unjust practices, and activating the profession towards political advocacy.

The social work profession's role in the carceral apparatus is apparent through the family policing system's criminalization of poverty. The majority of family policing investigations and family separations are for charges of parental neglect, which include the inability to provide food, clothing, housing, medical care, and childcare (Burton & Montauban, 2021). Instead of being met with basic needs assistance and other anti-poverty measures, social workers often report families to Child Protective Services (CPS). Implicit and explicit racial biases impact social service workers' perceptions of families and contribute to the racial disparities visible at every stage of child welfare decision-making: reports, investigations, substantiations, family separation, court supervision, and termination of parental rights (Hill, 2006; Roberts & Sangoi, 2018).

Indeed, over fifty percent of Black children in the U.S. will experience a child welfare investigation before their eighteenth birthday (Kim et al., 2017). In addition, Black families are disproportionately separated by the foster system and kept in the system for longer periods of time than their white counterparts (Roberts & Sangoi, 2018). Black parents also experience termination of parental rights at higher rates than white parents (Song, 2006).

Families interact with social workers throughout the entire family court process—through mandated reporters, caseworkers, family defense social workers, and court-mandated service providers. However, social work educators have largely ignored the profession's complicity in creating and upholding the modern family policing system, specifically ignoring the impact that anti-communism and McCarthyism have played in the profession's shaping (Andrews & Reisch, 1997). The wave of McCarthyism in the mid-1900s, a period of fear-mongering in which individuals and communities who were accused of having ties or ideology sympathetic to communism or socialism were viewed as as treasonous and subversive, shaped social work research and scholarship for a generation, as the civil rights movement and backlash to it were in full swing. Moreover, the complicity of the profession helped to popularize and perpetuate notions of individual and family diagnoses as the root of societal ills. These themes resonated in public discourse, amidst backlash to the civil rights movement, and guided the creation of the family policing system.

In the decades of advocacy for the families and communities the family policing system has since impacted, social workers have grappled with the tension inherent in their roles as advocates and simultaneously participants in the larger carceral web of policing. This tension is visible in standard practices like mandated reporting, which legally requires all social workers to report any suspicion of child abuse or neglect. Deepening the understanding of social work's history, which includes forms of resistance employed by individual social workers, will further crystalize the profession's obligations to advocate for families and will provide a roadmap for resisting harmful practices.

SHIFTING SOCIAL WORK BACK TOWARDS THE INDIVIDUAL

Although the early social work profession used charitable models that focused on "fixing" poor communities, in 1933, Franklin D. Roosevelt appointed several social workers to cabinet positions to help him shape and draft New Deal legislation, representing a shift in domestic policy and social work advocacy toward basic government support for its citizens. The New Deal was actively supported by many social workers and professional social work organizations (Finn, 2016). A key piece of the New Deal was the Social Security Act of 1935, which created the Aid to Dependent Children program (ADC), later renamed Aid Families with Dependent Children (AFDC), which provided welfare benefits primarily to white widows who were not expected to work (Roberts, 2017). The Social Security Act also created a number of other social safety net programs to help elderly and unemployed citizens. This change within the social work profession paved the way for more robust debates and the rise of radical advocacy. Radical and progressive social workers typically regarded the political-economic, social, and ideological structures of society as the root causes of individual, family, and community problems; their focus included critiques of capitalism as a social-economic system (Andrews & Reisch, 1997).

However, “progressive” soon became a coded term for individuals linked to or sympathetic to the Communist Party (Andrews & Reisch, 1997). In 1938, Smith College School of Social Work fired its Associate Dean, Bertha Capen Reynolds, a leading social work radical and the most published social work scholar of that decade, because of her Marxist political views. In her work, she reframed beliefs about the causes of poverty from individual failings to structural deficits, and critiqued New Deal social reforms for failing to address structural inequalities (Finn, 2016). Following her forced resignation, Reynolds was frequently the target of government investigation and intrusion and was unable to obtain a position at another school of social work (Reisch, 2018).

By the 1950s, McCarthyism was at its peak. The infamous McCarthy “blacklists” of individuals and communities accused of holding “communist” beliefs, including Reynolds and other scholars, impacted the profession of social work (Abramovitz, 1998). Even books that simply articulated the connection between human behavior and the administration of social welfare programs by explaining how psychological needs were connected to social forces were attacked for promoting a socialist agenda (Finn, 2016). Labor unions were labeled as communist and social work unions were crushed (Abramovitz, 1998).

Without the protection of unions and progressive leadership, social work faculty were dismissed at a number of universities, as well as public and private agencies (Reisch, 2018). To avoid accusations by anti-communists, many white, liberal social workers distanced themselves from their radical colleagues. The profession as a whole experienced collective anxiety over its tenuous occupational status (Andrews & Reisch, 1997).

Black activists, freedom fighters, and social workers, whose work is now acknowledged as foundational to the profession, were tied to communism: while some chose to publicly support the Communist Party, others were labeled communists by government officials because they criticized racial capitalism, or because they were Black and advocated for community support and investment from the government (Shepherd & Pritzker, 2021). In the Cold War and Civil Rights Movement climate of the 1950s and 1960s, government departments and officials used these accusations against Black liberation movements, whether real or not, to criminalize and surveil Black social workers and activists (Stanford, 2020).

Thus, for a generation, the organized social work profession, which consisted primarily of white women, largely withdrew from its previous advocacy efforts for marginalized groups. The social work profession became increasingly passive on social issues, because “to propose a measure to relieve poverty or to combat racism was to risk being called ‘communist’” (Ehrenreich, 1985, p. 142; Andrews & Reisch, 1997). Instead, the profession redirected its research to safe issues like family dynamics, and focused internally on professionalization (Reisch, 2018). Textbooks written during and after the McCarthy era, which shaped a generation of practitioners, emphasized the “acquisition of expertise” and omitted “discussions of the ideological bases of practice” (Andrews & Reisch, 1997).

This shift away from advocacy had a number of policy implications. The decline of social activism by the profession during the McCarthy period slowed the development of the welfare state, particularly regarding public assistance and health insurance, and facilitated government efforts to tighten restrictions and eligibility requirements of existing programs (Andrews & Reisch, 1997). Throughout the 1950s, social workers and policymakers placed less emphasis on offering material support to low income families and increasingly emphasized individually targeted rehabilitation services designed to encourage “independence” (Kohler-Hausmann, 2017).

Even during the height of the civil rights movement, leading social work publications made little reference to racism or racial inequality (Simon, 1994). In fact, most social work research and policy advocacy focused, explicitly or implicitly, on the supposed deviant features of communities of color, thus providing the intellectual foundation for policies that focused more on “fixing” alleged cultural deficiencies than on addressing the structural root of people’s problems (Reisch, 2018).

THE “WELFARE CRISIS”

The social work profession’s shift from viewing the impacts of racism and poverty as social phenomena to viewing them as a reflection of cultural deficiency resonated in public spheres in the early 1960s. States had largely restricted Black, Latine, and other immigrant families from accessing the anti-poverty programs established by The New Deal (Kohler-Hausmann, 2017). They specifically blocked Black families from obtaining ADC through a number of attacks on family structure: children born out-of-wedlock were deemed ineligible; in Mississippi, common law marriages, which many Black families obtained (Perry, 1999), were outlawed as illicit marriages, thus dropping over 8,000 mostly Black children from welfare rolls (Perry, 1999; Roberts, 2022). States also implemented “man-in-the-house” rules to deny benefits to Black mothers suspected of living with or having a sexual relationship with a man who would then be expected to financially support the family as a “substitute father” (Roberts, 2022).

Social workers were used to implement some of these policies: in 1963, Alameda County implemented “Operation Bedcheck,” deploying pairs of social workers and welfare investigators to search homes of families on welfare for men in the home (Kornbluh, 2007). The profession of social work, which had shifted to casework and professionalization in the 1950s, was so heavily associated with harming poor families on welfare that the National Welfare Rights Organization, a leading group advocating for the rights of public welfare clients, targeted some of their advocacy towards social workers in administrative positions in the public welfare bureaucracy (Marx, 2011).

Despite states' efforts to block Black families, ADC grew substantially over the 1960s, from 3.1 million in 1960 to 10.8 million in 1974 (Nadasen et al., 2009). This growth can be attributed to a multitude of factors, including federal oversight to ensure state compliance with racial protections, economic dislocations, increases in single-parent families, the mass migration of Black families to the North and West, and poverty lawyers' and activists' efforts to help eligible families obtain their entitlements (Kohler-Hausmann, 2017). Indeed, in the early 1960s, about one-third of eligible families were enrolled in ADC; by 1971, about 90 percent were receiving benefits (Reese, 2005). However, critics across the political spectrum interpreted this growth as a "welfare crisis" symptomatic of the pathology and laziness of the parents it served. Barry Goldwater's campaign for presidency in 1964 shaped the welfare debate on a national stage. Goldwater stated that the welfare state destroyed individualism and supported the growth of collectivism. Many of his themes would later form the multiple bases for the New Right's attack on welfare. Right-wing publications attacked the welfare state for undermining rugged individualism and private property, fostering immorality and non-productivity, contributing to crime—pointing to urban protests and the civil rights movement—and ultimately leading to communism (Williams, 1997).

ADC became a lightning rod for frustration as white populations were confronted with the visibility of racial injustices highlighted by the Civil Rights Movement, increased media attention to drugs and crime (and its racialized depictions), and a reckoning of women's sexuality and role in the labor market (Kohler-Hausmann, 2017). Journalists in mainstream news outlets such as The New York Times charged that Black and Puerto Rican families saw welfare as a “bank,” playing on deep-seated fears about a changing country (Horowitz, 1969). Debates about welfare dominated the media and political spheres.

Seeking to persuade the Johnson Administration to move swiftly to improve the plight of poor Black families through federally financed anti-poverty programs, Daniel Patrick Moynihan wrote The Negro Family: A Case for National Action, commonly known as the Moynihan Report. While Moynihan discusses the role of systemic racism in creating and upholding wealth inequality, he also argues that the increase in welfare dependency can be “taken as a measure of the steady disintegration of the Negro family structure.” He writes about Black families:

> [T]he family structure of lower class Negroes is highly unstable… The combined impact of poverty, failure, and isolation among Negro youth has had the predictable outcome in a disastrous delinquency and crime rate… [A] national effort towards the problems of Negro Americans must be directed towards the question of family structure (Moynihan, 1965).

The Moynihan Report cemented the issue of race to welfare and single-parent families in a way that made it difficult to talk about one without the others, and in doing so inadvertently fueled popular fixation on Black women’s sexuality and welfare receipt (Nadasen, 2007). This report was an influential response in a critical moment to the hysteria around welfare and public demand for changes to ADC and shaped how politicians and media portrayed and understood Black children and Black parenting.

The Saturday Evening Post commented, “Today’s welfare child, raised in hopelessness and dependency, becomes tomorrow’s welfare adult, pauperized and helpless” (Nadasen, 2007). *U.S. News* and *World Report* declared in 1965 that the increasing number of “welfare babies” would “breed more criminals, more mental defectives, more unemployables of almost every type,” and profiled a typical ADC recipient in Chicago as “A poor Negro girl:...She is insecure, uneducated, unsophisticated, and frightened" (Nadasen, 2007). The concerns about ADC were shaped and portrayed to the public by racial ideology and existing racial stereotypes about Black parents and children, and raised concerns around the alleged impact that Black children would have on white America.

THE PATHOLOGY OF CHILD ABUSE

Amidst the unfounded charges of an inherent pathology in the Black family structure, concerns about child abuse were taking shape in the public. In 1962, pediatrician C. Henry Kempe and several colleagues published *The Battered Child Syndrome* report.

Similar terms were used to describe Black parents in the Moynihan Report as parents who physically abuse their children in the *Battered Child Syndrome*. Children in the reports were characterized as "illegitimate" or "unwanted." Substance abuse in the reports was described as "drunkenness" or "alcoholism." Parents were diagnosed as "pathologic" or "psychopathic and sociopathic." Dysfunctional families were characterized by "divorce, separation, and desertion, female family head, children in broken homes…family disorganization, juvenile delinquency," or "sexual promiscuity, unstable marriages, and juvenile delinquency" (Wali, 2023).

The authors of the *Battered Child Syndrome* stated that there were no reports of successful psychotherapy, and thus the only safe remedy at the time of publication was the separation of children from their parents (Kempe et al., 1962). They did, however, introduce the empirically unsupported idea of parental violence against children as a diagnosable and treatable medical condition or mental illness (Burton & Montauban, 2021). The individual-centered psychological and medical construction of the problem turned policymakers away from considering its structural causes and allowed for physicians to maintain ownership and guide interventions for child abuse (Nelson, 1984; Hacking, 1991).

Following the publication of *The Battered Child Syndrome*, academics and popular media rushed to popularize the issue of child abuse. In the decade prior to the article's appearance, doctors, lawyers, social workers, educators, and other researchers and practitioners published only a combined nine articles specifically focusing on cruelty to children; in the decade after its publication, the professions produced 260 articles (Nelson, 1984). Mass-circulation magazines carried twenty-eight articles in the decade after Kempe's article, compared to only three in the decade before. Television saw a similar trend: child abuse was virtually absent from early television scripts, whereas after *BCS*, soap operas and prime-time series alike created dramas based on the problem (Nelson, 1984).

The public embraced the individualized idea of the pathological and psychopathic parent who physically abused their children, as opposed to the parent whose capacity to nurture was limited by social factors (Newberger, 1983). Most seasoned professionals tasked with working with these families, who had experienced the anti-communist era's push towards family dynamics and psychotherapy and away from social justice, embraced these individualized views (Finn, 2016).

For nearly a decade, lawmakers and the public had been inundated with messages about the supposed looming impacts of welfare babies, the Black family structure, and physical child abuse, specifically these children's supposed propensity to commit crimes and drain government resources. Racist depictions of the War on Drugs and crime, attributed to drugs and civil rights protests, found its way to white Americans' dinner table discussions (Kohler-Hausmann, 2017). All of this helped to place a public outcry for child wellbeing interventions on the mainstream agenda as the 1970s approached.

REMOVING BLACK CHILDREN

In 1961, the Department of Health, Education, and Welfare issued a directive that states could not deny ADC based on suitable-home tests unless they took steps to rehabilitate the family. For families that could not be rehabilitated, federal funds were allocated to put the child in foster care. That year, Congress amended Title IV of the Social Security

Act to provide federal funding to maintain these children apart from their families. Instead of denying families benefits, state ADC eligibility workers began taking Black children away from mothers deemed unsuitable: in 1961, 150,000 children were placed in out-of-home care (Roberts, 2022).

Beyond the federal financial incentive for family separation, policies around child well-being and welfare were also shifting. For example, in response to the increase in Black and Latina women receiving welfare benefits, policymakers instituted work requirements (Nadasen, 2007): a task difficult for single mothers with no childcare options. But a 1971 bipartisan childcare bill was vetoed by President Nixon, who called it “the most radical piece of legislation” to have ever crossed his desk, and charged that the bill represented a “communal approach to child-rearing” and had “family-weakening implications” (Rosenberg, 1992), echoing anti-communist terms and themes to describe and demonize a social welfare program. This intentional defunding of meso- and community-level support represented the prevailing conservative themes of the previous decades, and placed the onus for overcoming poverty and obtaining stability on the nuclear family, thereby detaching the state from financial responsibility for children and families (NPR, 2016; The Economist, 2021; Rosenberg, 1992).

The bill’s sponsor, Senator Mondale, understood that child well-being could not be tied to anti-poverty programs, but still felt the public demand for interventions for children. In response, Mondale pursued the Child Abuse Prevention and Treatment Act, or CAPTA (Wexler, 2018), which passed in 1974. Narratives of parental responsibility and treating social issues as individual pathologic concerns had been promoted by the medical and social work communities over the previous few decades. This resonated in the 1970s. CAPTA’s initial scope was broad and vague, and combined intentional acts and acts of omission into a singular phenomenon: child abuse and neglect. This created a false equivalence between intentional physical harm to children by their parents and conditions of poverty, effectively transforming child poverty from a social, economic, and racial justice issue into a problem of individual parental pathology and deviant behavior. Thus, the government was absolved from addressing structural, economic, and racial inequities that shaped children's wellbeing (Burton & Montauban, 2021).

CAPTA: A FOUNDATION

CAPTA is the foundation of the modern family policing system. CAPTA requires each state to have mandatory reporting provisions, which train social workers and other medical, educational, and childcare professionals to report any suspicion of vague definitions of child abuse or neglect and institutes legal and professional consequences for failure to report. The practice is wrought with implicit and racial biases, resulting in disproportionate reporting of Black families (Inguanta & Sciolla, 2021). The "Prevention and Treatment" of child abuse and neglect builds on the theoretical framework offered by the social work and medical communities from the 1950s through the 1970s by identifying risk factors in personalities and developing a treatment plan. Mental health evaluations are used to this day when a family is investigated by CPS, even though "searches for distinctive behavioral syndromes have proven elusive" (Melton, 2005) after decades of government and foundation-funded research (Burton & Montauban, 2021). These mental health evaluations continue to be used in court proceedings and as grounds to separate families and terminate parental rights. Instead of providing families with more resources, CAPTA funds investigations into families and "treatment" services administered by social workers, and sets the status quo for the way we address families ensnared in the family policing system.

IMPLICATIONS FOR TODAY'S SOCIAL WORK PRACTICE

An appreciation of history has been largely marginalized in U.S. social work (Finn, 2016). Social work scholar Michael Reisch claims that we are an ahistorical culture that has become accustomed to fragments of information, instead of the connective tissue (Reisch, 1988). Our current cultural and political institutions, including the social work profession, perpetuate ignorance of the past in order to sustain the perception of the present as a given; this limits the range of societal choices for the future (Reisch, 1993). The Council on Social Work Education must address social work history, for which there is currently no requirement for competency (Finn, 2016).

There is an inherent tension in the social work profession. The majority of the labor sector is still middle-class white women, while the clientele is largely Black, Indigenous, people of color, and low-income; these racial and class dynamics inform the implicit and explicit biases that impact communities. There is tension in the social worker's power over families because of social workers' participation in the family policing system through requirements such as mandated reporting such as mandated reporting, case notes that impact court proceedings, and visitation supervision between parents and children.

Nevertheless, there are examples of resistance in the history of social work that show individual social workers refusing to participate in harmful practices and using their positionality to end them, and of students changing the path and the education of the profession. For example, "Operation Bedcheck" was deemed unconstitutional after a social worker refused to participate in a mass morning raid on the homes of Alameda County's welfare recipients and was dismissed from his job. In *Parrish v. Civil Service Commission*, the plaintiff argued that such participation would have involved him in multiple violations of rights secured by the federal and state Constitutions and that his superiors could not properly direct him to participate in illegal activity. Following the lawsuit initiated by an individual social worker, the county subsequently abandoned mass morning raids to determine welfare eligibility and determined that such operations were forbidden by the applicable state and federal regulations. This raises room for envisioning other ways that social workers can push back against daily practices encouraged by their superiors and licensing boards and challenge their constitutionality and legality.

For example, the 2020 protests for racial equity prompted the creation of a group called Mandated Reporters Against Mandated Reporting. They work to end the practice of mandated reporting that families have called the “stop-and-frisk of caretaking” (Meiners & Schenwar, 2017) by providing case processing spaces for peer feedback and informal supervision that they do not receive from their agencies. In addition, calls to abolish mandated reporting have strengthened within the social work profession (Inguanta & Sciolla, 2021; upEND, n.d.).

Following 2020, CPS caseworkers also saw the way that they were trained to coerce their way into homes without a court order, thus subjecting the family to an invasive process that was heavily influenced by bias, and recommended that “Miranda warning” practices be instituted to require that parents be immediately notified of their constitutional rights (Newman, 2022). Social workers must fearlessly advocate from within the profession to challenge long-standing and harmful standards.

Student activism is crucial to the social work profession. After decades of social workers’ movement away from activism, the 1960s and the civil rights movement reinvigorated the profession’s social action—not of seasoned, white professionals, but of students and Black social workers. Students and Black social workers organized for change by critiquing their organizations, welfare bureaucracies, and school curricula, and protested social work’s lack of response to Black liberation movements (Abramovitz, 1998). This led to the emergence of a systems perspective, which is now the foundation of a generalist approach to social work (Finn, 2016). In the present day, students are continuing the legacy of activism. Social work students rewrote and replaced the mandated reporting training with a “Mandated Supporting” curriculum that Columbia School of Social Work students now receive (JMACforFamilies, 2022). Students at UIC Jane Addams College of Social Work developed an “Alternatives to Calling DCFS” guide for Illinois social workers (Shriver, 2021).

Social workers have also increased their academic advocacy around robust anti-poverty programs through peer-reviewed research that countered narratives of personal responsibility and promoted the idea that governments should support families. These studies have found that the Earned Income Tax Credit and Child Tax Credit, childcare subsidies, medicaid expansion, and an increased minimum wage all reduce reports of child maltreatment (Biehl & Hill, 2018; Kovski et al., 2022; Yang et al., 2019; Brown et al., 2019; Raissian & Bullinger, 2017).

Most importantly, what social workers can do to end harmful practices in the profession is to listen and follow the lead of communities who have been most impacted by the profession and overlapping systems, using positionality to ensure their experiences and leadership are centered, finding resources to ensure that communities are invested in and compensated for their labor, and being active in the community, not just working in it.

The anti-communist movements impacted generations of social work practice and training and shaped the conditions under which the modern family policing system was formed. Much of the profession was complicit in promoting ideas of personal responsibility and individual pathology, positing the profession as a solution to rectify deviant individuals, families, and communities amidst intentional policy choices that defunded family and community support. As social work continues to evolve, particularly in this crucial time period of the post-2020 racial reckoning, social workers must resist agency status quo when it is damaging and engage with macro-level advocacy to promote anti-poverty programs that strengthen community well-being and keep families safe and together.

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