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 in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.
Table of Contents

Editorial Board…………………………………………………………………….………………..Page 4
Editorial Letter…………………………………………………………………………..………….Page 5
Advisory Board and Acknowledgments.........................Page 6

Attrition Risk and Resilience Among Sexual Minority College Students
by Olivia Mancini…………………………………………………………………………Page 8

by Farah Fathi……………………………………………………………………………………Page 23

Emerging Concerns for International Social Work and Disaster Response: From Relief to Development and Sustainability
by Ashley Taubman and Ali Weisz .........................Page 37

No Sure Cure for Elder Self-Neglect: A Case Study
by Jeff Levin……………………………………………………………………………………Page 49

Psychosis Risk and Prevention of Severe and Persistent Mental Illness: Implications for Social Work Practice
by Jordan DeVylder…………………………………………………………………………..Page 59

Successful Community Reentry After Incarceration: Exploring Intangible Aspects of Social Support During the Reintegration Process
by Ursula Helene Kiczkowski .........................Page 73

Contributors…………………………………………………………………………………………...Page 87

The views expressed by the authors are solely their own and do not reflect those held by the Editorial Board or Columbia University School of Social Work.
Editorial Board

ANN ADAMS is a first-year student in the Policy Practice method, in the International Social Welfare and Services to Immigrants and Refugees field of practice and a Law Minor. She is an intern with the New York City Department of Education.

KATHLEEN CHIARANTONA is a first-year student in the Policy Practice method, in the Schools and School-based Services field of practice. She is an intern at the Urban Justice Center Domestic Violence Project.

LAUREN HARRIS is a second-year student in the Advanced Generalist Practice and Programming method, in the Contemporary Social Issues field of practice. She is an intern at the Osborne Association.

PHILLIP MAROTTA is a second-year dual-degree student at the School of Social Work and Mailman School of Public Health in the Advanced Clinical Practice method, in the Health, Mental Health and Disabilities field of practice.

NINA MERRILL is a first-year student in the Advanced Clinical Practice method, in the Health, Mental Health, and Disabilities field of practice. She is an intern at the Daughters of Jacob Nursing and Rehabilitation Center.

AMY SCHAPIRO is a first-year student at CUSSW and Management Fellow, in the Social Enterprise Administration Method. She is currently an intern at the Northern Manhattan Improvement Corporation.
Editorial Letter

Welcome to the Columbia Social Work Review! This year’s Editorial Board is proud to continue the tradition of years past with another edition, detailing several of the issues central to the field. Now more than ever, a rigorous examination of the issues facing social workers must be undertaken, and in doing so, connectivity across many fields of practice must be achieved.

Olivia Mancini examines the impact of sexual minority status on institutions of higher learning in “Attrition Risk and Resilience Among Sexual Minority College Students,” an issue that has our nation’s finest universities bleeding both social and financial capital. Farah Fathi shows us in “Why Weight Matters: Addressing Body Shaming in the Social Justice Community” that the alarmist messages surrounding the obesity epidemic today have influenced the social justice community to adopt a discriminatory stance against fat people. In “International Social Work and Disaster Response,” Ashley Taubman and Alexandra Weisz explore global disaster relief efforts for three major natural disasters of the past decade while also making post-earthquake reconstruction observations and recommendations in the field in Haiti. Jeff Levin’s first-person narrative “No Sure Cure for Elder Self-Neglect: A Case Study” is a considered look at client agency and worker limitations, and the much needed clinical alliance that is necessary for progress to be made. In “Psychosis-Risk and Prevention: Implications for Social Work Practice,” Jordan DeVylder discusses the impact of early clinical interventions prior to the onset of psychosis on the prognosis of severe and persistent mental illness. Ursula Kiczkowski shows us in “Successful Community Reentry After Incarceration: Exploring Intangible Aspects of Social Support During the Reintegration Process” the benefits provided by transactional social support to formally incarcerated men through original qualitative findings.

We hope that you enjoy this second edition of the Columbia Social Work Review. The following articles contribute to the critical way in which we must examine our roles and our profession.

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Acknowledgments

The Editorial Board would like to thank the Columbia University School of Social Work students and faculty, especially our Advisory Board, for supporting the publication in its eighth year and making it an integral part of the student experience at CUSSW. We are indebted to Thomas Bane, Editorial Board Member 2009-2010, for his continued support and unwavering dedication to our blind review process. We would also like to thank Alexis Wynne Mogul for her work copyediting. In addition, we would like to thank Jenni Kurosman, Jeannie Hii, and Dean Ann McCann Oakley for their administrative support to the Editorial Board throughout the publication process.
Attrition Risk and Resilience Among Sexual Minority College Students

Olivia Mancini

Retention is one of the most frequently studied issues regarding college students. Most of this research has focused on majority college students, e.g., White, middle-class. More recently, retention literature has expanded to look at reasons why minority (e.g., non-White, disabled) college students decide to stay at or leave a university. Lesbian, gay, bisexual, and transgender (LGBT) students, however, remain an under-acknowledged and little-studied group in retention literature. This article seeks to demonstrate how sexual minority students are at high risk of attrition and why this group deserves research devoted to reducing this risk. This article also discusses how changes to college policy can improve the campus climate and quality of life for LGBT students.

A Population at Risk

Retention of college students is a frequently studied issue (Sanlo, 2004). The reasons why a student may decide to leave or stay at a particular school is of great importance to colleges and universities. Beyond an interest in improving quality of life for students, tuition loss due to attrition (student drop out) is one of the primary negative financial influences on institutions of higher learning (Penn, 1999, as cited in Freeman, Hall, & Bresciani, 2007). Dozens of papers have been published on attrition risks and persistence among college students, and, in the more recent past, a growing number of studies have considered the health, resilience, and retention of minority (non-White) and disabled students due to increased awareness of the salience of these factors (Sanlo, 2004). Absent from this body of literature is information on the attrition and retention of lesbian, gay, bisexual, and transgender (LGBT) students, although this population is at high risk for many of the issues identified in retention literature as predictors of attrition (Sanlo, 2004).

More than 50% of students voluntarily leave their first
college or university in the United States, and 46% of these stu-
dents never earn a college degree (Freeman, et al., 2007; Berkner, 
He, & Cataldi, 2002). Data remain scant on how many sexual 
minority students have withdrawn from their schools, in part be-
cause admissions data do not track sexual orientation (even 
LGBT scholars like Ronni Sanlo admit that these data—unlike 
information about race and sex, which is typically less fluid and 
controversial—would be hard to collect, while the board of the 
Common Application, an application option offered by 414 uni-
versities, recently rejected a move to include sexual orientation as 
an optional checkbox, citing concerns about how the question 
would be “perceived by students.”) (Sanlo, 2004; Steinberg, 
2011).

However, the 2010 State of Higher Education for LGBT 
People found that 33% of all LGBT students and 38% of trans-
gender students have seriously considered leaving their institution 
due to sexuality-related problems they experienced on campus 
(Rankin, Blumenfeld, Weber, & Frazer, 2010). Sherrill and 
Hardesty (1994) found that 31% of sexual minority students sur-
veyed left their schools for a semester or longer, and 33% re-
ported dropping out completely due to issues surrounding their 
sexual orientation, including harassment (as cited in Sanlo, 2004).

Existing college retention theory, explored more deeply in 
the subsequent paragraphs, has helped guide college policy for 
other student groups in hopes of maintaining student enrollment. 
Retention theory has identified social isolation and alienation, 
difficulty identifying with peers and faculty, and prejudice as 
leading reasons for attrition (Sanlo, 2004). While all students run 
the risk of such experiences, the sexual minority population is 
especially vulnerable in these areas (Sanlo, 2004). More research 
is needed to identify LGBT students’ specific needs and to de-
velop intervention strategies that will allow these students to per-
sist to graduation.

**Risks Beyond Attrition**

The threat of cutting short one’s education is serious. 
However, sustained abuse, harassment, discrimination, and social
isolation can make an impact that goes far beyond decreased earning potential for those students who do not graduate from college. Several well-publicized incidents in late 2010 highlight the need to address the campus climate for LGBT students. One case involved a male student at a large university in New Jersey who committed suicide three days after two of his classmates secretly filmed his sexual encounter with another male student and posted the video on the Web (Hutchinson, 2010). The following week, another openly gay student hanged himself in his dorm room at a university in Rhode Island (Hubbard, 2010).

These were two of five gay youth suicides reported by the national media in the fall of 2010. While each incident was the result of its own separate set of circumstances, these tragic events have sparked serious national interest and concern over the quality of life for gay youths and students (Hubbard, 2010). In her study of the relationship between college students, homosexuality, and suicide, researcher Heather Murphy found that gay, lesbian, and bisexual college students were twice as likely as heterosexuals to have planned and to have attempted suicide in the previous year (University of Washington, 2007). Interestingly, students in this study who identified as heterosexual but reported being attracted to people of the same sex or engaging in same-sex sexual behavior also emerged as a higher risk group (University of Washington, 2007). These students were found to be three times as likely as heterosexuals to have made a plan to commit suicide in the past year and six times as likely to have actually attempted suicide in the same period (University of Washington, 2007).

Lesbian, gay, and bisexual students in Murphy’s study reported more verbal victimization than did heterosexual students, which included homophobic statements; overhearing others talk about gays, lesbians, and bisexuals in derogatory terms; and being harassed for their sexual orientation. More sexual minority students also reported experiencing physical victimization, such as being physically threatened or assaulted, and getting into fights. Murphy noted that the study showed that victimization—not sexual orientation—was the risk factor that increased suicidal behavior risk (University of Washington, 2007). As more research is
Attrition Risk and Resilience

gathered, the challenge to school administrators will be to help reduce on-campus victimization of sexual minority students to keep students enrolled, and, most importantly, to reduce their risk of suicidal behavior.

Retention Theory

Student retention has been studied from a number of perspectives looking to explain the interaction between the individual student and his or her institution of higher education. Starting with Tinto’s Student Integration Model (SIM) of 1975, these theories provide the foundation for intervention programs that have helped decrease student attrition. Retention literature is built on the bedrock of three frameworks that were introduced early on in the study of retention: Tinto’s SIM, Astin’s Theory of Involvement (1984), and Bean’s Student Attrition Model (1980) (McQueen, 2009). These theories, especially the SIM, have sparked dozens of research initiatives to prove, disprove, expand upon, and improve these models, resulting in a more refined idea of what contributes to student attrition.

The SIM has reached “near-paradigmatic status,” having been cited by over 400 papers and linked to 170 dissertations (McQueen, 2009). The SIM places academic and social integration at the heart of the attrition process. This model suggests that, through formal and informal interactions on campus and in academic and social settings, “students either affirm or reevaluate their initial goals and commitments,” and those who lack a necessary amount of interaction with others or experience negative interactions may reevaluate in favor of departing the institution (Fischer, 2007).

Astin’s Theory of Involvement relies on the “input-process-output” model, which posits that the more involvement a student has in various aspects of college life, which is defined as “the amount of physical and psychological energy that the student devotes to the academic experience” (Astin, 1984), the higher the likelihood that the student persists to graduation (Fischer, 2007). Fischer (2007) noted that both the SIM and the Theory of Involvement emphasize the importance of making connections to
individuals and groups as a predictor of student retention.

Bean’s Student Attrition Model is based on the idea that students arrive at a university with certain beliefs and expectations that are either affirmed or disproved through their experiences on campus (Fischer, 2007). Eaton and Bean (1995) updated Bean’s original theory from 1980 to include student background characteristics related to integration, such as socioeconomic status or past academic or personal achievements. This updated version theorizes that social and academic integration combine with characteristics of the university (e.g., administrative response to student needs, faculty-student interaction), as well as personal factors, such as wanting to be with a significant other at another school or losing scholarship funding, to influence the student’s attitudes (Fischer, 2007). These attitudes then determine the student’s feelings of commitment to the institution and his or her sense of belonging (Fischer, 2007).

Where Prevailing Theory Falls Short

Despite a substantial success in helping colleges develop policy and programming to reduce their attrition rates, retention theory suffers from the fact that the prevailing models are based primarily on “the experiences of a ‘typical’ college student who is likely White and middle to upper class” (Fischer, 2007). While many challenges faced by transitioning college students are universal, some issues specific to “nontraditional students” may combine with or supersede more universal concerns to shift priorities related to attrition. For example, receiving a scholarship increases the likelihood of retention for all students (Wohlgemuth, Whalen, Sullivan, Nading, Shelley, & Wang, 2007), but withdrawal of scholarship money would likely combine with or supersede other attrition risks (e.g., social isolation) for a student of a lower socioeconomic background. In other cases, the theory may not be applicable to certain groups. Tinto’s SIM, for example, maintains that separation from home communities is necessary for students to successfully transition to college (Fisher, 2007). However, later research on the retention of minority students found that personal support from off-campus
family and friends was crucial for persistence for some specific minority student groups (Fisher, 2007). In her own work on differences in college involvement by varying race and ethnicity, Fischer adds three factors that may affect adjustment and subsequent success in college: “minority status, socioeconomic disadvantage, and being a first generation college student” (Fischer, 2007). Future research should add “sexual minority status” to this list and guide the creation of college policy to address the specific risks facing these students.

**Attrition Risk Factors for Sexual Minority Students**

As described earlier, very little data exist on the risk and resilience of sexual minority students and college attrition. What is known, however, is that sexual minority students face high levels of stress that differ from those experienced by the general college population (e.g., on-campus discrimination, harassment, and exclusion) (Sanlo, 2004). Some of these additional stressors translate into risk factors for attrition, if analyzed in the context of prevailing retention theory.

**Social Isolation**

As Fischer stated, “There is a reasonable assumption underpinning models of attrition that low solidarity and feelings of isolation prevent social and academic integration” (2007). With the 2010 State of Higher Education for LGBT People study reporting that 23% of LGBT students at U.S. universities have experienced harassment (Rankin et al., 2010), discrimination is likely a prevalent factor contributing to the risk of attrition among sexual minority students. While a record 52% of Americans perceived gay and lesbian relations as “morally acceptable” in a 2010 Gallup poll (Saad, 2010), campus climates still appear less than fully welcoming to sexual minority students. In 2004, fewer than 10% of colleges and universities in the United States had sexual orientation specified in their nondiscrimination policies (Sanlo, 2004). This number has grown over the last several years as more schools have expanded their nondiscrimination policies.
to include sexual orientation; however, as of 2010, more than 33% of all transgender students and 13% of lesbian, gay, and bisexual students report fearing for their physical safety while on campus (Rankin et al., 2010). The recent suicides committed by sexual minority students, discussed above, have highlighted the vulnerability of this population and have increased public concern about the issue (“Raymond Chase”, 2010). Hopefully, this concern will bring about real changes made to public and university policy to improve the campus climates for these students.

As Tinto said, “students are more likely to persist and graduate in settings that involve them as valued members of the institution” (2001). Students who experience harassment and fear for their physical safety will no doubt struggle to perceive themselves as “valued members of the institution,” and, according to this theory, may be at higher risk of attrition.

**Academic Integration**

Academic integration is another important component of all three aforementioned retention theories. Though these theorists diverge on what contributes to or results in academic involvement (McQueen, 2009), Davidson, Beck, and Milligan were able to identify several salient factors, including taking an interest in class discussions and perceiving that faculty cares about students’ intellectual growth (2009). In her article “Campus Climate for Gay, Lesbian, Bisexual, and Transgender people,” Rankin found that 43% of LGBT college students believed their schools’ curricula did not represent the contributions of LGBT people (2003). This perceived lack of representation may affect the strength of sexual minority students’ academic integration [e.g., academic confidence and positive relationships with one’s teachers (Strage, 1999)], or, at the least, support the idea that LGBT students are undervalued in their educational environments.

**The Role of Race**

In her article on the roles of race and ethnicity in college involvement and outcomes, Fischer found that Black and His-
panic students are less likely than White students to succeed in the critical transition to college and less likely to persist to graduation (2007). Fischer determined that heightened risk for these students was the result of compounded factors: Black and Hispanic students are more likely to be first-generation college attendees; more likely to be from a lower socio-economic background; and more likely to struggle with adjustment as a racial minority, if their campus is predominantly White (2007).

If the Black or Hispanic student is also a sexual minority student, the list of risk factors grows beyond the threat of “racial hostility that inhibits their adjustment to college” (Fischer, 2007), to include the potential for harassment or discrimination based on sexual orientation. Moreover, compounding the adjustment issue for racial minority and sexual minority students is that many do not find acceptance in either of their minority groups. Research shows that sexual minority students of color are more likely to conceal their sexual orientation than White LGBT students are (Rankin, 2003). Rankin (2003) found that LGBT students of color did not feel comfortable being open about their sexuality among heterosexual people of color and felt “out of place” in predominantly White sexual minority settings. This effect can heighten these students’ feeling of isolation and increase their chances of attrition.

The Gender Effect

Belonging to two or three campus minorities can have a significant impact on a student’s mental health. In their study of sexual minority college women’s experiences with discrimination, Friedman and Leaper (2010) emphasized that sexual minority women experience both sexism and heterosexism, and reported that experiencing both kinds of discrimination had an “especially detrimental impact on psychological well-being.”

Socioeconomic Status

Studies show that any student who comes from a lower socioeconomic background is less likely to persist to graduation
Mancini

(Wohlgemuth et al., 2007). In a recent survey by Public Agenda, 56% of young adults said needing to work full time was the biggest impediment to them returning to college after they had left (Survey, 2010). Of those surveyed that had failed to graduate, 58% did not receive support from their parents or relatives, and 69% did not receive financial aid support (Survey, 2010).

Black and Hispanic students are more likely to come from lower socioeconomic backgrounds (Fischer, 2007), but for any sexual minority student, financial stress carries an additional risk, because it can be tied to sexual identity. Many students are dependent on some parental contribution to continue their educations. When a student’s sexual orientation is revealed to a parent, withdrawal of financial support is one of the first things that can, and often does, occur if the parent feels angered or betrayed by their son or daughter’s announcement (Sherrill & Hardesty, 1994).

Mental Health and Development

Fear of rejection—from parents, peers, or community—can keep sexual minority students from revealing their sexual identities as they work to determine what exactly their identities will be. Late adolescence and emerging adulthood is a period of significant identity development (Sanlo, 2004). This development is complicated for sexual minority students navigating what are usually heteronormative environments (Friedman & Morgan, 2009)—environments where heterosexuality and heterosexuals are considered “normal,” and nonheterosexual people are considered to be outside the norm. Chickering and Reisser (1993) established seven vectors of development for all college students, including developing competence, managing emotions, moving through autonomy toward interdependence, developing purpose, developing integrity, developing mature interpersonal relationships, and establishing identity (as cited in Sanlo, 2004). It is these last two that pose unique and heightened challenges for the sexual minority student, and Sanlo (2004) theorizes that increased concentration on these two areas of development as students explore and come to terms with issues of sexuality, gender, and
same-sex relationships may come at the expense of other developmental tasks.

That these issues would monopolize the sexual minority student’s developmental process seems reasonable because so many factors are to be weighed. If the student is open about his or her sexual minority status, he or she faces higher rates of harassment and exclusion (Friedman & Morgan, 2009). In addition to affecting a student’s chances of achieving academic success and maintaining enrollment, stigmatization and harassment can result in a variety of serious problems that can have deep impact on the student’s physical and mental well-being (Sanlo, 2004). These potential effects include feelings of alienation and isolation (primary risk factors in attrition), low self-esteem, depression, anxiety, substance abuse, self-destructive behaviors, and suicide (Sanlo, 2004).

Conversely, if the student hides his or her sexual minority status, he or she loses opportunities to form intimate and mature interpersonal relationships that are critical to development (Friedman & Morgan, 2009). According to the 2010 State of Higher Education survey, more than half of all LGBT students hide their sexual identity or gender identity to avoid intimidation. In addition to reducing opportunities to form close relationships, concealing one’s sexual identity can involve maintaining two identities, such as presenting a heterosexual identity to family and friends at home, while cultivating a sexual minority identity at school. Keeping the two identities distinct creates “enormous stress of identity management” (Sanlo, 2004), wherein the student may be in two very different phases of identity development depending on whether he or she is on campus or at home (Fassinger, 1998). This duality significantly complicates the identity development process (Sanlo, 2004).

**Protective Factors**

Whether sexual minority students are open or taciturn about their sexual orientation, some students experience harassment or significant feelings of isolation yet, nevertheless, the students persist to graduation. In fact, “most sexual minority youth
cope with the increased stress and some even excel” despite the pressures created by “threats of rejection, harassment, and abuse” (Sanlo, 2004). To what can the resilience of these students be attributed?

To answer this question would require research yet to be conducted (Sanlo, 2004), but some coping strategies used by persisting students can be inferred from existing literature. Both the SIM and the Theory of Involvement highlight the importance of students making connections to individuals and groups, which increases the likelihood of retention (Fischer, 2007). Indeed, Abrahamowicz (1988) found that students who were involved in campus activities, such as student groups, clubs, arts troupes, and social-community organizations, reported much higher levels of satisfaction with their university than those who participated in noncampus activities. This effect is seen in sexual minority students who are willing and able to join campus groups based on sexual orientation. In their study of sexual minority college women, Friedman and Leaper (2010) found that when these women joined groups based on their sexual orientation, they not only created bonds between the members, but group membership may have protected them from further discrimination—even as increased demonstration of their sexual orientation may have opened them to more potential stigma. By joining a group of people whose identities affirm one’s own, however, an amount of support and protection can be gained that may offset the impact of other stigmatization (Friedman & Leaper, 2010).

Other protective factors identified by the general retention theory discussed above also likely apply to sexual minority students, including higher academic achievement, institutional commitment, degree commitment, strong familial and peer support (Davidson et al., 2007), living on campus (Freeman et al., 2007), athletic involvement, and receipt of financial aid (Wohlgemuth et al., 2007).

**Conclusion**

As retention researcher George Metz (2005) pointed out, there is no “one size fits all” approach to student retention (as
Attrition Risk and Resilience

cited in Davidson et al., 2009). However, researchers have and continue to mete out salient factors contributing to the risk of student attrition and look for ways to enhance what they have identified as protective factors. This has led, in turn, to the adjustment of university policy to improve student retention rates by targeting at-risk students. Based on the concepts in existing retention literature, sexual minority students are at high risk for attrition because of ongoing discrimination and prejudice that reduce their satisfaction and sense of involvement. Universities must show these students that they are valued members of their communities. With 23% of LGBT college students reporting experiences with harassment (Rankin et al., 2010), expanding school nondiscrimination policies to include sexual orientation would be a strong step.

More research is needed, however, to pinpoint the specific attrition risks that sexual minority students face. The loss in human capital is significant for those students who depart from college and never return. The financial losses to the institution from which the student departs are also to be considered. Lastly, it is necessary to acknowledge that these students are visible and important members of college communities who enrich the quality of campus life for all students, and they deserve the same attention afforded other student groups in retention literature.

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Why Weight Matters: Addressing Body Shaming in the Social Justice Community

Farah Fathi

Alarmist messages surrounding the obesity epidemic have influenced many in the social justice community to adopt a combative stance against the purported “fat explosion.” However, by aligning itself with the corporate interests, biased research, and buried prejudices driving the nation’s fear of fat, the social justice community is distancing itself from its original purpose and unwittingly perpetuating a hostile and antagonistic environment for fat people. This paper will serve as a critique of the mainly untested obesity narrative and provide justification for why social workers should frame weight-based discrimination as an issue of social justice.

The national picture of obesity is a negative one. Alarmist headlines refer to fat people as “coronary time bombs” (Blake, 2009) and a “national security threat” (Frum, 2010), and messages surrounding the childhood obesity epidemic perpetuate a doomsday-like atmosphere that questions whether today’s youth will be able to outlive their parents (Hilpern, 2002). Now, even members of the social justice community have entered the anti-fat foray, with Elizabeth Clark, the Executive Director of the National Association of Social Workers, referring to obesity as a “scourge” (Newsweek, 2010).

However, emerging research suggests that such alarmist representations of obesity may be unwarranted. For instance, weight may be an unreliable predictor of future disease and mortality (Campos, Saguy, Ernsberger, Olivery, & Gaesser, 2006), and sustained weight loss is not always possible or even healthy (Bacon & Aphramor, 2011). Nonetheless, there is a noticeable silence among social workers denouncing the perpetuation of anti-obesity rhetoric. This inaction suggests a certain discomfort in providing support for size acceptance and may be indicative of a belief that weight loss should be the main aspiration for fat peo-
This is troubling, considering that weight-based discrimination may not be an entirely separate form of oppression, but rather a continuation of the same social forces aimed at oppressing other marginalized members of society. For instance, Campos et al. (2006) note:

Negative attitudes towards the obese are highly correlated with negative attitudes towards minorities and the poor, such as the belief that all these groups are lazy and lack self-control and will-power. This suggests that anxieties about racial integration and immigration may be an underlying cause of some of the concern over obesity. (p. 58)

It has similarly been observed that anti-fat sentiment is associated with negative views toward women (Campos et al., 2006), implying that weight-based discrimination is not only facilitated by other prejudices, but also may be a venue through which they are further supported.

Yet as long as the social justice community’s endorsement of the prevailing view of obesity endures, various forms of weight-based discrimination will remain unexplored, and any attempts to address them will be inadequate. This paper, therefore, encourages social workers to critically reevaluate their negative assumptions and explore innovative approaches toward advocating for size acceptance.

(Re)Examining the Relationship Between Weight and Health

Much of the difficulty in addressing weight-based discrimination arises from the stigma surrounding obesity, which is tightly woven into the accepted notion that it is universally unhealthy to be fat. This subsequently permits a culture in which weight-based discrimination and stigmatization are frequently justified as forms of health promotion (Ernsberger, 2009).

Yet, the empirical evidence assessing the relationship between obesity and adverse health outcomes is often contradictory,
Why Weight Matters

speculative, and marred by confounding variables. For example, mortality rates may be lower among those whose body mass index (BMI) defines them as “overweight” (BMI > 25) than those who are of “normal” weight (BMI between 18.5 and 25) or are “underweight” (BMI < 18.5) (Flegal, Graubard, Williamson, & Gail, 2005). Fat patients with coronary artery disease may have lower risk for cardiac death compared with thinner patients (Kang et al., 2006), and there are documented survival advantages of obesity against kidney disease, infection, heart disease, cancer, anemia, rheumatoid arthritis, AIDS, and chronic obstructive pulmonary disease (Horwich, Fonalow, Hamilton, MacLellan, Woo, & Tillisch, 2001; Kalantar-Zadeh, Abbot, Salahudeen, Kilpatrick, & Horwich, 2005; Kalantar-Zadeh et al., 2007; Kalantar-Zadeh et al., 2006; Pavelka et al., 2006).

Even if obesity were as detrimental to health as is commonly reported, there are still no definitive ways to treat it in the long-term (Ernsberger & Koletsky, 1999). An interesting irony of traditional weight-management approaches is that they are notoriously ineffective in promoting long-term weight loss and may actually be harmful (Aphramor, 2010). For instance, frequent weight cycling, preoccupation with thinness, negligence of other health issues, low self-esteem, and food obsession are commonly observed among dieters (Bacon & Aphramor, 2011). Research also shows that dieting may actually increase the likelihood that fat youth remain at their present weight or even gain weight (Neumark-Sztainer, Wall, Guo, Story, Haines, & Eisenberg, 2006).

However, these outcomes are not reported in the academic literature to the same extent as are negative associations between weight and health. Ernsberger and Koletsky (1999) examined this trend by reviewing two articles that studied the effects of obesity on heart disease and how often they were cited in the Annals of Internal Medicine. The authors stated that the anti-obesity article was referenced more frequently than the article making no connections between weight and negative health outcomes. Similar results are observed even when articles examine the same dataset, leading Ernsberger and Koletsky (1999) to conclude, “authors show a clear preference for articles that assign a high
risk to obesity, regardless of journal stature or data quality” (p. 248).

The reasons for overstating the health risks of obesity are diverse, but Campos et al. (2006) suggest that financial incentives are partly to blame, because much funding for obesity-related research is provided by the pharmaceutical and weight-loss industries. Therefore, researchers are encouraged to support anti-fat attitudes by broadening the definition of unhealthy weight and exaggerating the associated health risks of obesity in order to sell their products (Campos et al., 2006).

A conflict of interest has similarly given rise to the formation of the “obesity epidemic” in public health. The Centers for Disease Control and Prevention (CDC) in particular has played an influential role in hyping the epidemic to increase funding for their programs (Campos et al., 2006). For example, in 2004, the CDC released a study estimating that 400,000 deaths result annually from obesity; however, that number was found to be an overestimation, leading some to question whether the data were purposefully falsified (Kolata, 2004). In actuality, evidence indicates that people are only slightly heavier than they were a generation ago, with an average per person weight gain of 7 to 10 pounds (Campos et al., 2006; Flegal, Carroll, Kuczmarski, & Johnson, 1998). These gains subsequently inform the public health definition of the epidemic in which more people are classified as being “overweight” and “obese” (BMI > 30), leading Campos et al. (2006) to conclude that “this is hardly the orgy of fast food binging and inactivity widely thought to be to blame for the supposed fat explosion” (p. 55).

**Weight-Based Discrimination and Social Justice**

While much of the nation focuses on obesity prevention, discrimination against fat people remains largely unnoticed (Wann, 2009). A discussion of the sources of weight stigma and how they manifest into the everyday realities of fat people will not only facilitate an understanding of the gravity of weight-based discrimination, but also broaden the lens through which oppression is viewed.
Why Weight Matters

Origins of Stigma

Stigmatization is facilitated by conservative ideology that emphasizes individual accountability and self-control (Crandall, 1995). The concept of personal culpability in justifying discrimination is based on the assumption that being fat is a choice, resulting from a lack of discipline regarding eating and exercise habits (DeJong, 1980). These views negatively affect how others interact with and ultimately treat fat people. For example, stigmatizing conditions that are considered to be within personal control, such as obesity, are less likely to elicit helping behaviors and empathy, and are more likely to evoke anger and dislike (Puhl & Heuer, 2010; Weiner, Perry, & Magnusson, 1988). A perceived lack of body awareness attributed to fat people also instigates society’s need to persistently remind them of their size either through more subtle forms of discrimination or direct harassment. This societal practice of body policing assumes that discrimination is an appropriate means of promoting weight loss (Puhl & Heuer, 2010).

In public health work, labeling fatness as a disease is not only a flawed concept, but also forms a dangerous metaphorical link between health and morality (Oliver, 2006). That is, intrinsic within our ideas about health and morality is the notion that fat is bad and thin is good; therefore, thin people must be “good” and fat people “bad” by proxy. Therefore, using a disease metaphor to diagnose body deviancy is troublesome, as fat people cannot be separated from their bodies, and public health models emphasizing personal culpability and blame tend to contribute to a mass outrage not against the environmental contributors to ill health, but against fat people themselves.

Weight-Based Discrimination: Prevalence and Consequences

A discussion of the manner in which weight-based discrimination can adversely affect the physical, mental, social, and economic well-being of fat people provides further justification for framing weight-based discrimination as a social justice issue. Fat people are at a severe disadvantage when it comes to access-
ing adequate healthcare that addresses their needs with both care and respect. Hospital visits are particularly stress-inducing experiences, because fat patients tend to fear that they will be lectured and criticized by their physicians because of their size (Merrill & Grassley, 2008). Medical equipment is unaccommodating to the needs of fat patients, who may fear that examination gowns, blood pressure cuffs, and waiting room chairs will not be large enough to accommodate their size. This subsequently contributes to feelings of anxiety, shame, and embarrassment around being examined by their doctors as well as a sense of being less than human (Merrill & Grassley, 2008).

Health care providers often exhibit significant anti-fat bias. Physicians may view their fat patients as awkward, ugly, weak-willed, sloppy, noncompliant, and lazy (Foster et al., 2003). Nurses and dieticians similarly report having negative attitudes (Oberrieder, Walker, Monroe, & Adeyanju, 1995; Poon & Tarrant, 2009). Some mental health professionals have even proposed that “obesity” be considered a psychological disorder (Volkow & O’Brien, 2007).

Due to their negative experiences, many fat people delay care or avoid visiting their health care provider altogether. Fat women have fewer Pap tests and mammograms than their thinner counterparts (Wee, McCarthy, Davis, & Phillips, 2000). Even when fat women suspect that they have symptoms of gynecological cancer, many still delay having cancer screening tests (Amy, Aalborg, Lyons, & Keranen, 2006).

In schools, bullies frequently target fat children (Janssen, Craig, Boyce, & Pickett, 2004). These individuals miss school more often than their thinner peers, which may be a strategy to avoid harassment from their classmates (Geier et al., 2007). Weight-based teasing contributes to fat children’s avoidance of physical activities, as they fear being judged by their peers (Faith, Leone, Ayers, Heo, & Pietrobelli, 2002; Pierce & Wardle, 1997; Storch, Milsom, DeBraganza, Lewin, Geffken, & Silverstein, 2007). These individuals are consequently more likely to engage in binge eating and use harmful tactics such as self-induced vomiting, fasting, and smoking as a means of weight reduction (Neumark-Sztainer, Falkner, Story, Perry, Hannan, & Mulert,
Why Weight Matters

Peer victimization over body size contributes to depression and increased suicide attempts among school-aged children (Eisenberg, Neumark-Sztainer, & Story, 2003).

Inequality persists into young adulthood, as fat people are less likely to attend college (Crandall, 1994). A lack of college education contributes to fat people’s economic downward mobility, as Canning and Mayer (1966) seminally note: “obesity is, in part, characteristic of the lower social classes because the obese are prevented from obtaining the education and ultimately the occupation and income necessary to raise or maintain present social class levels” (p. 1174).

In the workplace, fat people are subject to discrimination, particularly in terms of hiring and wages. In experimental hiring scenarios, fat job seekers for managerial positions were less likely to be hired than thinner ones, despite having the same qualifications (Swami, Chan, Wong, Furnham, & Toveé, 2008). Similar experiments suggest that fat women are especially subject to this bias (Pingitore, Dugoni, Tindale, & Spring, 1994).

The impact of weight on earnings also differs across gender. Fat women are more likely to work in low-paying jobs and face more wage penalties because of their weight (Pagán & Dávila, 1997). In contrast, men appear to earn the same salary regardless of weight. However, fat men are overrepresented in labor-intensive occupations and underrepresented in managerial positions where they are typically paid less, which implies that fat men may be avoiding occupations where wage penalties based on weight are more common (Pagán & Dávila, 1997).

This discrepancy in earnings and other discriminatory practices suggest that, when compared to their thinner counterparts, fat people among the higher social classes are more downwardly mobile, whereas fat people among the lower social classes are less upwardly mobile (Ernsberger, 2009). Additionally, it provides more meaningful context to the common observation that poor people also tend to be fatter than non-poor people, as Ernsberger (2009) notes, “although there is some evidence that poverty is fattening, there is much stronger evidence that fatness is impoverishing” (p. 32).
Recommendations

This paper seeks to legitimize weight-based discrimination as a social justice issue by highlighting the origins of stigma and its adverse effect on the well-being of fat people. To promote size acceptance, it is necessary for social workers to advocate for a national health policy that is inclusive of all body types and encourages healthy living based on broader physical, mental, and spiritual factors, rather than solely on weight.

One such approach to wellness is referred to as Health at Every Size (HAES), which embraces body diversity, acknowledges that health is not solely determined by weight, advocates listening to internal body cues to signal hunger, and promotes finding exercise that is enjoyable and not done for the sole purpose of losing weight (Association for Size Diversity and Health, 2009). By taking a more holistic approach to health, individuals are encouraged to evaluate their bodies not exclusively in terms of a number on a scale; doing so helps prevent maladaptive eating habits and attitudes (Bacon, Stern, Van Loan, & Keim, 2005). Such an approach is also crucial to improve societal attitudes and reduce stereotypes by recognizing that weight is not always indicative of individual eating habits, physical activity levels, or psychological issues (King, Katrina, & Hayes, 2003).

Conclusion

Weight-based discrimination is a pervasive social force. Its presence is so ingrained in our culture that it is perceived as being a deserved form of discrimination, not only among those who perpetuate it, but among those who experience it as well. When the social justice community unwittingly participates in anti-obesity rhetoric, its existence is further perpetuated, and fat people are left without any allies—who will advocate for their acceptance and dignity if fat people themselves have an internalized anti-fat bias (Puhl, Moss-Racusin, & Schwartz, 2007)? An alarming contradiction exists when the social work profession, which promotes ideals of social inclusion, antihate, and acceptance, does not extend those same ideals to fat people. When we
live in a society where people would rather lose a limb than be fat (Schwartz, Vartanian, Nosek, & Brownell, 2006), it becomes apparent that anti-fat bias affects people of all sizes, and it is therefore up to those in the social justice community to reverse this trend, not to advance it.

**Note**

Throughout this paper, the term “fat” will be frequently used. Contrary to popular usage, this phrase is actually meant to neutralize weight stigma and is the preferred word choice compared with other, more stigmatizing medical terminology such as “overweight” and “obese” (Wann, 2009).

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Why Weight Matters


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Should obesity be included as a brain disorder? The
Emerging Concerns for International Social Work and Disaster Response: From Relief to Development and Sustainability

Ashley Taubman and Alexandra Weisz

When studying natural disasters, it is necessary to analyze the circumstances with a comprehensive approach that focuses on relief and moving the affected area from development to sustainability. Thus, it is imperative to consider all social, environmental, and psychological factors when addressing the complex needs of disaster response from a social work perspective. To establish immediate and long-term support networks, it is also necessary to bring together interdisciplinary teams to assist in disaster relief efforts. In the past decade, a number of devastating natural disasters have managed to cause death, destruction, and disease within the populations of a vast number of countries. This paper examines global disaster relief efforts for three major natural disasters of the past decade through a review of the literature and from observations made in the field.

Social work practitioners are taught to evaluate situations comprehensively, taking all social, environmental, and psychological factors into account. Therefore, when approaching natural disasters, it is necessary to analyze the circumstances using a comprehensive approach that focuses on relief efforts and moving the affected areas from a development standpoint toward a state of sustainability. Social workers aim to establish immediate and long-term support networks by bringing together interdisciplinary teams to assist in disaster-related efforts. In the past decade, devastating natural disasters have managed to wreak havoc, destruction, death, and disease on the populations of a vast number of countries. Although the actual occurrence of some natural disasters last only a few seconds, their impact influences life-course trajectories throughout generations. The following paper examines global disaster response efforts via field research and litera-
ture reviews after the Indian Ocean earthquake and following tsunami in Asia (2004), Hurricane Katrina on the Gulf Coast of the United States (2005), and the devastating earthquake in Haiti (2010).

In the wake of a natural disaster, communities consistently strive to rebuild infrastructure; however, it is imperative to not overlook the need for mental health professionals. In addition to addressing community rebuilding with nongovernmental organizations (NGOs) and governmental aid, this process should be led through cultural formulation while emphasizing the psychosocial impact on those affected and an overall need for mental health care professionals. In addition to examining global disaster response efforts throughout the past decade, this paper also explores, from a first-hand perspective, why the 7.0-magnitude earthquake in Haiti produced such a sudden-onset crisis. The Central Intelligence Agency states that Haiti is the poorest country in the Western Hemisphere (2011) and its poor infrastructure and economic instability highlight why vulnerable communities have limited access to “safety nets” and why the earthquake has made Haiti a global priority.

**Indian Ocean Earthquake and the Resulting Tsunamis**

On December 26, 2004, a massive earthquake occurred under the Indian Ocean off the coast of Indonesia. The 9.0-magnitude quake created a series of tsunamis that caused great destruction and loss of life throughout the Indian Ocean basin within several hours of the initial earthquake. The U.S. Geological Survey stated that the earthquake-generated tsunami produced the greatest death toll from any tsunami in five centuries, with a total of 275,950 fatalities (Associated Press, 2005). The tsunami wiped away entire villages on the Sumatran shore, tore through coastal areas of Sri Lanka, ravaged the coasts of India, Thailand, Malaysia, Myanmar, and the Maldives, and continued to Kenya, Somalia, and Tanzania. Coastal industrial infrastructure was crushed, structures were destroyed, and an estimated 1,126,900 people were rendered homeless (Olsen, Matuszeski, Padma, & Wickremeratne, 2005).
After this devastation, one of the greatest hurdles toward long-term recovery has been restoring the livelihoods of the survivors of the tsunami. Many of the hard-hit communities already had high levels of poverty, and the large populations of the coastal villages who relied heavily on fishing and farming suffered greatly. While rebuilding and reconstructing communities entails a more straightforward approach, the psychological stress in the aftermath of disasters is more difficult to address (VanRooyen & Leaning, 2005). Rebuilding the community focuses on the immediate needs of the citizens by giving them food and shelter. But discussing traumatic stress and psychologically difficult experiences requires mental health professionals as well as a willingness of the people affected by the disaster to participate. With this understanding, and fearing that psychological damage will impede long-term social recovery, leaders of affected countries are increasingly suggesting that donor nations send teams of international counselors to assist with post-traumatic reactions as a matter of urgency (Silove & Zwi, 2005).

In further examining this need, Hollifield, Hewage, Gunawardena, Kodituwakku, Bopagoa, and Weerarathnege (2008) conducted a study on the psychological symptoms and coping mechanisms of survivors in Sri Lanka roughly 20 months after the tsunami. The researchers found that among participants who were severely affected by the tsunami, the prevalence of post-traumatic stress disorder (PTSD) was 21%, depression was 16%, and anxiety was 30%. Respondents explained that having internal strength, family, friends, western medicine, and religions practices helped them to survive (Hollifield et al., 2008). Yet despite acquired coping mechanisms, a significant percentage of post-disaster affected populations still require mental health interventions.

Committed mental health professionals and corresponding affiliates worldwide strive to coordinate their response efforts to aid those populations seeking to restore their lives to a pre-disaster state. The 2004 tsunami devastated several developing countries in the Pacific region, and while America was rallying behind relief efforts, less than a year later, the United States would also be struck by its own natural disaster.
Hurricane Katrina

In August 2005, Hurricane Katrina struck the Gulf Coast, creating lasting and far-reaching effects. The hurricane caused massive flooding in the city of New Orleans and catastrophic damage along the coasts of Alabama, Mississippi, and Louisiana. An estimated 10 million people residing along the Gulf Coast of the United States were affected by Hurricane Katrina (Hamilton, Sutton, Mathews, Martin, & Ventura, 2009). As a result, Hurricane Katrina caused one of the largest and most abrupt relocations of people in U.S. history (Groen & Polivka, 2008).

Approximately 1.5 million people aged 16 years and older left their residences in Louisiana, Mississippi, and Alabama because of Hurricane Katrina (Groen & Polivka, 2008). Those who remained faced shortages of drinkable water, food, health care, and utility services, as well as long-term health risks from communicable disease outbreaks and environmental contaminants, directly or indirectly associated with the storm (Hamilton et al., 2009). Similar to the catastrophic impact of the 2004 tsunami, one of the pressing needs for the victims of Hurricane Katrina was for mental health professionals’ skills and support. More than 386,000 evacuees received medical or mental health services from shelters.

Survivors remained widely dispersed for significant periods, temporarily residing in all 50 U.S. states and the District of Columbia (Mills, Edmonson, & Park, 2007). Post-disaster research has found that both separation from family and relocation elevate one’s risk for post-disaster mental health problems (Najarian, Goenjian, Pelcovitz, Mandel, & Najarian, 2001). In fact, a recent meta-analysis investigating the effects of displacement on mental health outcomes concluded that displaced persons display worse mental health than nondisplaced comparison groups do. The meta-analysis also found that persons displaced within their own country experience worse outcomes than refugees relocated to other countries do (Porter & Haslam, 2005). Of the Hurricane Katrina evacuees, approximately 410,000 had not returned to their homes by October 2006, and of these, about 280,000 had not even returned to their counties of origin (Groen
In the two weeks following Hurricane Katrina, Mills, Edmonson, and Park (2007) sampled residents of New Orleans who were evacuated to the American Red Cross of Central Texas in Austin. The researchers sought to examine how demographic and disaster-related experiences predict acute stress symptoms among Hurricane Katrina evacuees. Acute stress disorder (ASD), a major stress response in the first month post-trauma, or early PTSD, was the mental health outcome of interest. The researchers found that the emerging predictor of ASD symptom severity was race/ethnicity. The Non-White participants in the sample were both more severely exposed to traumatic experiences and had lower mean income levels than White participants, which suggest that racial status affected the vulnerability levels of the survivors. Minority status itself has been shown to increase the risk of PTSD after trauma, although this effect may be largely because of differential exposure to poverty and violence (Mills, Edmonson, & Park, 2007).

The pre-existing high rate of poverty in New Orleans (close to 28%) amplified the disaster’s impact on individuals through decreased disaster preparedness (Mills, Edmonson, & Park, 2007). Therefore, when the middle class evacuated New Orleans, disparities between the very rich and very poor were even more accentuated. Many of the poor were forced to endure the storm in their homes or move to shelters as a last resort, and many were profoundly affected by the inadequate resources and response (Cutter, 2005). As a result, Hurricane Katrina left destroyed homes and lives in its wake. This forced Americans to look at the poverty that continues to exist in the United States. Ultimately, the inadequate response to the hurricane’s aftermath exposed a failure in emergency response on the local, state, and federal levels, and as such, a failure in the nation’s overall emergency management system (Cutter, 2005). Although America has traditionally been an immediate responder to other suffering nations when a natural disaster occurs, the insufficient and delayed response of the United States to Hurricane Katrina was unacceptable. This pattern was quite distinct from when the earthquake occurred in Haiti: among the first responders to deliver relief sup-
plies was the United States Coast Guard (Morrissey, 2010).

Earthquake in Haiti

On the evening of January 12, 2010, the strongest earthquake to hit Haiti in more than 200 years struck the Western Province city of Leogane. The quake’s epicenter was located 17 km southwest of the densely populated capital Port-au-Prince (UNICEF, 2010a). The quake affected one-third of Haiti’s population of nine million, leaving 300,000 dead and one million individuals homeless. The Creole speaking country is arguably the poorest country in the Western Hemisphere, suggesting a rationale as to why “the coping mechanisms of these communities were and are now stretched to the limit” (UNICEF, 2010b). Haiti’s political fragility and lack of solid infrastructure demonstrate how the environment’s external factors can exacerbate suffering in a disastrous earthquake.

The Haiti Study Tour

From March 14 to 21, 2010, I had the opportunity to join Fordham University’s Graduate School of Social Services Haiti Study Tour, which was organized to assist with on-site disaster relief efforts within the Haitian community soon after the 2010 earthquake. Led by Marciano Popescu, Ph.D., associate professor at the Graduate School of Social Services, the Haiti Study Tour provided students with a unique chance to strengthen their social work skills from an international perspective.

With this goal in mind, Dr. Popescu designed a course, International Social Development and Community-Building in a Global Context, which brings students to different developing countries where they have the opportunity apply theories they learned in class to a real world global context. Dr. Popescu, who traveled with 11 students to the Dominican Republic and Haiti, emphasizes that students cannot truly learn about international development unless they do something that is related to global issues, and asserts that this earthquake has made Haiti a global priority (Sassi, 2010). Thus, the Haiti Study Tour set out to iden-
tify, assess, and evaluate the needs of the disaster-affected communities and post-trauma survivors. Specifically, participants used comprehensive approaches in the development sector by meeting with both government and community leaders to address lifeline resources within the entire Haitian population. After meeting with various NGOs and community leaders, we assessed the most pertinent concerns related to disaster relief efforts such as access to food, water, shelter, medical attention, bathing facilities, electricity, educators, and mental health providers. In examining the response efforts on multiple levels, we had the opportunity to assess post-disaster community needs of the Haitian population in both the Dominican Republic and Haiti.

We spent the first two days in the Dominican Republic, where we met with government officials who are responsible for designing the nation’s social policy platform, and with UNICEF representatives who are coordinating response efforts in Haiti (Sassi, 2010). The UNICEF organization in the Dominican Republic provides operational support to the Haiti operation and strives to meet the needs of displaced Haitians across the border, particularly vulnerable children (UNICEF, 2010a).

**Poverty of Port-au-Prince, Haiti**

After assessing the Dominican Republic’s disaster-related efforts, our 12-person group crossed the border into Haiti where we immediately noticed the displaced camps packed in overpopulated tent cities. While driving through the capital of Port-au-Prince, we began seeing endless seas of camp sites precariously perched in unsafe areas between rubble and other hazards lacking basic shelter and basic social services (UNICEF, 2010b). The chaos was seemingly endless as broken-down medical facilities relocated their patients to the yards of their institutions, under tents, or simply on the ground. The streets were flooded with debris, children were walking aimlessly throughout the city, and mothers were washing their babies in buckets of unsanitary water in the sweltering heat. Here the Haiti Study Tour was able to integrate theory and practice, as students had the opportunity to experience the relationship between impoverished and vulnerable
communities and environmental threats.

**Konbit Pou Ayiti: Working Together For Haiti**

As the Haiti Study Tour continued to drive west of Port-au-Prince, we arrived at our final destination in Jacmel, where we partnered with the nonprofit organization Konbit Pou Ayiti (KONPAY; Working Together For Haiti). Jacmel, a city of 35,000 that is known for its vibrant art scene, lost its city hall, 54 schools, and some 1,800 homes to the earthquake (Sassi, 2010). Additionally, 4,400 homes were partially destroyed, and more than 5,700 families were displaced to tent cities set up by NGOs and the Canadian government.

Established in 2004, KONPAY aims to empower and improve the lives of the people of Haiti by collaborating with other NGOs. The collaboration allows KONPAY to build networks to share innovative technology and expertise to strengthen Haitians’ solutions to social, environmental, and economic problems. Specifically, KONPAY partnered with the Haiti Study Tour to promote awareness on a global level and increase urgency to take action to address the current situation in Haiti. According to Popescu:

> The importance of working with KONPAY was that it focuses on dignified relief and reconstruction efforts that empower Haitians to organize and provide for themselves . . . It gave students a chance to speak with Haitians to ‘learn from them what is needed.’ (Sassi, 2010).

While in partnership with KONPAY and working on a local level, the Haiti Study Tour’s mission was to implement a Work for Cash employment program that incorporated sociological and ecological methods through deforestation and compost techniques. The Work for Cash program was based on self-assertive and empowerment approaches. We designated three main themes to help facilitate the employment program: leadership/management, direct work, and marketing/community education. The unprecedented number of displaced Haitians has
placed a considerable burden on the already weak infrastructure of roads, shelters, medical facilities, and schools. After meeting with local communities’ lawyers and professors and conducting site visits, we were able to identify and prioritize the Haiti Study Tour’s fundraising goals. We created fundraising goals to build latrines, bathing facilities, and educational amenities, as well as to provide mosquito nets to help prevent the spread of malaria.

The Haiti Initiative

Upon the Study Tour’s return to New York City, we had the opportunity to bring new knowledge and ideas regarding global disaster relief into our classrooms and field placements. As a result of the trip, we were able to integrate theory and practice, as well as strengthen our skills in international development and social work. Columbia University School of Social Work held a Haiti forum entitled “Rebuild, Renew and Restore: A Riveting Dialogue on Haiti’s Future.” The forum consisted of panelists from the School of Social Work, the School of International Public Affairs, and Columbia University Graduate School of Journalism. The panelists were able to share their first-hand experiences in assisting in disaster-related efforts. Together, we promoted awareness and increased education among other graduate students and met our fundraising goals to help rebuild the city of Jacmel.

Inspired by international NGOs and the resilient Haitian community, I partnered with the Haiti Study Tour’s team leader Kara Lightburn to further address the needs of the Haitian community by providing disaster-related services. Together, we created The Haiti Initiative (THI), which built a network of agencies, institutions, communities and individuals designed to support each other in disaster relief efforts. Based on the Asset Based Community Development (ABCD) approach co-founded by John L. McKnight and John P. Kretzmann for the Obama Presidential Campaign, we tailored the THI model to more specifically meet the needs of disaster response efforts in Haiti.

Ultimately, THI identifies and uses individual and community strengths by investing in human capital. Our practices are
designed using a humanistic approach that implements empowerment and self-assertive perspectives. We aim to create networks of support through an interlinked comprehensive structure and system by strengthening community ties. THI encourages and provides the capacity for the community to develop ownership of their direction and achieve long-term independence. Similar to the structure of the KONPAY work for cash program, The Haiti Initiative aims to establish relief efforts through community empowerment so individuals have an opportunity to take local ownership in development efforts rather than remain passive consumers of international aid.

**Conclusion**

We believe that community mobilization and strengthening the capacity of existing resources in Haiti to conduct social interventions remains an immediate and pressing need. Poor government infrastructure and economic instability in affected disaster communities highlight the urgency to establish relief efforts that are designed to help vulnerable populations develop and become self-sustained. As international aid focuses on supplying displaced camps with essential lifeline resources, their approach still raises provocative questions. For example, what precautions are implemented to control the increasing numbers of rape and crime victims?

While it is possible to completely repair damaged and destroyed infrastructure over the near future, it is imperative to address the psychosocial impact on Haitians as well. It is our mission, as social work students and as future social work professionals, to promote awareness of the situation in Haiti. We must highlight the importance of early recovery action, the stabilization of the situation, and the prevention of further deterioration.

Disasters will happen. To lessen their impacts in the future, vulnerable communities need to strengthen their resiliency as well as gain awareness of potential risk factors that could impede their quality of life in the event of a disaster. Damaged housing and infrastructure need to be rebuilt and made more resistant to environmental threats. Disasters are income-neutral and
color blind, yet their impacts are not (Cutter, 2005). Research on the 2004 Indian Ocean tsunami, the 2005 Hurricane Katrina in the United States, and the 2010 earthquake in Haiti demonstrates, once again, that impoverished communities suffer greatly from catastrophes that result from natural disasters, as this population often lives and works in highly vulnerable locations.

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Taubman and Weisz

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No Sure Cure for Elder Self-Neglect: 
A Case Study

Jeff Levin

Self-neglecting elders often ignore their own health needs and live unsafely in conditions of squalor. Their choice to live in isolation prevents intervention by loved ones, medical professionals, or agencies such as Adult Protective Services. This case study of a 76-year-old man details the many ways in which self-neglect can affect individuals and those around them. The ethical questions involved illustrate a social work dilemma of weighing an individual’s right to make lifestyle choices versus forcing one to adapt to society’s standards.

Mr. B is a 76-year-old White man who has been living alone in Manhattan for the past 38 years. He stands 6 feet tall, has a gray beard, and lumbers with a cane. Mr. B arrived at the nursing home where I work as an intern having just completed a hospital stay to treat foot ulcers due to complications from both diabetes and gout. When I met him, he had just completed 8 weeks of physical therapy at the nursing home and had moved to long-term care. Mr. B could not return home until Adult Protective Services (APS) conducted a cleaning of his Upper West Side apartment, which was court ordered after his landlord filed a lawsuit against him.

He was one of my first clients, and I felt lucky to be working with Mr. B. He seemed happy to have my companionship for 1 to 2 hours weekly, and he was cognitively intact, which facilitated easy communication. What appeared initially as a straightforward case quickly changed as I learned more about Mr. B. and his life history.

Many of Mr. B’s troubles centered around the lawsuit his landlord filed against him for the condition of squalor in which he was keeping his rental apartment. A few individuals were already playing key roles in assisting Mr. B. in navigating the legal system. Mr. B had a caseworker at APS, who would be a resource for him once he returned to the community. He also had a Guard-
ian Ad Litem, a court-appointed representative put in place by a judge during eviction proceedings, who was helping him fight his case in court. Everyone involved was waiting for APS to conduct its “deep clean,” an intense cleaning and inspection that would make his apartment safe to inhabit. The nursing home, which was my field placement, was required to house a resident who did not have a safe place to go to upon discharge from the hospital.

My assignment was to clinically assess Mr. B in terms of his personal hygiene, social withdrawal, hoarding tendencies, and his overall tendency toward self-neglect. Over the past five years, his poor diet and hygiene had necessitated repeated hospital visits. Without a prior diagnosis of either mental illness or self-neglect, much of the initial insight into his home situation came to social work staff through conversations with his Guardian and APS case worker.

In an effort to understand Mr. B’s current behaviors, I asked him for a great deal of detail about his life. By using the Life Review Method, which is often used with depressed elders (Serrano, Latorre, Gatz, & Montanes, 2004), I heard about the critical events that had shaped Mr. B and changed him. This therapeutic technique also offered a path to identifying and exploring unresolved conflicts that may be contributing to his present difficulties. My goal was to deconstruct Mr. B’s life story to determine when and why he withdrew socially, his financial troubles began, and he stopped attending to his health. For Mr. B, our time together meant that he had someone with whom to talk.

Mr. B described his childhood years as normal and healthy. “I remember my mother telling me to be home for dinner. I rode a bicycle, went to movies, and sometimes played baseball in the schoolyard,” he told me. I probed for critical points in his life when changes took place that may have altered his outlook. This conversation flowed naturally into discussing family relationships. He briefly mentioned his sister, her three grown sons, and one friend, but he considers none of his relationships intimate. He stated that his ability and desire to connect with people is poor. I learned that Mr. B does not articulate emotional attachments, and the loss of a relationship was discussed with the same flat affect as when he conveyed his financial prob-
No Sure Cure for Elder Self-Neglect

lems. His separation from his wife in 1972 left him sad, but he described it as the best thing for both of them, as they had grown apart. He offered no additional feelings or regrets. In another conversation, I probed about the loss of his mother 17 years ago and what it meant to him. Mr. B stated that the most significant change was that she stopped visiting him once or twice each year. He claimed no emotional impact upon the loss of a loved one.

During my clinical assessment, I realized how easy it was to focus on his weaknesses, and began to shift the emphasis onto his strengths. Mr. B had been surviving in New York City, until this point, with no help from anyone. Even though he had an uncertain future in his home and his illness had robbed him of some physical energy, he was determined to return to the community, and he was cooperative with me. Mr. B usually understood everything that was told to him in terms of the logistics around returning home, which was a great asset to our work together.

Unlike Mr. B.’s determination, his gentle demeanor became an obstacle in our work together and exposed several coping mechanisms that he used to avoid facing difficult conversations. For example, when probed about his brief time in the army in Germany, he digressed to a story about the composer Wagner. During a conversation about his childhood, he discussed Catholicism and St. Jude, to whom he prayed when he felt the need. When I inquired further, he answered with a religious lesson rather than explaining the significance of prayer to him. On another occasion, my suggestion that he consider living in some alternative residences led to him talking for ten minutes about Paramount Pictures, where his father worked as a young man.

I tried solution-focused therapy at certain points in our dialogue, an approach that focuses on solution building rather than problem solving (Iveson, 2002). If I could not get a full understanding of the cause of his self-neglect and social withdrawal, maybe we could work together on healthy living habits without talking about the past. Those efforts were met with Mr. B.’s insistence that he has his own way of doing things. His system of soaking his feet in a pail of water to avoid foot ulcers worked for him. He did not want to take showers, nor did he want to eat food that was less likely to aggravate his diabetes. I did, however, get
his permission to apply to two long-term residences where, if accepted, Mr. B could live independently while receiving daily services. At first Mr. B was reluctant, as he wanted to return to his home of 38 years. Eventually he shared with me his fear of being evicted from his home, and for that reason, he allowed me to explore these options. Although Mr. B did not embrace change easily, he recognized its inevitability.

The only personal problems Mr. B would acknowledge were financial, and he avoided even those conversations by telling stories. What Mr. B seemed to most want from me was to listen to him speak about history, literature, entertainment, and religion, and although we spent time doing that, it did not help accomplish our goal of safely discharging him. I remained unable to identify critical junctures where things had changed for him, and wondered how to continue my assessment. At my supervisor’s suggestion, I began reading about what we both perceived as, primarily, a case of self-neglect.

**An Under-Studied Population**

My research goal was to try to identify the cause for Mr. B’s self-neglecting behaviors. Pavlou and Lachs (2006) defined the self-neglecting older population by their inattention to hygiene, typically stemming from an unwillingness to access the resources or services available to facilitate a healthier lifestyle. The authors summarized a group of studies in an effort to consider self-neglect in older people as a geriatric syndrome, meaning that self-neglect may be tied to the circumstances around an elder’s combination of illnesses and decline in old age. It was difficult to apply this research to Mr. B’s case for many reasons. In light of Mr. B’s case, the Pavlou and Lachs review was fairly inconclusive, because each of the studies included used varying definitions of self-neglect, making it difficult to compare the findings clinically. In addition, the general idea of Mr. B’s self-neglect as defined as or linked to a geriatric syndrome did not seem plausible. Mr. B’s sister, who lived in the Washington, DC, area, shared with me over the phone that his self-neglect and withdrawal began around age 60, well before his decline in
No Sure Cure for Elder Self-Neglect

Mr. B’s sister was not involved in his care, but since Mr. B listed her as a contact in his file, I reached out to her to learn what I could. She felt that he had always shown signs of social withdrawal, but it worsened around age 60. At the same time, she noticed an increase in his hoarding behavior. It was at this time in Mr. B’s life that his mother died, and his professional and financial struggles worsened. Her information identified several stressors and suggested the possibility of depression.

Abrams, Lachs, McAvay, Keohane, and Bruce (2002) assessed the contribution of depressive symptoms and cognitive impairment to the prediction of self-neglect in elderly persons living in the community. The authors evaluated 2,161 elderly adults on the basis of a variety of sociodemographic and clinical characteristics. Their results indicated both depression and cognitive impairment as predictive of self-neglect. Furthermore, the study showed that cognitive impairment is a greater predictor than depression. I discussed with my supervisor the possibility of depression as a clinical diagnosis for Mr. B, but we both agreed that some obvious markers of depression were not present in his mood, as he does not disproportionately experience sadness to any greater degree than he does happiness. His affect was typically pleasant.

My supervisor opted not to have a psychiatrist consult on his case, because she did not believe we would learn anything new. I was beginning to realize that Mr. B’s behaviors may not have a clear diagnosis. However, it was his doctor at the nursing home who had suggested the possibility that he had an undiagnosed personality disorder. Further research led me to consider Diogenes syndrome. Diogenes syndrome, as defined by Reyes-Ortiz (2001), consists of severe self-neglect, domestic squalor, social withdrawal, syllogamia or collecting syndrome, and refusal of help. Pavlou and Lachs (2008) defined Diogenes syndrome as composed of at least one of the following characteristics: persistent inattention to personal hygiene and/or environment, repeated refusal of helpful services that improve quality of life, or self-endangerment resulting from unsafe behaviors. Only a few outdated studies have been completed, so diagnosis can be difficult,
but I felt that Diogenes syndrome described Mr. B’s condition well.

One of the few studies on Diogenes syndrome, by Clark, Mankikar, and Gray (1975), looked at 30 elders, aged 66 to 92, each living in domestic squalor and having other common features that suggested Diogenes syndrome. All subjects were known to their local social service departments, and some regularly refused help. Assessment revealed that subjects were cognitively intact as well as above average in intelligence. All required urgent hospital admission with a variety of diseases and deficiencies, and hoarding was another common factor. The study suggested that the loss of professional or family supports could result in a reactive rejection of society’s standards (Clark, Mankikar, & Gray, 1975). Given society’s lack of acceptance of such living conditions, it is fair to note that none of the subjects was impoverished. With the exception of financial stability, Mr. B fit characteristics of Diogenes syndrome.

I also speculated that Mr. B may have encountered loneliness. I knew he had no romantic relationships at this point, and his relatives lived out of state. As his professional life slowed down, his opportunities to engage with others may have been lost. His statement that being alone was his preference could have been a coping mechanism for being alone. Despite his professed desire to be alone, I wondered whether he might have still felt lonely.

A Diagnosis Is Not a Cure

The confidence I felt about my research and assessment for my client was brief, as the realization set in that such a diagnosis did not provide us with a next step. According to Reyes-Ortiz (2001), the goals for an individual with Diogenes syndrome are an improvement in general health and quality of life, but change in diagnosed individuals is difficult and prognosis is usually poor. The author states that there is a 50% mortality rate after hospitalization, and another 25% of patients are placed in long-term care facilities. The author does not offer any time frame related to mortality. According to the research of Reyes-
Ortiz, I would likely not be successful in helping this client change his methods of self-care.

Mr. B mentioned often that he was anxious about the upcoming cleaning that APS would conduct, and how he feared that many of his possessions would be discarded. He described to me the piles of books, old magazines, and video tapes that were in his living room, and I could feel his intense attachment to these possessions. Ayers, Saxena, Golshan, and Wetherell (2010) conducted a study of late-life compulsive hoarding in which 18 adults over 60 years old were interviewed and tested using a variety of methods. They concluded that compulsive hoarding starts in childhood and adolescence, increases in severity with age, and often goes undetected in older adults.

Research states that older adults with compulsive hoarding are usually socially impaired and living alone. In a study by Kim, Steketee, and Frost (2001), service providers reported on 62 elders who met criteria for compulsive hoarding. The most popular items hoarded were paper, containers, clothing, food, books, and objects from other people’s trash. It is not surprising that of those clients that received the study’s intervention, only 15% reduced their hoarding, and more than half experienced no reduction in hoarding. I thought of the prediction from Mr. B’s sister that “it will all just start again when he goes home,” and her idea seemed consistent with the study results. At the time, I was able to sense in her voice her past experiences and unsuccessful interventions with her brother. Simply going into the individual’s residence and cleaning does not improve the situation; hoarding usually resumes once outside agents leave (Reyes-Ortiz, 2001).

One unique aspect of this case was that Mr. B would be going home regardless of our success in addressing his self-neglect, as he eventually stated his desire to return to the community rather than accept other residential options. My attempts to explain to Mr. B that his well-being depended on his self-care, and that there are resources to help him in the community, encountered denial and disinterest. Despite the dangers posed by his own self-neglect, it was my ethical responsibility to send him home, and to do so with a safe discharge.
Complex Logistics of Returning Home

After six weeks of work, and after APS conducted their highly anticipated “deep cleaning,” Mr. B and I began to plan his discharge and address each of the barriers that stood in the way. First, Mr. B needed a home health aide to come in and assist with laundry, shopping, cooking, and showering if he allowed. We arranged for insurance to cover the cost. Second, Mr. B needed a new bed, and his phone and electric services needed to be turned on, as he had not paid his bills in the seven months since his initial hospitalization. For that same period, the post office had been returning all of his mail to senders, as Mr. B did not notify them of his absence from his apartment. Next, his bank card had expired, so he needed a way to get money. His lease expired during his stay at the nursing home, and his landlord had expressed frustration to Mr. B’s Guardian Ad Litem about the rent not being paid, which raised concerns for me as to how Mr. B would be treated upon returning home. Because Mr. B never found help from a community social worker to inquire about aid programs, his rent had crept higher over the years and now exceeded his monthly income, which came solely from social security. The Guardian Ad Litem and the APS worker seldom checked in with him. This put more pressure on me to coordinate communications and keep my client up to date.

Mr. B understood that my task was to assist him, and that we needed to accomplish certain tasks in order for him to return home. We walked to the bank together to renew his ATM card. On a different day, we walked to a nearby barber shop so that he could get a much needed haircut. I called a New York City housing agency to learn more about the process of eviction in case it became something we faced. Also, we got his phone and electricity restored, and I encouraged him to call and keep a dialogue with his sister, so that she could be of some help around discharge time. Finally, looking to the future, we completed two applications to housing facilities that we hoped would provide a comfortable home for Mr. B when the time came for him to leave his apartment. Each time a task was accomplished, Mr. B had the great feeling of being one step closer to his goal of returning.
No Sure Cure for Elder Self-Neglect

home. Mr. B’s patience was the adhesive in our alliance. At the end of our time together, his home health aide did not arrive on the day of his discharge, so I was the one to escort him home. Although it was difficult for us to say goodbye, we parted ways having achieved a safe return home.

Conclusion

A great deal of further research is needed on all aspects of self-neglect in old age. As we age, we all need people in our lives to help us negotiate our care. Mr. B’s circumstances were compounded by the fact that he did not have anyone nearby, such as a relative, friend, or neighbor that he could count on, to go into his apartment and ready it for his return, purchase groceries, or bring important papers to him that may have helped him along the way. This 76-year-old man is alone in the world and was not able to advocate for himself. Mr. B faces new challenges at home, the most important consisting of improving his self-care. My research and my instinct both tell me that he will not be able to effectively address this. We were lucky to work well together, and we accomplished at a minimum his goal of returning home. One day, at the end of a session in which we talked about his parents and their old age, he said to me, “I think about these conversations we’re having. I can see your training and where we’re going with all this. I think about it.” This gave me confidence in our work together, and at that moment I wondered how often he had an individual provide him with attention and respect. Before discharge, he asked me if I could still visit him occasionally after he returned home, “just to have someone to talk with.” I am not permitted to do so, as it is against nursing home policy, but I wish I could honor his request, as I think I have more to learn from Mr. B.

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57 Columbia Social Work Review, Volume II


Psychosis Risk and Prevention of Persistent and Severe Mental Illness: Implications for Social Work Practice

Jordan DeVylder

The prognosis of schizophrenia and other psychotic disorders may be improved through efforts to identify at-risk individuals and to provide early interventions prior to the first episode of psychosis. Psychosis-risk syndrome is gaining recognition as a distinct clinical condition, and may be included as a diagnosis in the upcoming version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). As direct mental health practitioners, social workers are in an ideal position to both address the diverse psychosocial needs and improve the accessibility of services for this difficult-to-define population. As macro-level practitioners, social workers can provide a valuable perspective on ethical issues while advocating to reduce the stigma surrounding the provision of intensive mental health services to individuals struggling with psychosis-risk syndrome.

In recent years, an increasing emphasis has been placed on early identification and intervention in mental health research. A diagnosis known as psychosis-risk syndrome may soon be included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and will eventually be incorporated into general mental health practice (Yung, Nelson, Thompson, & Wood, 2010; Corcoran, First, & Cornblatt, 2010). Emerging evidence supports the potential for early assessment and intervention to improve the long-term prognosis of schizophrenia and other psychotic disorders (Miller et al., 2003; 2002; McGorry et al., 2002). Developing effective treatments for the attenuated symptoms that present prior to the onset of the illness may improve outcomes and possibly even prevent the chronic mental illness from occurring in its entirety. These symptoms can include non-diagnosis-specific negative symptoms such as social withdrawal and a lack of motivation, as well as less-intense forms of the positive symptoms unique to psychosis, such as paranoid delusions and hallucina-
tions (Miller et al., 1999). The definition of psychosis risk is based on either the presence of attenuated psychotic symptoms, the occurrence of a brief and self-remitting psychotic break, or by a family history of a psychotic disorder, accompanied by a recent decline in functioning (Yung, McGorry, McFarlane, Jackson, Patton, & Rakkar, 1996; Yung et al., 1998).

Social work constitutes a substantial portion of mental health services provided nationwide, often serving as the first point of contact with the mental health system for many individuals. Therefore, the social work profession is integral to the development and implementation of practice and policy for the psychosis-risk population. The present paper examines psychosis risk in the context of micro- and macro-level social work. The clinical segment focuses on the early identification of psychosis-risk symptoms and the potential for psychosocial intervention approaches that are specific to this population. Clinical involvement at this early stage allows a rapid response to the first psychotic episode, which greatly influences the severity of disability associated with schizophrenia and other psychotic disorders (Marshall, Lewis, Lockwood, Drake, Jones, & Croudace, 2005; Drake, Haley, Akhtar, & Lewis, 2000). Macro-level issues of interest to social workers focus on addressing the ethics of treating a population that has not yet developed a mental illness, as well as ameliorating the stigma involved in seeking treatment at this vulnerable stage.

**Assessment of Psychosis**

Clinical methods used to identify individuals at an elevated risk for schizophrenia have recently progressed from heredity-based estimates to comprehensive assessments of psychosis-risk symptoms. Early definitions used the family history method, in which the high-risk designation was based solely on genetic relatedness. In the absence of other diagnostic strategies, the family history method carried a rather modest predictive validity of approximately 10%, and was limited to offspring of a parent with schizophrenia (Cornblatt & Obuchowski, 1997). Such a low conversion rate raises significant ethical questions, as providing
Psychosis Risk and Prevention

treatment at this stage would mean treating nine “well” individuals for every one “sick” person (Addington, 2003).

Recently, dedicated assessment tools have been used to identify individuals who meet the relatively stringent criteria of psychosis-risk syndrome, a diagnosis proposed for inclusion in the DSM-V (Yung, et al., 2010; Corcoran, et al., 2010). Contemporary definitions of psychosis risk revolve around symptoms rather than heredity. These symptoms can be similar to those experienced in schizophrenia, but of attenuated severity or duration. Psychosis risk can still be defined based on family history as well, but only when it is accompanied by a recent decline in functioning (Yung et al., 1996). The Structured Interview for Prodromal Syndromes and Scale of Prodromal Symptoms (SIPS/SOPS) looks specifically at recent symptoms and changes in functioning. SIPS/SOPS is an assessment tool that allows clinicians to identify psychosis risk with greater validity than the family history method used in earlier studies (Miller et al., 1999). Individuals identified by the SIPS/SOPS diagnostic instrument convert to psychosis at rates as high as 43–46% after 6 months and up to 50–54% after 12 months (Miller et al., 2003; 2002). Social work training in SIPS/SOPS and other assessment tools may lead to increased identification of psychosis-risk syndrome in the general population, allowing more opportunities for early intervention.

Intervention

Opportunity for the development of preventive treatments has expanded as researchers have become increasingly adept at identifying an at-risk period for psychosis. Research in this area is promising, with one randomized-control trial demonstrating the superiority of low-dose risperidone in combination with cognitive behavioral therapy (CBT) over “needs-based intervention” finding a significant difference in rates of transition to psychosis (9.7% versus 35.7% for the control condition) and a reportedly low incidence of side effects (McGorry et al., 2002). Another randomized-control trial of psychosis-risk intervention found a strong but statistically insignificant trend supporting the efficacy of olanzapine over placebo in preventing the onset of psychotic
disorder (34.5% versus 16.1% conversion). This study likely suffered from deficiencies in statistical power, as it had a low sample size limited by the lack of research participants who met psychosis-risk criteria (McGlashan et al., 2004). The authors believed that these results showed promise for the intervention; however, this must be interpreted with caution because of the failure of the effect to withstand statistical testing.

Regarding treatment modalities, medication alone and interventions focused primarily on attenuated psychotic symptoms may not produce the widespread changes in personal and social functioning that would be needed to prevent long-term psychiatric disability. Instead, this group may require intensive multi-systemic interventions that incorporate issues related to school, employment, housing, family, and other interpersonal relationships as integral components of the pathway to recovery (Fowler et al., 2010). However, psychosocial intervention for psychosis-risk syndrome is a new and developing field, with strong promise but little available published data.

The only published data on psychosocial intervention at this phase comes from McGorry et al. (2002), who identified a significant reduction in rates of conversion to psychotic disorder among participants receiving CBT. However, the CBT group was simultaneously receiving a low-dose antipsychotic medication, preventing a clear interpretation of whether this effect was due to the pharmacological treatment, psychosocial treatment, or both. Despite the lack of published data, most psychosis-risk clinics do include supportive therapy sessions as well as case management for addressing specific problems, such as housing and income issues, while some also include additional psychosocial interventions such as stress-management treatment (Gleeson, Larsen, & McGorry, 2003; Addington et al., 2007).

Many psychosis-risk clinics embrace the use of family interventions to address psychosocial issues in the client (Lefley, 2009). The psychosis-risk period is an ideal time for family-based interventions, as many families are present and willing to provide support and assistance to the client. These families do not show the resentment that tends to emerge in family members at later stages of chronic mental illness (Wong, Davidson,
McGlashan, Gerson, Malaspina, & Corcoran, 2008). Emotional involvement, warmth, and positive comments from family members are associated with an improved symptom profile in the client, suggesting that early psychosocial interventions targeting the family may improve prognosis among adolescents with psychosis-risk syndrome (O’Brien, Gordon, Bearden, Lopez, Kopelowicz, & Cannon, 2006). Although evidence for the efficacy of interventions in the psychosis-risk stage is lacking, there is maintained conviction that the potential benefits of developing an effective intervention justify further exploration (Wyatt & Henter, 2001). In this realm, social work can establish itself as a driving force in the prevention of psychotic disorders through the development of effective psychosocial and family interventions.

Reducing the Duration of Untreated Psychosis

One potential point of intervention for social workers involved with at-risk clients pertains to the early identification of conversion to psychosis. Duration of untreated psychosis (DUP) is the interval between the onset of psychotic symptoms and the initial contact with mental health services. Surprisingly, despite the widespread impact of symptoms, individuals in their first episode of psychosis delay initiating treatment for a substantial period of time. Studies estimate that the DUP lasts a median of 26 weeks and a mean of 1–2 years, with some patients waiting many years to seek treatment (Larsen et al., 2001; Loebel, Lieberman, Alvir, Mayerhoff, Geisler, & Szynanski, 1992).

However, early detection programs can significantly reduce the duration of untreated psychosis (Melle et al., 2004; Johannessen et al., 2001). Ongoing psychotherapy through psychosis-risk services provides a venue for rapid identification and assessment at the onset of psychosis. For those not in treatment, community early detection programs in conjunction with utilization of psychiatric care improves access to early interventions and leads to widespread decrease of DUP. In one study, researchers documented a reduction in mean DUP from 114 weeks to a mean of 26 weeks, following the implementation of an early detection program (Johannessen, et al., 2001). Empirical studies associate
longer DUP with increased symptoms and decreased quality of life, as well as a lower likelihood of remission and, consequently, impaired functioning between episodes of psychosis (Marshall et al., 2005; Drake et al., 2000). Shorter DUP, on the other hand, is associated with improved functioning, reduced symptoms, and improved responsiveness to ongoing treatment (Perkins, Gu, Boteva, & Lieberman, 2005; Robinson, Woerner, McMeniman, Mendelowitz, & Bilder, 2004).

Early medical interventions embrace a different form than treatments for fully developed chronic medical conditions, and this same approach should be considered for early intervention with psychiatric conditions, including psychosis (Francey et al., 2010). Routine treatment for schizophrenia includes long-term antipsychotic medication with intermittent hospitalizations, which may not be an appropriate approach for the psychosis-risk population (Lehman & Steinwachs, 1998). Some researchers propose less-stressful alternative treatments, including in-home services, anxiety medication, and emotional support for the client and his or her family (Moran, 2009; Cullberg, Thoren, Abb, Mesterton, & Svedberg, 2000). One study found that the duration of illness prior to psychosocial treatment had a greater impact on negative symptoms and length of later rehospitalization than duration of psychosis prior to the initiation of antipsychotic medications (De Haan, Linszen, Lenior, De Win, & Gorsira, 2003). Further research is necessary to explore the efficacy of psychosocial interventions compared to psychopharmacological treatment (Bola, Lehtinen, Culberg, & Ciompi, 2009).

Social Workers’ Macro Role

As a profession devoted to the integration of direct clinical services with community level interventions, social workers are positioned to address macroscopic issues related to the ethics, accessibility of services, and social perception of psychosis-risk syndrome. Social workers can advocate for greater access to and use of preventive services for psychosis risk while at the same time addressing the ethical impact on the provision of services prior to illness onset.
Ethics of Intervention Prior to Onset of Mental Illness

Ethical issues are prevalent in psychosis-risk research. By definition, some individuals who meet criteria for psychosis risk will never develop a full psychotic disorder, regardless of whether or not they received treatment. Individuals with psychosis-risk syndrome who later exhibit a remission of symptoms are known as “false-positives,” in that they were incorrectly identified as positive for developing a psychotic disorder (Miller et al., 2003; Yung et al., 2003). In lieu of the benefits of early intervention, the primary benefit of treatment is lost to those who turn out to be false-positives. For this group, the negative effects of unnecessary treatment include the stigma of receiving psychiatric treatment and the effects of unneeded medication, which may outweigh the perceived benefits.

Receiving treatment as a false-positive means that counseling, and possibly medications, are being provided for a syndrome that will never develop. However, individuals with psychosis-risk syndrome do still have clinically significant psychiatric symptoms and would benefit from treatment. In a chart review of 47 individuals enrolled in services at a psychosis-risk research clinic, 90% of individuals identified as at-risk had previously received psychiatric services (Preda, Miller, Rosen, Somjee, McGlashan, & Woods, 2002). Even clients who do not develop a psychotic disorder often develop other Axis I psychiatric disorders and still have psychological issues that can benefit from early intervention (Schaffner & McGorry, 2001). For example, the McGorry et al. (2002) study, which provides the only published evidence for an efficacious intervention at the psychosis-risk stage, also found improved scores across all areas of functioning among the group that did not develop a psychotic disorder. This indicates that psychosis-risk treatment does not solely benefit those that later develop schizophrenia.

Psychiatric treatment may improve symptoms, but it simultaneously exposes the recipient to the effects of stigma. These effects include a reduction in self esteem, perceptions of devaluation of discrimination, and social withdrawal (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Stigma presents
a risk of damage to self-image, destabilizing interpersonal relationships, and inflicting feelings of being “fragile, damaged, or a little bit sick” (Corcoran, Malaspina, & Hercher, 2005). However, initial examination into this issue suggests that most individuals receiving services see the evaluation as beneficial; they prefer to receive accurate information regarding their at-risk status rather than to continue being confused about the meaning and prognosis of their developing symptoms. The clarification of the condition appears to ameliorate much of the stigma related to treatment (Addington, 2003).

Ethical issues relating to non-maleficence, or treatment risk, become more complex when antipsychotic medications are prescribed. An early intervention study showed that at-risk individuals who were given low doses of antipsychotic medication converted to psychosis at a much lower rate than those who simply received case management (McGorry et al., 2002). The trade-off is that these drugs may have quite severe side effects. Psychosis-risk studies conducted to date have prescribed very low doses of antipsychotic medications, such as olanzapine and risperidone, which only produced minor side effects that were easily managed through consultations with the psychiatrist (McGorry et al., 2002; McGlashan et al., 2004). Despite negligible medical side effects, antipsychotic medications cause significant weight gain that negatively affects self-image and long-term risk of obesity and diabetes (Corcoran, et al. 2005). This will continue to be a difficult ethical issue as further research is conducted on the pharmacotherapy of psychosis-risk syndrome.

**Advocacy**

As the issue of psychosis risk becomes more recognized in the community, it will be met by novel manifestations of stigma and barriers to treatment. In these circumstances, responsibility for addressing communal and societal issues falls under the purview of the social work profession. One topic of concern is the inequity in access to services early in the course of mental illness. For example, African Americans have historically been vulnerable to prolonged exclusion from treatment due to greater
levels of community stigma and socioeconomic disparities. Consequently, this population can be less likely to receive psychiatric care following their initial contact with service providers compared to other racial and ethnic groups (Merritt-Davis & Keshevan, 2006).

One study found that African Americans compared to Asians or Whites are significantly more likely to make three or more contacts with mental health service providers before receiving treatment, are less likely to be referred by their general practitioner, and are more likely to have police involvement in their initiation of mental health services (Commander, Cochrane, Sashidharan, Akilu, & Wildsmith, 1999). Furthermore, a nationwide study by the Centers for Disease Control and Prevention identified numerous barriers to recruitment among racial minority populations, including the knowledge of human subject abuses by past researchers, an absence of information regarding current research practice, distrust of informed consent and institutional review boards, and suspicion of research scientists. These barriers exist despite a general belief among this population that medical research is important and beneficial (Freimuth, Quinn, Thomas, Cole, Zook, & Duncan, 2001). Although complicated racial inequities endure, social workers can provide community psychoeducation in an effort to reduce stigma while simultaneously working to rectify racial disparities in the attention paid to psychiatric issues by primary care physicians.

Conclusion

Despite growing evidence for a distinct psychosis-risk period preceding the onset of schizophrenia, individuals at risk for psychosis have received minimal attention on a societal level. New issues may arise once psychosis risk becomes a more recognized diagnosis and treatment shifts from research clinics to community care. The psychosis-risk population exists on the cusp of mental illness. It is difficult to predict the issues that may arise for this group, as no equivalent group has been so formally defined in the past; mental illness tends to be identified by existing behavior rather than susceptibility. Formal recognition is needed to pave
the way for the development of evidence-based interventions aimed specifically during the psychosis-risk phase, as well as to allow treatment coverage by insurance providers. Concurrently, this group needs support in the recognition that they may not develop a full psychotic disorder and should not be inflicted with the stigma that unfortunately accompanies chronic mental illness.

In looking toward the future, the proposed addition of psychosis-risk syndrome to the upcoming *DSM-V* (Yung, et al., 2010; Corcoran, et al., 2010) highlights the increasing prominence of preventive measures in the treatment of schizophrenia and other psychotic disorders. In both macro- and micro-realms, social workers are well poised to influence the development and implementation of services for this population. Effective intervention at this phase may depend less on psychiatric hospitalizations and antipsychotic medications and more on modifying learned behaviors, providing emotional and family support, and making accurate assessments early in the course of illness. As this diagnosis develops and evolves from a set of symptoms to a formal syndrome, there will be a growing need to alleviate stigma related to seeking treatment, and to carefully consider ethical issues regarding appropriate treatments for an at-risk population.

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Psychosis Risk and Prevention


Psychosis Risk and Prevention


Successful Community Reentry After Incarceration: Exploring Intangible Aspects of Social Support During the Reintegration Process

Ursula Helene Kiczkowski

The United States prison population and rate of incarceration have climbed to the highest worldwide, and mass incarceration has become a concerning social issue. Research demonstrates that incarceration adversely affects social networks, increases risk factors for children of incarcerated parents, and economically and politically disenfranchises communities and neighborhoods. Through critical examination of the existing rubric of incarceration, reentry emerges as an integral point of intervention for social workers to disrupt the chronic cycle of recidivism and downward spiral caused by incarceration. While past research has provided a cursory knowledge of the risk and protective factors that predict reentry success, much remains obscure. The purpose of this qualitative study is to explore the intricate, recondite, and intimate ways that family members function to assist the formerly incarcerated individual during reentry. By analyzing data through a transactional social support paradigm, this paper expands upon and enhances existing literature on the implicit functions of familial social support during prisoner reentry. Implications for social work practice with formally incarcerated individuals are explored based on key findings from the study.

In 2008, the Pew Charitable Trusts reported that the United States rate of incarceration reached an astonishing 1 in 100 people behind bars (The Pew Charitable Trusts Center on the States, 2008). Among Hispanic men aged 18 and older, this rate is 1 in 36, and for African American men between the ages of 18 and 34, the number jumps to 1 in 9. This surge in the population imprisoned by the U.S. penal system represents the highest rate of imprisonment of any country in the world. Alongside a precipitous growth in the national incarceration rate are record numbers of individuals completing prison sentences and reentering society.
(Pinard, 2007). Upon reentry, several barriers are laid bare by high recidivism\(^1\) and prevent former prisoners released from correctional custody to truly re integrate into the community. Furthermore, the collateral consequences of incarceration can be prohibitive and debilitating to healthy reintegration into social, familial, community, and work life upon release. Due to the stigma of imprisonment on occupational, social, and familial settings, the prospects of long-term success for people with criminal records can be dismal. Through critical examination of the existing rubric of incarceration, reentry emerges as an integral point of intervention for social workers to disrupt the chronic cycle of recidivism and downward spiral of incarceration.

While there is cursory knowledge of the risk and protective factors that predict reentry success and recidivism, much remains to be examined. Some empirical studies have demonstrated the positive impact of family support systems on reintegration, yet the intricate, invisible, and intimate ways that family members function to assist the released individual are largely undocumented. The purpose of this research study is to develop a deeper understanding of the implicit functions of less tangible but equally valuable aspects of familial social support. A transactional social support paradigm is used to expand upon and enhance existing literature on the implicit functions of familial social support during prisoner reentry. Implications for social work practice with formally incarcerated individuals are explored based on key findings from the study.

**Mass Incarceration, Reentry, and Recidivism**

Mass incarceration in the United States is a social issue that demands both clinical research and attention at the policy level. According to the United States Bureau of Justice Statistics, in 2009 the total federal, state, and local adult prisoner population consisted of nearly 2.3 million individuals (Glaze, 2009). Furthermore, the United States incarcerates at a rate of approximately 750 per 100,000 residents, representing the highest rate worldwide (Bouffard, 2007; Clear, 2008; Day, 2005; Hartney, 2006; Martinez, 2007; The Pew Charitable Trusts Center on the States,
Reentry and Successful Reintegration

2008). This is significantly higher than that of European inmate populations, including the Russian Federation (628 per 100,000 residents), Belarus (426 per 100,000 residents), and Georgia (401 per 100,000 residents). Additionally, racial disparity in incarceration rates is a conspicuous and problematic reality (The Pew Charitable Trusts Center on the States, 2008; Cooke, 2005; Hartney, 2006; Pettit & Western, 2004; Western & Pettit, 2002). African-Americans are between 6 and 8 times more likely, and Latinos twice as likely, to be incarcerated than Caucasians; African-American men make up 45% of the prison population. Research demonstrates that mass incarceration adversely affects social networks, increases risk factors for children of incarcerated parents, economically and politically disenfranchises communities and neighborhoods, and ultimately contributes to a pernicious cycle of social exclusion and disadvantage for individuals, families and communities affected by incarceration (Kjelsberg & Frestad, 2008; Petersilia, 2001; Pettit & Western, 2004).

Disturbingly high recidivism rates underscore many of the social, economic, and psychological consequences of incarceration and the challenges of community reintegration. At a minimum, 95% of prisoners complete their prison or jail sentences and reenter the community (Hughes & Wilson, 2002). Recent estimates indicate that at least 700,000 individuals are released yearly (Austin, 2001; Bureau of Justice Statistics, 2010; Draine & Herman, 2007; Johnson-Listwan, Cullen, & Latessa, 2006; Simonson, 2006; Travis & Petersilia, 2001). Of this cohort, it is estimated that two-thirds will return to correctional custody (either as a result of parole violations or a new offense) within the 3-year period following their release (Mears, Wang, Hay, & Bales, 2008; Mellow & Christian, 2008; Petersilia, 2001; National Reentry Resource Center, 2010). Increasing successful re-entry experiences has the promise of reducing fiscal strain, societal costs, and personal collateral consequences associated with incarceration that weigh on the individual, family, community, and government.
This research was conducted as a qualitative study consisting of face-to-face interviews with three formerly incarcerated men. As a second-year social work intern in a New York City reentry program, I met the three gentlemen over the course of 5 months. The interviewees were invited to participate in the research, and it was communicated both in writing and verbally that involvement was voluntary. Written informed consent was obtained from each participant. In-depth, semi-structured interviews were conducted through seven open-ended questions. The interview outline consisted of questions that explored the individual's primary relationships during reintegration from prison and what in these relationships he found most meaningful. The questions were as follows:

1. Could you tell me a bit about the main relationships in your life during your reintegration?
2. Please tell me about your most valued relationship/s among these?
3. Can you describe your relationships with these person/s? What do you find helpful in those relationship/s?
   Intangible things
   Aside from material things like housing or food, are there things that you gain?
   Do you feel supported emotionally?
   Do you feel a purpose?
   Do you feel needed or important to that person/s?
   Do you feel appreciated or valued?
   Do you feel cared for?
   How do they (s/he) show they (s/he) care/s?
4. What do you value most in those relationship/s?
5. What do you find most useful in those relationship/s?
6. Do you feel you have a clear role in your family or circle of friends?
7. How do you feel this would have been different if you had been staying in a shelter or transitional residence?

All three men are fathers and, at the time of interview, were under
parole supervision and living with family or an intimate partner. Names of interview participants were replaced with the pseudonyms Dale, Stanley, and Mark to maintain anonymity. Dale is an African-American male in his mid-50s who lives with his long-time partner (who I refer to as Tina). In his most recent prison sentence, Dale served 2 1/2 years. Stanley, a West Indian male in his mid-50s, served 3 years for his most recent offense. He lives with a woman who, for the past decade, has sporadically been both friend and girlfriend. Finally, Mark is an African-American male in his late 30s who completed a 12-year sentence. He lives with his mother, father, and younger sister. All three men reside in New York City.

The role of family during the reintegration process was examined through qualitative analysis of participants' perceptions and interpretations of family dynamics and relationships. Strong consideration was given to the impact of domicile on each family's ability to perform the less-tangible, though strongly meaningful, aspects of support. Interview data were grouped into one of two categories: features of primary relationships or transactional social support.

Results

Features of Primary Relationships

All interviewees indicated that their most valued relationships were with immediate family members, including children, parents, and romantic partners. When asked what they found most useful in these relationships, all suggested informal, less-tangible articulations of support, such as love, caring, guidance, and realization of social role. Much of the anecdotal evidence they imparted, the moments or situations that produce this support, would be lost had they not been residing with family. Living with family members afforded all three men opportunities for the exchange of support.

Dale stated that along with his daughter, his partner Tina was the central figure in his reentry. In the final 3 months of his sentence, Dale and Tina worked deliberately on building their
communication skills and strengthening their relationship. When he was released to Tina’s residence, he immediately began relying heavily on instrumental and emotional sources of support from her. These included housing, financial assistance, emotional support, and help with navigating the responsibilities, requirements, and psychosocial stressors that accompany reentry. Dale also commented repeatedly on the pleasure and meaning gained from playing an active, parental role in his adult daughter’s life.

Stanley and Mark both identified their teenage children as providing the most valuable relationship during their reentry. Stanley's son is 15 years old and lives with his mother. Mark's 17-year-old daughter has an infant and lives with the child's father and family. Stanley and Mark see their respective children on a weekly basis and engage with them in a variety of positive, productive, and interactive activities. Stanley plays ball with his son, helps him with homework, and takes him to museums, parks, his home, the movies, and arcades. He converses extensively with his son and offers advice and guidance liberally.

Mark socializes with his daughter and serves as relief caretaker for his granddaughter. Their shared time is rich with laughter, conversation, and counsel. He accompanies his daughter to school at times, when he perceives a need to advocate on her behalf, and provides input on how to be a “good parent.” Mark reported that in addition to his daughter, his relationship with his mother was most valuable during reentry. He assists her with errands, cooking, and household tasks. When she was hospitalized shortly after his release, Mark assumed many of these domestic tasks in her absence. He expressed satisfaction in being able to provide for his father and sister in these ways and to reciprocate the caring gestures he felt from them. While playing an active role in contributing to the well-being of his family members, Mark described receiving meaningful support from them as well. This was conveyed through “advice…a lot of ‘I love yous;' and [the] help that they provide.” Some of the most salient examples of the informal support imparted to Mark by his family members were elucidated when he discussed his readjustment to society after 12 years of prison life and isolation from society.
Reentry and Successful Reintegration

I think about the first day I got released from prison. The world [had] changed. It's a very, very devastating effect, when you walk out of prison... The first thing I noticed was that people were all walking around with cell phones, or some type of gadget… it’s like ‘Wow, what is there to talk about?’ ... All day long, everybody's walking and talking.

Mark’s words provide a window into the subtle psychological and emotional adjustments that occur at times in the reintegration process. Mark explained how his family members assisted him in adjusting to many simple yet profoundly overwhelming developments that he was negotiating in his environment. They eased his process of acclimation.

[Your family knows] you're in a state of shock. And...they are able to walk you through the transition and explain 'This is what's going on, this is what's new, lemme teach you how to operate a cell phone, lemme teach you how to use DVDs.' Your family is there to coach you through everything. They gonna crawl you until you walk again.

These excerpts illuminate some of the many ways that healthy family dynamics can operate as stabilizing forces during the potentially chaotic and challenging reentry process. They speak to the unique role that those who are intimately involved in this process have in easing the strain and discomfort that accompany reintegration into civilian life. Explicit efforts on the part of family members to assist their reentry process are easily considered social support. Yet what we begin to see is that there are more subtle forms of support, found within the context of family and home, which urge us to conceptualize and dissect social support in a more expansive fashion. These intricacies became particularly apparent when respondents articulated the benefit provided by transactional social support.
Transactional Social Support

Transactional social support is understood as the interrelated systems of caring, assistance, and support that increase the capacity of respondents to provide meaningful contributions to others. The multidirectional exchange of support within the family system not only provides necessary social support (instrumental and emotional) to the vulnerable individual, but also allows him or her to find a sense of purpose by contributing to others in important and consequential ways (Martinez & Christian, 2009; Naser & LaVigne, 2006). The positive gain from this process is exponential as all parties are strengthened and empowered. The application of a life-course perspective illuminates how transactional support fortifies social bonds and allows for the fulfillment of important social roles within the family such as provider, caretaker, and productive family member (Elder, 1994; Hutchinson, 2005; MacMillan & Copher, 2005). It conditions a core of resilience and sense of mastery, which, along with meaningful role fulfillment, is eroded by the social, political, and psychological architecture of the incarceration process.

Transactional support was emphasized and evidenced in all three interviews. Respondents ascribed more value to relationships in which they were able to contribute and assume a supportive role for their loved one. This was apparent in comments such as Mark’s response to the question of what was most helpful for him within his primary relationships: “To find out the importance that the male role model plays in the family. We play a major impact in the family. People always come to me for advice…it’s very important.”

It is noteworthy that when asked what was “most helpful” in his relationships, Mark identified not something given to him, but rather something he provided to those for whom he cares deeply. Without the support of his family, Mark's ability to assume meaningful familial roles and provide love, assistance, and care to his mother, daughter and granddaughter would be greatly compromised. Residing with family rather than in a shelter enabled Mark to care for his granddaughter for extended periods of time. When asked to clarify why seeing the importance of the
male role in the family was most helpful, he responded, “Because your life has more meaning when you're playing your role in society and in life in general... It's definitely something that motivates you.”

Stanley's response to the first interview query (“Could you tell me a bit about the primary relationships in your life right now?”) also illustrated transactional support. After stating that the most important relationship in his life is his 15-year-old son, he went on to explain, “he needs a person to guide him, a role model. Even though in the past I had problems with the law, that don't stop me from teaching him the right from the wrong.” The significance of his presence in and contributions to his son’s life were central in Stanley’s evaluation of meaningful social relationships. This deviates from traditional, unidirectional views of social support. However, I purport that the ability of these men to contribute in meaningful ways to their loved ones, and the welcoming of these gestures by loved ones, function poignantly as sources of support.

**Discussion**

Research has indicated some pragmatic, circumstantial, and behavioral factors that predict successful reentry, including a strong family support system. However, the intricate, recondite, and intimate ways that family functions to assist the formerly incarcerated are less understood (Martinez & Christian, 2009; Naser & LaVigne, 2006; Naser & Visher, 2006; Yahner & Visher, 2008). Research findings in the present study corroborate with scholars in the field by enhancing the existing literature on familial social support during prisoner reentry. This appeared prominently throughout the interviews. Participants noted family members with whom they exchanged caring gestures, support, and affection as key in their reintegration. Parenthood was central in the men’s stories (offering support), for instance, as was feeling cared for (receiving support). Both receiving and providing support and care compelled the men to be more conscientious and intentional in their decision-making and behavior. What they described in these relationships overall were pro-social attitudes and
behaviors stemming from strengthened sense of purpose and sense of self.

Juxtaposing the findings of this study with existing literature on the role of family support during reintegration raises many questions and begs for further research. This study paves the way for future qualitative analysis that is critical in our quest to understand predictors of successful reentry into the community after incarceration. Rigorous research into the nuanced role of family, the impact of domicile, and the very definition of social support has the potential to bridge the gap and ease the contradiction between empirical evidence and policy implementation in regard to family support and prisoner release.

Despite limitations in study design and sample selection, considerable insight was obtained into the ways in which formerly incarcerated individuals gain social support from family and intimate partners. The qualitative nature of the study design, in conjunction with a small sample size, limits the generalizability of the study results. Additionally, future analyses must examine reentry success in broader terms through longitudinal mixed methods approaches. Quantitative empirical studies with robust sample sizes would provide a population-level assessment of the benefit of transactional support to formally incarcerated individuals. However despite the aforementioned limitations, there is considerable insight that can be gained from these findings for practicing social workers and for anyone who works in the field of prisoner reentry in the United States.

Given that social workers practice as clinicians, researchers, and policy makers at the micro, mezzo, and macro levels, the profession is uniquely poised to take on the issue of reentry with a holistic perspective and to engage in addressing it from multiple angles. Prisoner reentry is an issue of social justice and civil rights that affects a large portion of our population. It is our responsibility as agents of social change to make a sincere commitment to restoring basic human rights and full participation in society for all citizens.
Reentry and Successful Reintegration

Note

1 For the purposes of this analysis, recidivism refers to rearrest, reconviction, and/or reincarceration occurring at any point during the 3 years following release from prison.

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Reentry and Successful Reintegration


Contributors

JORDAN DEVYLDER is a second-year student in the Advanced Generalist Practice and Programming method with a concentration in Health, Mental Health, and Disabilities. He is currently an intern with the Center of Prevention & Evaluation and the Center for Practice Innovations at New York State Psychiatric Institute. He holds an M.S. in Experimental Psychology from Georgia Institute of Technology. His email address is jed2147@columbia.edu.

FARAH FATHI is a second-year student in the Policy Practice method with a concentration in Family, Youth and Children's Services and a minor in International Social Welfare. She is currently placed at the NYC Department of Youth and Community Development. She holds a bachelor's degree in psychology from North Central College. Her email address is fnf2102@columbia.edu.

URSULA H. KICZKOWSKI completed her M.S. in Social Work from CUSSW in May 2010. As an Advanced Generalist Practice and Programming student focusing on Contemporary Social Issues, she did her second year field placement in the Social Work/Reentry Program at the Office of the Appellate Defender. Since graduating, Ursula has been working in an alternative-to-incarceration program at the Center for Alternative Sentencing and Employment Services as a social worker on their ACT team providing mental health services to individuals with felony convictions and serious mental illness. Her email address is ursulahelene@gmail.com.

JEFF LEVIN is a first-year student at CUSSW. He is interested in aging as well as working with members of the LGBTQ community, and he plans to pursue the Advanced Clinical Practice method with a concentration in Health, Mental Health, and Disabilities. Jeff’s current placement is at Jewish Home Lifecare in New York City.
Manhattan, where he provides clinical services to individuals, family members, and groups. His email address is jml2238@columbia.edu.

OLIVIA MANCINI is a first-year student at CUSSW and will continue next year in the Advanced Clinical Practice program. She holds a B.A. in History and her background includes research, writing, and teaching. She currently teaches two courses at Pennsylvania State University's World Campus. Her email address is ocm2108@columbia.edu.

ASHLEY TAUBMAN is a second-year Advanced Clinical Practice student with a concentration in Health, Mental Health, and Disabilities and a minor in International Social Welfare. Currently, she is interning at Soundview Throgs Neck Community Mental Health Center via the Albert Einstein College of Medicine at Yeshiva University where she works with adults who have severe and persistent mental illness. Her email address is ant2107@columbia.edu.

ALEXANDRA WEISZ is a second-year student in the Advanced Clinical Placement method with a concentration on Family, Youth and Children. Currently, she is in the Trauma-Focused Cognitive Behavioral Therapy Program at Columbia and is placed at the New York Society for Prevention of Cruelty to Children, where she works with children and adolescents who have experienced significant trauma. Her email address is amw2173@columbia.edu.