Journal of Sociology and Social Work
June 2021, Vol. 9, No. 1, pp. 20-31
ISSN: 2333-5807 (Print), 2333-5815 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/jssw.v9n1a3
URL: https://doi.org/10.15640/jssw.v9n1a3

A Socio-Behavioral Model of Clinical Social Work Practice

Larry W. Whorley[1], DSW, LCSW

Abstract

The socio-behavioral model of clinical social work practice is based upon an integration of social learning, social role, social resources, and ecological theories. Social behavior is defined as an exchange of interpersonal resources balanced against a denial or withdrawal of resources (barriers). The model's intervention strategy involves (1) enhancement of the client's personal, social, and natural resources as well as social connectedness and (2) reduction of recovery barriers (personal, social, and natural barriers as well as social isolation). The clinician and client are seen as social change agents who implement this intervention strategy at micro-, meso-, and macro- system levels. Also, the social change agent role promotes client empowerment and contributes to strengthening of the social fabric. In addition, social workers historically have been divided regarding their focus upon either individual/family or community organization/social action intervention. The socio-behavioral model serves as a bridge between these two service orientations. Also, the social worker's role in encouraging client self-advocacy, community engagement, and linkage with social resources strengthens a distinctive professional role within the mental health field.

Keywords: socio-behavioral, clinical social work, resources, social connectedness

1. The Socio-Behavioral Model

The socio-behavioral model incorporates social learning, social role, social exchange (resources) theories, and the ecological perspective. This model has been applied to addiction treatment (Whorley, 2019), couples therapy (Stuart, 2003), community and organizational settings (Rothman & Thyer, 1984), and general social work practice (Thomas, 1967). It has both a sociological and psychological emphasis. The approach provides an important framework for addressing the issues of protective factors for mental health recovery and recovery barriers. Metaphorically, protective factors (personal resources, social resources, natural resources, and social connectedness) are the "engine" advancing progress, while recovery barriers (personal, social, natural barriers, and social isolation) are the "brakes."

From the perspective of the socio-behavioral model described in this article, the mission of clinical social work is the enhancement of mental health recovery through improved psychosocial functioning at micro-, meso-, and macro- system levels. This is accomplished by both the clinician and the client (i.e., individual, group, or family) acting as "social change agents" to increase individual, family, neighborhood, and community strengths as well as to decrease personal and social barriers to mental health recovery.

2. Mental Health Recovery

Mental health recovery has been defined from different perspectives, leading to uncertainty in clinical social work practice and the general mental health field (Onken, Craig, Ridgway, Ralph, Cook, 2007; Starnino, 2009). Therefore, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) developed a unified working definition of recovery from all mental disorders, including substance use disorders. This definition states that mental health recovery is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential." (SAMHSA, 2010).

[1] 853 Henderson Dr. Lexington, Kentucky 40515, USA, larry.whorley@outlook.com

The definition specifies four dimensions that support mental health recovery: (1) Health (Managing one's diseases), (2) Home (A stable and safe place to live), (3) Meaningful daily activities (e.g., job, school, volunteerism, independence, income, and resources to engage in the community), and (4) Community (Social relationships; social support; love). These four dimensions include personal strengths (resources), social resources, and social connectedness as crucial determinants of recovery.

3. The Challenges of Mental Health Recovery

The challenges of the recovery model create a critical need for client resilience in the face of an expectations of an active role in recovery. The client's active role in recovery has become a critical emphasis of the recovery-oriented movement (Davidson, 2016). However, an active role places more responsibility upon the client to practice self-management techniques and to connect with social resources such as agencies, government offices, and peer support organizations. This is seriously challenging work for anyone but especially for those clients who have an external locus of control and a passive attitude toward recovery ("Resilience | Psychology Today," 2019).

Therefore, the client will be better equipped to meet the challenges when treatment is focused upon enhanced personal strengths and support from social resources from the client's immediate support (e.g., family, close friends, peer support group sponsors), neighborhood, and community resources as well as social welfare resources at the societal level.

4. Recovery Capital

The concept of recovery capital provides a framework for understanding personal and social resources. "Recovery capital is the sum of personal and social resources at one's disposal for addressing drug dependence and, chiefly, bolstering one's capacity and opportunities for recovery" (Granfield &Cloud, 1999; 2009, Cloud & Granfield, 2008; Granfield & Cloud, 2001). Grandfield and Cloud defined recovery capital as the "the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from AOD (alcohol and another drug) problems." Internal resources are personal sources (i.e., personal strengths), while external resources are social resources. Further research has extended the recovery capital concept to general mental health (Tew, 2013).

Granfield and Cloud (2008) highlighted the impact of cultural barriers as negative recovery capital. Membership in an anti-social subculture such as a prison culture, a culture of addiction, and a gang culture require resocialization to progress in recovery. For example, White (1996) described a culture of addiction, i.e., growing up in a social environment in which behavior associated with addiction is the norm. Carlie (2002) indicated that gangs are a "society within society" in opposition to a culture of recovery.

Recovery capital also has a multiplier effect. Wilson (1996) indicated that individual change becomes a bridge to community connectedness and social change. Also, Best & Gilman (2010, 10-11) suggested that recovery capital (available personal resources and social resources) grows beyond the individual to the family, neighborhood, community, and societal levels.

4.1. Resources

4.1.1. Personal Resources

Personal resources (personal strengths) are the client's physical health, coping skills, job skills, self-management skills, knowledge, insight, judgment, and rational beliefs. Enhanced personal resources contribute to resilience and a sense of personal empowerment.

4.1.2. Agency Social Resources

Agency services optimally include a strong therapeutic alliance between client and therapist; flexible appointment scheduling to accommodate working clients, use of clinical practice guidelines, and measurement-based care. In addition, skilled professional and administrative support staff; adequate facility security; language translation/interpreter services, and vouchers for food, transportation, and daycare also are valuable agency resources. A twenty-four-hour crisis line and case management are invaluable services as well.

4.1.3. Social Environmental (Community) Resources

Community resources include a variety of people, groups, organizations, and public policies that can contribute to mental health recovery. Such resources include mental health/substance use disorder agencies, childcare facilities, public assistance, financial services, educational organizations, housing assistance, healthcare services, religious/spiritual institutions.

4.1.4. Natural Resources

Germain & Bloom (1999) noted that the human species has lost its connectedness to the natural world. Yet, natural resources such as food production and clean air extend the lives of people in recovery, allowing them more opportunities for personal growth and social connectedness. It is therefore critical to focus upon the natural environment to protect resources and combat barriers such as food insecurity and pollution.

The ecological approach targets change at multiple levels of social systems in which the individual participates. These levels include: the micro-level (e.g., the person and relatives/close friends), meso-level (e.g., interaction with organizations, businesses, community members), and macro-level (e.g., community, national, and international policies and laws, and natural phenomena such as climate change).

5. Social Connectedness

5.1. Social Resource Theory

The concept of social connectedness may be understood by recovery capital and social resources theory. Both involve the social exchange of personal and social resources. For example, social resources theory clarifies the nature of interpersonal resources, exchange patterns, and intervention based upon resource exchange (Mitchell, Cropanzano, & Quisenberry, 2012) .

Social resources theory is derived from social exchange theory (Foa and Foa, 1974, 2012; Markovsky & Kazemi, 2012; Rettig & Leichtentritt, 1999). Social interaction is defined as an exchange of interpersonal resources (Foa & Foa, 2012). Six categories of interpersonal resources exist: love (affection, caring, warmth), approval (respect), and services (labor) are particularistic (i.e., personalized resources). That is, people are selective with whom they exchange personalized resources such as affection and respect.

The remaining resources are information, goods, and money. The latter resources are impersonal, i.e., people generally are not as concerned about personal attributes such as race, sex, ethnicity, religion, and personality traits of others with whom such resources are exchanged with others.

5.2. Social Resource Exchange Patterns

Social resource patterns involve the exchange of various combinations of personalized and impersonal resources. Resource exchange patterns include an intimate pattern (each partner exchanges personalized resources), a formal pattern (each role partner exchanges impersonal resources), and a mixed resource exchange pattern (one partner provides a personalized resource such as a service, while the other responds with an impersonal resource, money). For example, a barber who provides a service (haircut) receives money in return from the customer (a mixed exchange pattern).

Also, the mixed social exchange pattern is relevant to civility. Civility has declined in American society, especially in urban areas (Fyfe, Bannister, & Kearns, 2006). Civility is associated with manners (e.g., holding a door for a stranger) and respect for others (approval). For example, a business owner and a customer may exchange impersonal resources (money for goods). This is a simple impersonal exchange pattern, but civility would emerge by the customer thanking the owner (approval) for the goods (a mixed pattern: an exchange of approval and goods).

Resources also are exchanged at the meso- and macro- levels. For example, an employee provides labor (service) in exchange for payment (money) provided by the organization (Cropanzano & Mitchell, 2005).

Social roles primarily determine the dominance of each pattern of interpersonal resource exchange. For example, the parental role more often involves the intimate exchange pattern involving affection between parent and child. However, customers and cashiers are generally unconcerned with whom they exchange money for goods. Therefore, the impersonal pattern is dominant.

Significantly, social connectedness is distinguished from the simple availability of social resources. The crucial factor is bonding between the individual and social resources. The strength and longevity of connectedness are also paramount, for social interaction may be a casual encounter between strangers, simple acquaintances, friends, "close friends," and family members of varying intensity of connectedness. Therefore, social connectedness is dependent upon a long-term period of repeated resource exchange episodes that strengthen the bonds among the individual and others.

5.3. Social Connectedness and Health

Social connectedness is critical as a protective factor in physical and mental health recovery (Cornwell & Waite, 2009; Federici & LMHC, 2019; Seppala, 2014; Bathish., Best, Savic, Beckwith, Mackenzie & Lubman. 2017, pg. 3). Conversely, there is research evidence that social isolation and loneliness create serious harm over a lifetime. For example, loneliness increases the probability of early death (Haslam, et al, 2015; Holt-Lunstad, Smith, Baker, Harris, & Stephenson. 2015). Also, social isolation and loneliness are associated with inactivity, tobacco use, other unhealthy lifestyle choices (Shankar & McMunn, 2011) and poverty (Zavaleta & Mills, 2017).

6. Barriers to Mental Health Recovery

6.1. Personal Barriers

Personal barriers are limitations in motivation and physical/cognitive/emotional capacities (i.e., the opposite of personal resources). Non-adherence and resistance to treatment goals and treatment techniques are the mirror image of a client's fulfillment of the client's social role (e.g., completing "homework," discussing personal issues during sessions, medication adherence, and social participation to increase social connectedness). Physical incapacity includes medical conditions, genetic predisposition to illness, organicity, and disability. Intellectual/cognitive incapacity includes developmental disorders, dementia, and limited critical thinking skills, irrational beliefs, and certain psychiatric symptoms (e.g., paranoia, delusions, hallucinations). Emotional incapacity includes distress intolerance, emotional dysregulation, anxiety, depression, and hypomanic symptoms.

6.2. Social Barriers

Social factors are often a deterrent to recovery (Tew et al., 2011). Cloud & Granfield (2008) described cultural barriers as negative recovery capital. Membership in an anti-social subculture such as prison culture, a culture of addiction, and gang culture requires resocialization to progress in recovery. For example, White (1996) described a culture of addiction, i.e., growing up in a social environment in which behavior associated with addiction is the norm. Carlie (2002) indicated that gangs are a "society within society," in opposition to a culture of recovery.
Social barriers also include deficiencies in agency services (e.g., incompetent staff, barriers to access such as limited appointment schedules, waiting lists, and the lack of treatment specialties needed for clients). Community barriers such as stigma, discrimination, high unemployment, inadequate healthcare, unsafe neighborhoods, poverty, food insecurity, and cultural barriers rob clients of opportunities for the benefits of mainstream society.

6.3. Natural Barriers

Natural barriers include infectious diseases (e.g., pandemics), extreme weather (severe storms, tornadoes, and hurricanes), drought, flooding, arid conditions, and climate change. For example, extreme cold or heat can increase social isolation, while drought can force relocation away from agency services.

6.4. Social Isolation

Unfortunately, social connectedness has declined in modern society, and subsequent polarization in the American population has increased (Hawkins, Yudkin,, Juan-Torres, & Dixon, 2018; Putnam, 2001; Putnam & Garrett, 2020). This has led to a weakening of the social fabric, incivility, and increasing recovery barriers for physical health, mental health, and substance use disorders.

7. Socio-Behavioral Intervention

The general strategy of socio-behavioral therapy involves enhancement of protective factors and reduction of recovery barriers. Intervention at multiple system levels is directed toward both these goals. The decrease in one results in an increase in the other. For example, a reduction in psychiatric symptoms (e.g., personal barriers as measured by DSM-5 scales) will enhance personal resources. Also, enhanced social connectedness will reduce social isolation. In addition, the client's daily practice of a self-management technique such as self-monitoring of mood can alert the client and clinician to the need to increase a specific protective factor such as social connectedness for social support. Examples of intervention at different system levels follow.

7.1. Micro-System Level Intervention

7.1.1. Behavioral Self-Management

Behavioral self-management is an established, evidence-based approach (Dive, 2003; Drusset al, 2010; Stuart, 1977). It promotes an active, empowering role that enhances personal resources while reducing personal and social barriers. Self-management involves one's use of behavioral techniques to change one's behavior

(Sarafino, 2010, 4). Behavioral change is achieved by the practice of behavioral techniques such as self-reward, self-monitoring, distraction, cognitive restructuring, and relaxation exercises between sessions.

Self-management techniques also can be helpful with chronic medical disorders such as chronic pain, heart disease, arthritis, diabetes, asthma, bronchitis, and emphysema (Lorig et al, 2020; Anekwe & Rahkovsky, 2018). Also, behavioral self-management has been applied to meso-level systems such as organizations as well (Gerhardt, 2007).

Behavioral self-management support also is an integral part of the approach (Resources for Integrated Care, 2021). Coordination with other agencies assisting clients in learning to practice self-management is essential (e.g., literacy programs, job training programs, and educational resources).

7.1.2. Self-Advocacy Training

Self-advocacy training of clients within treatment programs has been an innovation during the past decade (de Miranda, 2008). The socio-behavioral model assists clients in enhancing personal resources by learning self-advocacy skills and taking advantage of opportunities to participate in the recovery movement (de Miranda & McGirr, 2010; White, 2016).

The Wellness Recovery Action Plan (WRAP-Plus) includes self-advocacy instruction that can be used by individuals and discussion groups (Copeland & Dummerston, 2010). Jonakas et al (2011) found that WRAP Plus participants were significantly more likely to practice self-advocacy with their therapists than control subjects.

Access to Medication-Assisted Treatment (MAT) for opioid use disorders has necessitated self-advocacy. For example, drug courts have sometimes resisted MAT, even though the National Drug Court Institute (NDCI, 2020) and the National Institute on Drug Abuse have endorsed MAT as a best practice for the treatment of opioid use disorder (NIDA, 2020).

7.1.3. Client and Family Psychoeducation

Psychoeducational sessions offer opportunities to discuss such issues as stigma, discrimination, and the need for prevention, and treatment resources. There are also opportunities for the client and family members to reflect upon the information and discuss their reactions in the past, i.e., their interpersonal resource exchanges. Some insight may be gained vis-à-vis the need for understanding and support (affection and approval) among family members.

Also, Hazelton developed a program entitled, Living in Balance, that provides information about substance use disorders as well as an opportunity to reflect upon the impact upon the clients' lives (Hoffman et al, 2015). Hazelton also offers a psychoeducational program for families (Jay, 2014).

7.1.4. Behavioral Exchange Therapy

Behavioral exchange therapy is derived from social resources theory and is employed in couples therapy (Stuart, 2003, 237-251; PsychotherapyNet, 2013). The method teaches role partners to identify their behaviors and the behaviors of the other according to the six categories of interpersonal resources. Each role partner is asked to identify those resources desired from the other. Also, they are asked to identify examples of the other's behavior that denied these resources (e.g., arguments, pouting, and aggressive behavior).

Each partner is asked to specify the preferred expression of the desired resources from the other (e.g.,verbal affection, physical affection, or sexual activity). The therapist helps the couple negotiate their future interpersonal exchanges, with an emphasis on avoiding negative behavior that prevents desired exchanges. For example, a role partner may fail to show affection or assist the other with housework.

7.1.5. Clients Teaching Skills to Others: The Protégé Effect

Clients' children often have a history of a traumatic childhood. Adverse Childhood Experiences Questionnaire scores are higher (Spratt, McGibbon, & Davidson, 2018). They need coping techniques that may not be available until behavioral problems surface. In the interest of early intervention, such children need help in strengthening their personal resources.

Parents can be a social resource for their children and can teach them coping techniques such as relaxation exercises and self-advocacy skills. This also is an advantage to a client, for one of the best methods to learn techniques is teaching others through the protégé effect (Murphy, 2012). Also, communication skills and motivational interviewing techniques may assist a client in persuading family members to attend an initial family peer support meeting or meeting with a counselor.

Clients also provide mental health, recreational, job skills, and hobby classes to peers in community support facilities such as mental health-oriented clubhouses. Also, participation provides opportunities for intimate and mixed exchange patterns, encouraging civility. (Timmerman, 2012).

7.2. Meso-System Level Intervention

7.2.1. The Volunteer Social Role

Volunteer work has been found to enhance personal resources (Thoits & Hewitt, 2001). Such personal resources include happiness, life satisfaction, self-esteem, a sense of control over life, physical, and mental health. Also, volunteering among older adults has been shown to have the following benefits: a decline in physical health problems, decreased depression levels, and improved mortality rates (Lum & Lightfoot, 2005).

VolunteerMatch.org is a valuable website for the exploration of volunteer opportunities in the client's community. For example, one may identify opportunities by entering a city/state or zip code. Results indicate both in-person and on-line activities. A variety of interests are available, including advocacy, human rights, animal protection, seniors, children, adolescents, food insecurity, clothing, and LGBTQ+ activities.

Volunteer activities involve many instances of the intimate exchange pattern. A volunteer typically provides a service (e.g., reading to a nursing home resident), and the recipient responds with approval (e.g., "Thank you."). Such resource exchange generates a sense of "warmth," i.e., an atmosphere of safety and belonging for both role partners.

7.2.2. *Peer - to - Peer Mutual Support*

Mutual social support has been a critical component of addiction recovery for decades (White, 2009). For example, addiction-oriented peer support groups have multiplied over the past decades after formation of Alcoholics Anonymous in 1935 (e.g., Narcotics Anonymous, SMART Recovery, and Women for Sobriety).

Mental Health America offers a comprehensive listing of peer support groups at: https://www.mhanational.org/find-support-groups#:~:text=Specialized%20support%20group%20resources%20include%3A%201%20Recovery%20International.,support%20group.%2010%20Attention%20Deficit%20Disorder%20Association.%20. These groups offer in-person and on-line meetings (social resources). Family peer support also is available (e.g., AL-ANON and Families Anonymous). Some peer support organizations address specific mental health conditions (e.g., Depression and Bipolar Support Alliance and the Anxiety and Depression Association of America). Peer support groups that have a general focus include Emotions Anonymous, National Alliance on Mental Illness, and Mental Health America.

Peer support meetings provide opportunities to develop personal resources (e.g., social skills) and to participate in intimate patterns of social resource exchange. Norms encourage the expression of affection (caring), approval, and service among members. Support groups provide information vis-à-vis members' experiences in recovery, techniques for coping, and positive reinforcement for participation. Significantly, the exchange of affection and approval resources creates an atmosphere of "warmth." Indeed, some members come to perceive the support group as their "family." Sometimes, members describe the fellowship as the first "true" family that they have ever known.

The increase of intimate and mixed patterns of interpersonal resource exchange with relatives/friends, people in the neighborhood, and other community members enhance not only the client's resources but the family and recovery movement. Increased instances of the mixed exchange pattern among mental health consumers and community members also enhance a positive public perception of mental health recovery.

7.2.3. Management of Therapist – Client Conflict

There are often "collaterals" who require service as well. The term is adapted from the Veterans Health Administration: "A collateral is a spouse, family member, or significant other who receives services as a part of the patient's care" (VHA, 2021). In this paper's usage, collaterals are people or social systems in the client's life who need support and/or protection but exist outside of the official client role. They are often unrecognized in caseload statistics and workload. Services are provided to them for the welfare of the client and the community.

"Supported collaterals" receive services such as psychoeducation, referrals, and inclusion in sessions with client permission. For example, supportive services include family psychoeducation to improve family understanding of mental disorders and peer support for concerned persons (e.g., AL-ANON, Families Anonymous, and NAMI Family to Family). Thus, enhanced resources for "supported collaterals" benefit clients.

"Protected collaterals" are at risk for violence, abuse, neglect, or exploitation. Duty-to-warn, child protection, and elder exploitation referrals are examples. Therapists often will have no direct contact with protected collaterals in such cases as suspected child abuse/neglect or older adult abuse/neglect.

Also, the therapist is in a protective role when advocating for vulnerable groups (e.g., domestic violence and the homeless population). Conflict between the therapist and client may emerge due to the necessity to protect individuals or groups who are protected collaterals. Clients often are threatened when reports may incriminate them.

Perlman (1979) observed that the client-social worker relationship is a controlled one. Neither therapist nor client controls certain aspects of the relationship. For example, legal requirements such as mandatory reporting of suspected child abuse/neglect and Duty -to -Warn require the therapist to protect others, regardless of the client's resistance. This should be an essential message in treatment orientation.

7.2.4. Managing Client Social Connectedness with Agencies

Role induction is the process by which a clinician ensures that a client has an accurate understanding of the roles of the client and therapist before treatment begins. Evidence-based practice guidelines require written patient instructions to clearly define expected role behavior (SAMSHA, 2015; King & Hoppe, 2013, 385-393; Lingle, 2013). This involves a written statement of client and therapist roles: (1) the rationale and framework of the treatment relationship, (2) the structure of the treatment process and expected outcomes of care, and (3) rights and responsibilities of the clinician and the client. The Cooper-Norcross Inventory of Preferences provides clients the opportunity to express their preferences for treatment focus and methods (Cooper and Norcross, 2015). For example, clients are asked to indicate their preferences for goal orientation and psychotherapy approaches.

7.2.5. Effective Referral and Agency Linkage

Referral to another practitioner may be necessary if the client has a strong preference for an approach distinctively different from the training and orientation of the socio-behavioral therapist. For example, there would be a mismatch between a socio-behavioral therapist and a client who strongly prefers a psychodynamic approach.

A valuable online resource may be found at Findhelp.org. This website provides information regarding social welfare resources available by zip code area. Local agencies are categorized by food, housing, goods, transit, health, money, adoption and foster care, education, work, and legal resources.

Written rather than verbal information should be provided to the client, (and family, if appropriate), and receiving agency to facilitate social connection. Referral instructions should include the following: (1) an explanation of the reason for the referral, (2) the services that the referral resource will offer, (3) instructions for preparation before initial contact, (4) the expected benefits of involvement with the resource, and (5) costs involved, including fees, travel time, and time commitment of services, and (6) answers to client questions should be written down as well as discussed.

Also, case managers and peer support specialists can enhance linkage by transporting clients to their initial appointments (Center for Substance Abuse Treatment, 2015). This can address not only transportation needs but social support if the client has anxiety about contact with the referral agency. Motivational interviewing by the referring agency to facilitate clients' compliance is effective (Carroll et al., 2001; Rapp et al., 2008; Freeman, 2020). Motivational interviewing also is of potential assistance when the client arrives to strengthen retention at the new agency.

7.2.6. Employee Assistance Programs

The workplace is a common meso-level setting in which employees, supervisors, managers, and owners encounter a variety of psychosocial problems. Employee assistance services have emerged both within organizations and through referrals. Employee assistance services have a long social work history, beginning with Bertha Reynolds, a social worker who practiced occupational social work (i.e., employee assistance) through affiliation with the Maritime Seaman's service, the military, and the American Red Cross during WWII. This early employee assistance specialty particularly focused upon mental health services and services for military families (Kathryn Conley Wehrmann, Mcclain, & National Association of Social Workers, 2018, 111-113.). Future opportunities for the development of this specialty appear robust ("Employee Assistance Programs — Social Work's Influence | Social Work Today Magazine," n.d.).

7.3. Macro-System Level Intervention

Macro-level socio-behavioral intervention involves both the client's response to community and societal barriers as well as personal efforts to promote social change. Encouraging a social action role for the client within a clinical setting is non-traditional. However, joining in collective (social) action is empowering.

McLaughlin (2009) noted that the connection between social justice and advocacy may distinguish social work from other professions. Her research indicated that clinical social workers tended to associate social justice with their practice. However, she noted that advocacy was reported to be practiced at a low frequency for most.

Many advocacy organizations provide collective action in support of mental health recovery (Funk, Minoletti, Drew, Taylor, & Saraceno 2005; Rose, 1990). Support may be volunteer work, donations, or writing comments about legislation recommended by an organization. As a supporter of such an advocacy organization, the client becomes a social change agent. This demonstrates that there is a way for the client to have some control and make a difference, and prevents "learned helplessness." VolunteerMatch.org provides a valuable on-line resource to identify opportunities for advocacy (Virtual Volunteer Opportunities – VolunteerMatch). Also, opportunities with national advocacy organizations include Mental Health America, Depression and Bipolar Support Alliance (DBSA), National Alliance on Mental Illness (NAMI), Faces & Voices of Recovery (www.facesandvoicesofrecovery.org), Facing Addiction with NCADD (www.facingaddiction.org), Shatterproof (www.shatterproof.org), and the National Alliance for Medication-Assisted Recovery (http://www.methadone.org).

Information regarding voter registration, voting locations, and mail ballot procedures is easily maintained in clinic waiting rooms. Also, providing information about citizens' rights and opportunities to send e-mails, text messages, and letters to political offices is another valuable resource in waiting rooms. Also, information concerning environmental issues such as climate change and endangered species is important. However, an important caution relates to avoiding perceived pressure to participate or donate to a specific political party or political candidate.

8. Conclusion

Socio-behavioral therapy places a significant emphasis upon the individual as a potential social change agent. Indeed, if the person's welfare and the welfare of the surrounding environments are inseparable, then individuals' improved psychosocial functioning will positively impact the social and natural environments. On the one hand, the individual must value social connectedness and act to contribute by supporting others, volunteering, civic participation, and advocacy. Individuals who nourish this connectedness can become agents of social change. However, if there is only a personal benefit from intervention (e.g., manageable psychiatric symptoms or improved self-esteem) without connectedness with the wider recovering community, mental health recovery is, in a socio-behavioral sense, incomplete.

This focus upon social change is reflected in the "The Global Definition of Social Work" (International Federation of Social Workers, 2014). Yet, Newcom and Sachs (2013) observed that the profession withdrew from social activism and social justice as it developed. Socio-behavioral therapy renews the importance of addressing all levels of the "Person-in-Environment System," including higher levels of social systems.

Also, the socio-behavioral model provides a bridge between clinical (micro) and meso/macro social work practice. This counters the increasing emphasis upon individually-oriented methods (Levin, Haldar & Picot, 2015). This long-standing divide has been divisive for the social work profession (Austin, Anthony, & Mathias, 2016; Austin, Coombs, & Barr, 2005; Henning, 2016; McMillen, Morris, & Sherraden, 2004; Rothman, & Mizrahi, 2014).

The inclusion in treatment plans of opportunities for mental health advocacy as well as community engagement (e.g., volunteer activities) also distinguishes the role of clinical social work from other mental health disciplines.This clearly differentiates the social work professional focus upon the nexus between the person and environment(s) rather than attending to specialized medical or psychological issues. Indeed, this is the "Person-in-Environment System" which social work has embraced (Karls, J., O'Keefe, M., & National Association of Social Workers, 2008).

References

Alcoholics Anonymous AA). (2019). Retrieved the AA website: https://aa.org/.

Anekwe, T. D., & Rahkovsky, I. (2018). Self-Management: A Comprehensive Approach to Management of Chronic Conditions. *American Journal of Public Health*, 108(S6), S430–S436.

Anxiety and Depression Association of America, ADAA. (2000). Retrieved from website: Home | Anxiety and Depression Association of America, ADAA.

Austin, M. J., Coombs, M., & Barr, B. (2005). Community - Centered Clinical Practice. *Journal of Community Practice,* 13(4), 9–30. https://doi.org/10.1300/j125v13n04_02

Austin, M., Anthony, E., Knee, R., and Mathias, J., 2016. Revisiting the Relationship between Micro and Macro Social Work Practice. *Families in Society: The Journal of Contemporary Social Services*, 97(4), pp. 270-277.

Bathish, R., Best, D., Savic, M., Beckwith, M., Mackenzie, J., & Lubman, D. I. (2017). "Is it me or should my friends take the credit" *Journal of Applied Social Psychology*, 47(1), 35–46.

Best, D. & Gilman, M. (2010, February). Recovering Happiness. Drink, and Drugs News, 10-11.Retrieved from: https://drinkanddrugsnews.com/wp-content/uploads/2012/12/DDN2feb10.pdf.

Carlie, M. K. (2002). Into the abyss : a personal journey into the world of street gangs. Springfield, Mo.: M. Carlie.

Carroll, K. M.,Ball, S. A., Nich, C., Martino, S., Frankforter, T. L., Farentinos, C., Woody, .E. (2006). Motivational interviewing to improve treatment engagement and outcome in individuals seeking treatment for substance abuse: A multisite effectiveness study. *Drug and Alcohol Dependence.* 81, 301–312.

Center For Substance Abuse Treatment (U.S. (2015). Comprehensive case management for substance abuse treatment. U.S. Department Of Health And Human Services, Substance Abuse And Mental Health Services Administration, Center For Substance Abuse Treatment.

Cloud, W., & Granfield, R. (2008). Conceptualizing Recovery Capital: Expansion of a Theoretical Construct. *Substance Use and Misuse*, 43(12–13), 1971–1986.

Cornwell, E. Y., & Waite, L. J. (2009). Social Disconnectedness, Perceived Isolation, and Health among Older Adults. *Journal of Health and Social Behavior*, 50(1), 31–48

Cropanzano, R., & Mitchell, M. S. (2005). Social Exchange Theory: An Interdisciplinary Review. *Journal of Management*, 31(6), 874–900.

Davidson, L. (2016). The Recovery Movement: Implications for Mental Health Care and Enabling People to Participate Fully In Life. Health Affairs, 35(6), 1091–1097. https://doi.org/10.1377/hlthaff.2016.0153

Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D., & Tebes, J. K. (2006). Peer Support Among Individuals with Severe Mental Illness: A Review of the Evidence. *Clinical Psychology: Science and Practice*, 6(2), 165–187. https://doi.org/10.1093/clipsy.6.2.165(n.d.).

Depression and Bipolar Support Alliance. Retrieved December 6, 2020, from DBSA - Depression and Bipolar Support Alliance (dbsalliance.org)

de Miranda J. (2008). Training your patients to become advocates for themselves and for systems change. *Alcoholism and Drug Abuse Weekly*, 3.

de Miranda, J. & McGirr, K. (2010, March-April). Mixing advocacy with treatment. *AddictionProfessional,* 8, 22-24.

Dive, L. (2003). Self-management and addiction, Visions Journal, 1, 12-13.

Druss, B.G, Zhao,L., Von Esenwein,S.A., Bona, J.R., Fricks, L., Jenkins-Tucker, S., Lorig, K.(2010). *Schizophrenia Research.* 118, 264–270.

Emotions Anonymous 12 Step Program of recovery. (n.d.). Emotions Anonymous 12 Step Program of recovery

England, C. (2014). The Importance of Self-Advocacy in Mental Health Recovery. Theravive. Theravive.com

Employee Assistance Programs — Social Work's Influence | Social Work Today Magazine. (n.d.). Retrieved from Social Work Today Magazine website: https://www.socialworktoday.com/news/pp_102617_1.shtml

Facing Addiction with NCADD. (n.d.). Retrieved from www.facebook.com website: https://www.facebook.com/facingaddiction/

Faces & Voices of Recovery website: Home - Faces & Voices of Recovery (facesandvoicesofrecovery.org)

Families Anonymous. (n.d.). Retrieved from Families Anonymous website: https://www.familiesanonymous.org/

Federici, M. (2019, December 16). The Value of "Connectedness" in Recovery. Coalition Recovery. Retrieved January 13, 2021, from Coalition Recovery website: The Value of Appreciation in Recovery • Coalition Recovery

Foa, U. G., & Foa, E. B. (1974). Societal Structures Of The Mind. U. G. Foa, E. B. Foa.Springfield, Ill. Thomas.

Foa, E. B. & Foa, U.G. (2012). Resource Theory of Social Exchange. Chapter 2. In Tormblom, K. & Kazemi, Handbook of Social Exchange: Theoretical Extensions, Empirical Insights, and Social Applications, Critical Issues in Social Justice. Springfield Science + Business Media. New York.

Freeman, S. D., (October 9, 2012) Using motivational interviewing as a strength-based model.[Webinar] Building and Nurturing Communities of Color. Retrieved from https://docplayer.net/33140167-Using-motivationalinterviewing-as-a-strength-based-model.html.

Funk, M., Minoletti, A., Drew, N., Taylor, J., & Saraceno, B. (2005). Advocacy for mental health: roles for consumer and family organizations and governments. Health Promotion International, 21(1), 70–75.

https://doi.org/10.1093/heapro/dai031Fyfe, N., Bannister, J., & Kearns, A. (2006). (In)civility and the City. Urban Studies, 43(5–6), 853–861. https://doi.org/10.1080/00420980600676063

Gerhardt, M. (2007). Teaching Self-Management: The Design and Implementation of Self-Management Tutorials. *Journal of Education for Business*, 83(1), 11–18. https://doi.org/10.3200/joeb.83.1.11-18

Germain, C. B., & Bloom, M. (1999). Human behavior in the social environment: Ecological View. ColumbiaUniversity Press, pg. 33.

Hawkins, S., Yudkin, D., Juan-Torres, M., & Dixon, T. (2019). Hidden tribes: A study of America's polarized landscape.

Henning, B. L. Connections. Why should macro social work matter to a micro-social worker? (2016). NASW. CT. Newsletter, NASW Connecticut Chapter. Rocky Hill, CT. 1, 4.

Retrieved from:
http://naswct.org/wpcontent/uploads/2016/10/October-December-2016-Newsletter

Holt-Lunstad, J., Smith, T. B., Baker, M., Harris, T., & Stephenson, D. (2015). Loneliness and Social Isolation as Recovery Barriers for Mortality. Perspectives on Psychological Science, 10(2), 227-237. https://doi.org/10.1177/1745691614568352

Karls, J. M., O'keefe, M. E., & National Association of Social Workers. (2008). Person-in-Environment System Manual. Washington, DC: NASW Press.

Kathryn Conley Wehrmann, Mcclain, A., & National Association of Social Workers. (2018). Social work speaks: National Association of Social Workers policy statements, 2018-2020. Washington, D.C: NASW Press.

Khoury, E., & Rodriguez del Barrio, L. (2015). Recovery-Oriented Mental Health Practice: A Social Work Perspective. *British Journal of Social Work*, 45 (suppl 1), 27–44. https://doi.org/10.1093/bjsw/bcv092.

King, A. & Hoppe, R. (2013). "Best practice" for patient-centered communication: A narrative review. *Journal of Graduate Medical Education*, 5, 385-393.

Kourgiantakis, T., Hussain, A., Ashcroft, R., Logan, J., McNeil, S., & Williams, C. C. (2020). Recovery-oriented social work practice in mental health and addictions: a scoping review protocol. BMJ Open, 10(8), e037777. https://doi.org/10.1136/bmjopen-2020-037777

Lingle, C.L., (2013). Evidence-based practice: Patient discharge education barriers to patient education. Nursing Thesis and Capstone Projects, 67.

Lorig, K. (2020). Living a healthy life with chronic conditions: self-management skills for heartdisease, arthritis, diabetes, depression, asthma, bronchitis, emphysema, and other physical and mental health conditions. Boulder, Co: Bull Publishing Company.

Lum, T. Y., & Lightfoot, E. (2005). The Effects of Volunteering on the Physical and Mental Health of Older People.*Research on Aging*, 27(1), 31–55. https://doi.org/10.1177/0164027504271349

Markovsky, B., & Kazemi, A. (2012). Formalizing Foa's Social Resource Theory of Exchange. Handbook of Social Resource Theory, 81–98.

McMillen, J.C., Morris, L., & Sherraden, M. (2004). Ending Social Work's Grudge Match: Problems versus Strengths. *Families in Society*, 85(3), 317-325.

MHA|Mental Health America. (2019). Retrieved from mhanational.org website: https://mhanational.org/

Mitchell, M. S., Cropanzano, R. S., & Quisenberry, D. M. (2012). Social Exchange, Exchange Resources, and Interpersonal Relationships: A Modest Resolution of Theoretical Difficulties. Handbook of Social Resource Theory, 99–118. https://doi.org/10.1007/978-1-4614-4175-5_6

Murphy Paul, Annie. 2012. The Protege Effect: Why Teaching Someone Else is the Best Way To Learn. The Protégé Effect | Psychology Today

National Alliance on Mental Illness. (n.d.). Retrieved from www.nami.org website: Home | NAMI: National Alliance on Mental Illness.

Narcotics Anonymous (2018). WORLD SERVICEBOARD OF TRUSTEES BULLETIN #29, Retrieved from Bulletin #29 (na.org).

National Alliance for Medication-Assisted Recovery (http://www.methadone.org). National Coalition for Mental Health Recovery (NCMHR) (https://www.ncmhr.org/)

National Drug Court Institutehttps://nicic.gov/sources/national-drug-court-institute-ndci-alexandria-va National Drug

Court Institute - NDCI.org website: https://www.ndci.org/NIDA International Drug Abuse Research Abstract Database, https://www.drugabuse.gov/international/abstracts/predictive-factors-drug-addict-patients-treatment results.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: A review of the literature. *Psychiatric Rehabilitation Journal*, 31(1), 9–22. https://doi.org/10.2975/31.1.2007.9.22

Perlman, H. (1983). Relationship: the heart of helping people. Chicago: University of Chicago Press. 74.

PsychotherapyNet. (2013). Behavioral Couples Therapy Video. Retrieved from https://www.youtube.com/watch?v=vJJWrBA5vto

Putnam, R. D. (2001) Bowling Alone: The Collapse and Revival of American Community, New York, NY: Simon & Schuster.

Putnam, R. D., & Shaylyn Romney Garrett. (2020). The upswing : how America came together a century ago, and how we can do it again. New York: Simon & Schuster.

Rapp, R. C. & Otto, A. L. (2008). Improving linkage with substance abuse treatment using briefcase management and motivational interviewing. *Drug and Alcohol Dependence*, 94, 172-182.

Rettig, K. D., & Leichtentritt, R. D. (1999). Social Indicators Research, 47(3), 307–342. https://doi.org/10.1023/A:1006837329353

Resilience | Psychology Today. (2019). Retrieved from Psychology Today website: https://www.psychologytoday.com/us/basics/resilience

Rose, S. (1990). Advocacy/Empowerment: An approach to clinical practice for social work,*Journal of Sociology and Social Welfare*, 17, Article 5.

Rothman, J., and Mizrahi, T. (2014). Balancing Micro and Macro Practice: A Challenge for Social Work. *Social Work*, Volume 59, 91–93.

Sarafino, E. (2011). Applied Behavior Analysis: Principles and Procedures in Behavior Modification, Hoboken, N.J., Wiley, 352.

Self - Management Addiction Recovery Program. (2013). SMART Recovery Handbook, 3rd Edition. Mentor, OH: Alcohol and Drug Abuse Self Help Network, Inc. Self-Management Support Resources for Integrated Care. (n.d.). Retrieved January 3, 2021,from Welcome to Resources for Integrated Care | Resources for Integrated Care website: https://www.resourcesforintegratedcare.com/concepts/behavioral-health/self-management_support

Seppala, E., Rossomando, T., Doty, J. (2013). Social Connection and Compassion: Important predictors of health and well-being. *Social Research: An International Quarterly*, 80, 411-430.

Shatterproof (www.shatterproof.org)

Shankar, A., McMunn, A., Banks, J., & Steptoe, A. (2011). Loneliness, social isolation, behavioral, and biological health indicators in older adults. *Health Psychology*, 30(4), 377–385.https://doi.org/10.1037/a0022826

Spratt, T., McGibbon, M., & Davidson, G. (2018). Using Adverse Childhood Experience Scores to Better Understand the Needs of Young Carers. *The British Journal of Social Work*, 48(8), 2346–2360. https://doi.org/10.1093/bjsw/bcy001

Starnino, V. R. (2009). An Integral Approach to Mental Health Recovery: Implications for Social Work. Journal of Human Behavior in the Social Environment, 19(7), 820–842. https://doi.org/10.1080/10911350902988019

Stuart, R. (Ed.). (1977). Behavioral Self-Management. New York, NY: Brunner/Mazel.

Stuart, R. (2003). Helping Couples Change: A Social Learning Approach to Marital Therapy.New York, NY: Guildford.

Substance Abuse and Mental Health Services Administration. (Producer) (2015). Three strategies for effective referrals to specialty mental health and addiction services [Video webinar]. Retrieved from https://www.integration.samhsa.gov/about-us/Referrals_Webinar_PPT_FINAL.pdf.

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., & Le Boutillier, C. (2011). Social Factors and Recovery from Mental Health Difficulties: A Review of the Evidence. *British Journal of Social Work*, 42(3), 443–460. https://doi.org/10.1093/bjsw/bcr076.

Tew, J. (2013). Recovery capital: what enables a sustainable recovery from mental health difficulties? *European Journal of Social Work*, 16(3), 360–374. https://doi.org/10.1080/13691457.2012.687713.

Thoits, P. A., & Hewitt, L. N. (2001). Volunteer work and well-being. *Journal of Health and Social Behavior*, 42(2), 115–131. Retrieved from https://pubmed.ncbi.nlm.nih.gov/11467248/

Thomas, E. J. (1967). The socio-behavioral approach and applications to social work. New York: Council on Social Work Education.

Timmerman, M. (2012). [Review of Evidence-Based Recommendations for Participation Station]. In Participation Station: Health Administration Capstone Presentation.

Veterans Health Administration, Chapter 5. Patient Records. (n.d.). Www.Hl7.org. Retrieved January 4, 2021, https://www.hl7.org/documentcenter/public/wg/secure/Vapolicy.htm#:~:text=A%20collateral%20is%20a%20spouse%2C%20family%20member%2C%20or

White, W. L. (1996). Pathways : from the culture of addiction to the culture of recovery : a travel guide for addiction professions. Center City, Minn.: Hazelden.

White, W. (2009).The mobilization of community resources to support long-term addiction recovery, 36, 146-158.

White, W. (2016).William White: The State of Recovery Advocacy in the U.S.: An interview with Patty McCarthy Metcalf. Retrieved at https://facesandvoicesofrecovery.org/newsevents/newsroom.html/article/2016/12/12/william-white-the-state-of- recovery-advocacy-in-theUS-an-interview-with-patty-McCarthy-metcalf.

Whorley, L. (2019). A Socio-Behavioral Model for the Treatment of Addiction. *Journal of Psychology and Behavioral Science*, 7(1). https://doi.org/10.15640/jpbs.v7n1a11

Women for Sobriety. (n.d.). Retrieved from Women for Sobriety website: https://womenforsobriety.org/

Zavaleta, D., Samuel, K., & Mills, C. T. (2016). Measures of Social Isolation. *Social Indicators Research*, 131(1), 367–391. https://doi.org/10.1007/s11205-016-1252-2