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Address

The Editor: *Clinical Sociology Review*
C Ring 631
Kingsway Campus
University of Johannesburg
Auckland Park
2006
Tel +27 (0)11 559 2885
Email: tuys@uj.ac.za

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# Harvey Warren Zorbaugh (1896-1965)

Jan Marie Fritz
University of Cincinnati
University of Johannesburg

Harvey Warren Zorbaugh was born in East Cleveland, Ohio (U.S.) on September 20, 1896. He received a B.A. degree from Vanderbilt University and a Ph.D. in sociology from the University of Chicago. Starting in the mid-1920s, sociologists directed or were centrally involved in clinics in several U.S. cities. In Chicago, Zorbaugh was one of the directors of the Lower North Child Guidance Clinic.

Zorbaugh wrote about a number of topics including education, comic books, gifted children, and urban problems. His *The Gold Coast and the Slum*, published in 1929, is considered a classic sociology book in the U.S. In the 1940s, Zorbaugh hosted "Play the Game," a television show focusing on charades that was one of the first game shows on television in the U.S. He suggested the program (as he and his wife had played charades for years at their home) and then became its master of ceremonies. The show first aired on DuMont (DuMont n.d.) and then later on ABC. He also produced "Quizdom Class," a radio show with high school seniors as contestants (Anonymous 1965). Most of Zorbaugh's career was with New York University (NYU) where he was a specialist in gifted children. When he retired in 1962, he was chair of the Department of Educational Sociology as well as executive of the university's communication arts group.

In 1927, Zorbaugh was one of three associate editors of a new journal, *The Journal of Educational Sociology: A Magazine of Theory and Practice*; his responsibility was being the book review editor. The journal was to publish 10 issues a year; in the first year a subscription was $3.00, and a single issue was 35 cents.

In the first issue of *The Journal of Educational Sociology,* Zorbaugh (1927) described a clinic that was going to be put in place by his department at NYU:


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> The School of Education of New York University is projecting a research behavior clinic, under the department of educational sociology, which it is hoped will contribute its bit to the knowledge of the processes of social adjustment that clinics throughout the country are slowly accumulating. The Social Behavior Clinic will be unique in at least two respects. It will be directed by a sociologist, and will devote more than ordinary effort to the analysis of the relationship of social situations to personality adjustment. It will have, in the School of Education's experimental schools, opportunity for manipulation of the child's school situation heretofore largely denied to behavior clinics.

Zorbaugh was described in the contributors' section of this 1927 issue as "a Clinical Sociologist interested in the sociological approach to the study of individual and social behavior" (Staloup, 1927:66).

In 1930, Zorbaugh established NYU's Clinic for the Social Adjustment of Gifted Children. The staff members included a psychologist who was enrolled in NYU's educational sociology program, a psychiatrist and "a specialist in diseases with psychological concomitants" (Anonymous 1930:122).

Zorbaugh wrote many articles and reviews for *The Journal of Education Sociology*. One of them, his 1939 "Sociology in the Clinic," is provided here.

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## About the author

Jan Marie Fritz, a Certified Clinical Sociologist (CCS), is a Professor at the University of Cincinnati (United States), Distinguished Visiting Professor at the University of Johannesburg (South Africa) and Adjunct Professor at Taylor's University (Malaysia). She also is the editor of Springer's Clinical Sociology Book Series. Her email address is jan.fritz@uc.edu

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# SOCIOLOGY IN THE CLINIC*

HARVEY ZORBAUGH

The past twenty-five years have witnessed a great change in the behavior of sociologists. A quarter of a century ago the majority of sociologists might fairly have been labeled either philosophers or reformers. They dreamed on the one hand of cosmic cycles in the affairs of men; on the other hand, of utopia realized on earth. Today the great majority of sociologists — at least of the younger generation of sociologists — are scientists, attempting to develop methodology and techniques which will yield a greater understanding of, and, we may hope, control over a man's social behavior.

Many factors inherent in the cultural trends of our generation have contributed to this change. It has not been the result of sociological thought alone, much less the achievement of a particular "school" of sociology. On the other hand, it was at the University of Chicago, in the graduate department of sociology, in the decade following the war, that the sociologist's changed conception of his role was first clarified and began to yield fruit in the type of research now characteristic of sociological science.

The sociology department of the University of Chicago was an exciting intellectual atmosphere to the graduate students of that decade. The older concept of sociology was represented in the person of Albion Small, head of the department, then in the last years of his notable career. The emerging concept of sociology as science was represented by Robert E. Park and Ernest W. Burgess. In his first year the student came under the influence of both points of view.

Small was a scholar, in the finest sense of the word. He took the student through the history of sociological thought, requiring that the student document his progress as he went. Small was a logician

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as well. He insisted that the student should, if he could, reason his way through the documentary evidence. Small, the logician, strove to force the student to clarify and sharpen his conceptual tools, giving the student a rigorous exercise in semantics. Small was, furthermore, a philosopher, and strove to stimulate his students, through their study of the history of society, to achieve a valid philosophy and valid values of their own.

Park and Burgess, on the other hand, demanded that the student apply his developing sociological concepts to an analysis of the behavior of the community about him. Park, impatient with the older sociological theory, was on fire with belief that sociology could become, was becoming, a natural science. Park had a tremendously original mind, a rate ability to stimulate the minds of his students, and to transmit to them his enthusiasm. Park was, moreover, intellectually the most generous of men. His ideas were his students' ideas. He asked only that his students put them to work. All of his students would admit that credit for whatever contributions they have made to sociology must be shared with Park.

Park's mind, on the other hand, was largely intuitive. Science was, to him, a burning ideal and a way of thought rather than a methodology. It was Burgess who kept the student face to face with the necessity of working out an adequate and valid methodology for attacking his problems. It was to Burgess students turned over and over for methodological criticism and help. It was due to Burgess's originality and generosity that many of their projects bore fruit. Every student who has gone out of the University of Chicago to make a place for himself in sociological research owes much to Burgess for the discipline necessary to make research fruitful.

Students reacted differently to this intellectual atmosphere, according to their differences in temperament and experience. Many and heated were the debates that went on, among graduate students, in seminars, over the tables of the university commons, in smoke-filled dormitory rooms. There were those who felt that there could be no such thing as a science of sociology, that the sociologist should be content to try to give meaning to the history of society. There were others who conceded that a scientific approach to society was possible,

but felt empirical studies incapable of control, could contribute little to such a science, and that its tools could be only those of logical process. The majority, however, fired with Park's and Burgess's enthusiasm, believed that a science of sociology must grow out of empirical studies of the social behavior of the community, and that methodology and techniques for such studies could be developed.

The establishment, in 1922, of the Community Research Fund, under a grant from the Laura Spelman Rockefeller Memorial, made possible the first comprehensive program of sociological research into the behavior of the community. This research has yielded, and continues to yield, data and generalizations that amply justify Park's and Burgess's belief in a scientific sociology, and have made a significant contribution to such a sociology.[1] It would seem fair to say that Park and Burgess, during this decade at the University of Chicago, played a role in the development of modern sociology comparable to that played earlier by G. Stanley Hall, at Clark University, in the development of modern psychology. As one attempts to evaluate the data and generalizations contributed to scientific sociology by their students, in the light of the trends of our contemporary society, one regrets, however, that these students do not reflect in their research more of the respect for the mind itself as a tool for arriving at truth, more of the recognition of the necessity of a valid philosophy through which truth may become socially fruitful, that Albion Small strove to give them.[2]

It was natural, and inevitable, that as sociologists turned from the study of documents to the study of collective behavior of men, many sociologists should become particularly interested in the social aspects of the individual's behavior — the attitudes through which individual and group become part of a pattern, the effect of

1 Nels Anderson, *The Hobo*; Frederic M. Thrasher, *The Gang*; Louis Wirth, *The Ghetto*; Ernest Mower, *Family Disorganization*, and his subsequent studies of the family; Harvey Zorbaugh, *The Gold Coast and the Slum*; Clifford Shaw, Frederick Zorbaugh, Henry McKay, and Leonard Cottrell, *Delinquency Areas*, and Shaw's subsequent studies from the Behavior Research Fund and the Institute of Juvenile Research; Hiller, *The Strike*; Walter Reckless, *The Natural History of Vice*; Ruth S. Cavan, *Suicide*; Herbert Blumer, *Movies and Conduct*; Robert Faris and H. Warren Dunham, *Mental Disorders in Urban Areas*; to name only a few of these studies.

2 Louis Wirth is a notable exception, in the writer's opinion, to this statement.

group relationship upon the individual's behavior, the effect of the individual upon the group's behavior, the mechanisms of interaction involved. This interest has loomed large in the research of the Chicago "school." It has led to much research on the borderland between sociology and psychology. If one chooses to call this field of research social psychology, it is evident that sociology has made significant contributions to a scientific social psychology.

This contribution has by no means been confined to the work of the Chicago "school." All over the country, younger sociologists, through varying backgrounds of experience, were fired with the belief that the scientific method is applicable to the study of social behavior, were carrying their research into the community, were, many of them, focusing their interest increasingly upon the relationship of group and individual. No more significant contribution has been made in this area of research — to mention but one example — than the Lynds' *Middletown* and *Middletown in Transition*.

Many sociologists interested in this field felt the need for access to clinical situations, in which their concepts and hypotheses as to the relation of the group and the individual might be tested, modified, validated. Moreover, many sociologists felt that sociology had significant contributions to make in the readjustment of the individual to social living.

Sociologists found, however, that the psychiatrist, social worker, and psychologist had staked out the clinical field as their own, and gave scant welcome to the sociologist, scant consideration to his ideas. Sociologists were perhaps largely to blame for this situation. In their newly acquired worship of objectivity they were intolerant of many of the values and procedures of the clinic and social agency. Indeed, many younger sociologists developed, with reference to the psychiatrist, psychologist, and social worker, a conflict group psychology which was a denial of the objectivity they proclaimed.

The result was that sociologists began to talk of "sociological" clinics. A "sociological" clinic was to be a clinic which the sociologist controlled, or which a particularly brash young sociologist might undertake on his own. Clifford Shaw and the writer organized two such "sociological" clinics in Chicago in 1924 — the Lower North and

South Side Child Guidance Clinics, since affiliated with the Institute for Juvenile Research. May it be said, Shaw and the writer were not brash enough to undertake to be clinics by themselves. Psychiatrists, psychologists, and social workers completed the staff. But these clinics were to be directed by sociologists, to serve as laboratories for validating sociological hypotheses as to individual adjustment and behavior.

In 1926 the writer was offered the opportunity of becoming a member of the faculty of the School of Education of New York University, where the department of educational sociology was projecting the establishment of a "sociological" clinic. The writer came to New York, eager to grasp the opportunity — sure that a clinic, sociologically oriented and directed, emphasizing research, would contribute much to the educational work of the sociology department — through testing hypotheses, developing teaching materials, affording field experience for students.

The writer vividly remembers a conversation, shortly before the clinic began its work, in which Walter Pettit of the New York School of Social Work participated. After considerable discussion and debate, Walter Pettit remarked, "You still have a lot to learn." The writer had a lot to learn. Some of the things ten years' experience with this clinic have taught him as to the role of a clinic in the work of a department of sociology are worth mentioning here.

In the first place, one cannot work long in a clinical situation before one is forced to accept the fact that a clinic's first responsibility is service to its clients. Research must wait upon service. This means that, unless the clinic has a very large case load, the materials through which given hypotheses may be tested are slow in accumulating. Moreover, cases that seem to offer opportunities for critical experiments often cannot be so utilized if the clinician accepts his responsibility to the client. As a result, the clinical situation bears the fruit of research but slowly. To those impatient for immediate results, the clinic proves to be a disappointing laboratory.

Again, the clinic affords but a restricted opportunity for field experience for students of sociology. Responsibility of the clinic to the client stands in the way. Untrained students, even under

supervision, cannot enter into relationship with clients with any hope of a constructive outcome for the client. And the results may be disastrous to the client.

On the other hand, out of clinical work there are constantly arising problems that give rise to hypotheses for legitimate sociological research. For example, the finding in our own clinic that problems revolving about conflicts over the child's eating are referred predominantly from Jewish families. Whatever psychiatric mechanisms determine the way the Jewish mother may use the food patterns of her culture, there is obviously a sociological factor involved that is not only of theoretical significance, but of practical importance in approaching and dealing with such problems.

Many other illustrations might be given. Moreover, the ramifications of many of these problems may be formulated for research by able graduate students. Considerable such research has already grown out of clinically derived hypotheses as to factors involved in children's adjustment to the school.[3]

It would seem hardly necessary to warn sociologists interested in clinical research that a wholly "sociological" clinic is a fruitless undertaking. Without the meeting of minds trained not only in sociology, but as well in medicine, psychiatry, psychology, and case work, too many factors are unrecognized or unanalyzed to make case records of research value.

Such a meeting of minds is increasingly possible as sociology, psychiatry, case work, and medicine draw more closely together in understanding. The work of the Institute for Juvenile Research, the Hanover Conferences, the Coloquia on Personality of joint committees of the American Psychiatric Association and the American Sociological Society, the Institute of Human Relations at Yale are significant symptoms of this meeting of minds. The recent publication by Plant, a psychiatrist, of *Personality and the Cultural Pattern*, and by Faris

3 Julius Yourman, "Children Identified by Their Teachers as Problems," *The Journal of Educational Sociology*, February 1932, pp. 334-343; Louise Snyder, "The Problem Child in the Jersey City Elementary Schools," *ibid.*, February 1934, pp. 343-352; Mildred Fisher, "Measured Differences Between Problem and Nonproblem Children in a Public-School System," *ibid.*, February 1934, pp. 353-362.

and Dunham, sociologists, of *Mental Disorders in Urban Areas* vividly illustrate the promise of this meeting of minds, through achieving a more fundamental understanding of human behavior, to increase and validate the hypotheses of all the behavior sciences concerned, including those of sociology.

There is no question that clinical experience greatly enriches the sociologist's teaching material. In this respect, the department of educational sociology clinic has paid tremendous dividends, greatly increasing the validity and vitality of the teaching of those who have participated in its work. The case records of every sociologically oriented clinic are a mine of living material on the role of social and cultural factors in shaping the individual personality and in conditioning its adjustment, on the role of sociological factors in conflict and maladjustment, on the interaction of personalities in the family, gang, school, and community, on the processes that give rise to the many types of antisocial behavior, on the effect of various patterns of group life upon members of the group. Such material aids greatly the teacher's attempt to lead the student to apply his theoretical concepts to the analysis of the social behavior of the community.

The writer believes, then, as a result of his experience, that the clinic has much to contribute to sociological theory. The clinic, further, serves greatly to enrich the work of a department of sociology. To achieve these results a clinic need not, however, be the proprietary interest of a sociology department itself. As the behavior sciences draw closer together, sociology departments will increasingly find their clinical needs met by participation in general university clinics, and in the work of clinics and other social agencies in the community.

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# How Functional Reviews in the Health Sector Exacerbated Occupational Stress Among Clinical Officers at Public Hospitals in Malawi

Paliani Chinguwo
University of the Witwatersrand

## Abstract

Malawi has a cadre of mid-level health professionals called clinical officers. In the wake of an acute shortage of medical doctors, clinical officers perform tasks conventionally designated for medical doctors. This paper seeks to explain how implementing some functional reviews in the health sector exacerbated occupational stress among clinical officers at public hospitals in Malawi. The study adopted a qualitative research design with a case study as a research strategy. The study was conducted at four district hospitals and one central hospital, all of which are state-owned in Malawi. The paper argues that implementing some functional reviews increased the risks of occupational stress among clinical officers at public hospitals. The paper demonstrates that implementing some functional reviews has aggravated occupational stress among clinical officers at public hospitals. The paper concludes that the implementation of some functional reviews has perpetuated interprofessional conflicts between clinical officers and medical doctors as well as forms of occupational violence by doctors against clinical officers. The paper further argues that interprofessional conflicts and occupational violence are ultimately drivers of occupational stress among clinical officers. Finally, the paper recommends that a psychosocial risk assessment should be conducted to avoid or minimise the risks of occupational stress and burnout among clinical officers posed by implementing functional reviews in the health sector.

**Keywords:** clinical officers; psychosocial hazards; occupational stress and burnout; restructuring, functional reviews.


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# 1. Introduction

Since the 1970s, developing countries have been putting efforts into implementing systemic reforms towards improving the performance of the public sector (Wescott, 1999, Durevall, 2001, Atkinson, 1995, Chiweza, 2010). In this paper, such systemic reforms are referred to as *restructuring*. Restructuring is defined as "…not simply public sector change… it incapsulates sustained, purposeful change to improve the efficiency, equity and effectiveness of the public sector or some combination of those" (Atkinson, 1995). Hence, the proponents of restructuring argue that the logic behind implementing restructuring in the public sector is to improve efficiency, effectiveness and accountability in terms of service delivery (Tetřevová, 2007, Riany et al., 2012, Young, 2002, Durevall, 2001, Wescott, 1999).

Within the framework of restructuring the public sector, *decentralisation and functional reviews* are some of the most common health sector reforms being implemented in developing countries (Mosca, 2006, Sumah et al., 2016, Lakshminarayanan, 2003, Atkinson, 1995). Decentralisation is sometimes described as a fourfold typology: delegation, deconcentration, devolution, and privatisation (Mosca, 2006, Sumah et al., 2016). "Delegation transfers responsibility to lower organisational levels; deconcentration to lower administrative levels; devolution implies transferring authority to a lower political level; and privatisation takes place when tasks are transferred from public into private ownership" (Sumah et al., 2016). Conducting functional reviews within government ministries is one way of improving the effectiveness of service delivery in the public sector (Wescott, 1999, Bennell, 1994, Tunčikienė et al., 2013, Durevall, 2001). Functional reviews within ministries can cover a wide range of benchmarks, such as an evaluation of organisational structures, establishment and staffing levels, management systems, and systemic and structural restrictions (Wescott, 1999, Bennell, 1994, Durevall, 2001). Functional reviews are also utilised to identify key obstacles in the effectiveness and efficiency of staffing (Bennell, 1994, Durevall, 2001).

Restructuring is associated with mental disorders among workers, such as occupational stress (OS). For instance, restructuring can

disrupt interprofessional relations and transform the work routine and the demands placed on individuals (Bourbonnais et al., 2005a). Ultimately, the disruption of interprofessional relations and the transformation of work routines may sometimes become sources of OS in the workplace (Bourbonnais et al., 2005a, Ganster and Rosen, 2013). Against this background, this paper seeks to demonstrate how disruption of interprofessional relations and transformation of work routine (*ibid.*) as a result of functional reviews, contributed to OS among clinical officers (COs). This paper argues that the implementation of some functional reviews in the health sector increased the risks of OS among COs at public hospitals in Malawi. Using the case of COs and with the aid of the job demand-resource (JD-R) model, this paper explores how the implementation of some functional reviews in the health sector exacerbated OS among COs at public hospitals. The key research question that this paper sought to interrogate was as follows: "Can functional reviews in the health sector become sources of occupational stress (OS) among clinical officers (COs) at public hospitals in Malawi?"

Since the main aim of the study was to explore the practical experiences of COs with the implementation of functional reviews *vis-à-vis* OS, which were anticipated to be subjective in nature, a qualitative research design was deemed most appropriate for the study.

The outline of the paper is as follows: the paper begins with an overview of the literature on the contextual background of functional reviews in light of changes in the workplace and the connection between such changes and OS among health workers; the organisation of healthcare services in Malawi; position of COs in health service delivery in Malawi; theoretical framework; and contribution of the study. Thereafter, the paper discusses the methodology of the study, which is followed by a presentation of the results. Finally, the paper articulates the interpretation of the results and then highlights the limitations of the study and practical recommendations.

# 2. Contextual background

## *Organisation of Healthcare Services*

Healthcare services in Malawi are provided through three subsectors. The three subsectors are: the public at free of charge, private for-profit, and private not-for-profit (Malawi Government, 2017). The public subsector is the major healthcare service provider that includes all health facilities under the Ministry of Health, district, town and city councils, Ministry of Defence, Ministry of Internal Affairs and Homeland Security (Police and Prisons) and the Ministry of Natural Resources, Energy and Mining (*ibid.).* The private for-profit subsector includes all privately owned health facilities, while the private not-for-profit subsector comprises health facilities owned by faith-based institutions, nongovernmental organisations (NGOs), and statutory corporations (*ibid.)*. The major faith-based provider is a group of mission hospitals called the Christian Health Association of Malawi (CHAM)[1], which accounts for approximately 29 percent of all health services (*ibid.*). Linked to each other through a referral system, the healthcare services in Malawi are organised at four levels as follows:

1. **community level** provided by community health workers (e.g., health surveillance assistants), health posts, dispensaries, village clinics, and maternity clinics;
2. **primary level** provided by health centres and community hospitals;
3. **secondary level** consisting of state-owned hospitals and CHAM hospitals at the district level; and
4. **tertiary level** consisting of five state-owned central hospitals located in the four major cities of Blantyre, Zomba, Lilongwe, and Mzuzu (Malawi Government, 2017, Malawi Government, 2018a).

1 Mission hospitals are owned by Christian religious denominations such as Roman Catholics, Presbyterians, Seventh Day Adventists, Anglicans, etc. Other religious faiths like Islam also operate health facilities outside CHAM.

More recent statistics of the health workforce in Malawi are reported in a survey on human resources for health in Africa that was conducted by the World Health Organization (2021). This survey showed that out of 47 African countries, only four, namely, Seychelles, Namibia, Mauritius, and South Africa, had a density of medical doctors, nurses, and midwives per 1000 population that reached or exceeded the sustainable development goals (SDG) density threshold of 4.45 health professionals per 1000 population. In contrast, Malawi is among the 16 (out of 47) countries in Africa reporting the lowest densities that fall within the range of 0-1 health professional per 1,000 population (World Health Organization, 2021).

## *Position of Clinical Officers*

Clinical officers (COs) are a cadre of mid-level health professionals in Malawi who serve as substitutes for medical doctors in the wake of an acute shortage of the latter (Bradley and McAuliffe, 2009, Chilopora et al., 2007, Gajewski et al., 2019, Grimes et al., 2014, Jiskoot, 2008, Mkandawire et al., 2008). Upon completion of O-Level education, candidates for the CO position are trained locally at Malawi College of Health Sciences for a three-year diploma course in anatomy, physiology, pharmacology, paediatrics, medicine, surgery, obstetrics and gynaecology (Chilopora et al., 2007, Gajewski et al., 2019, Jiskoot, 2008, Mkandawire et al., 2008, Muula, 2009, Grimes et al., 2014, Bradley and McAuliffe, 2009, McAuliffe et al., 2009a).

After completing a 12-month internship at a central or district hospital, trainees for the CO position are licenced to practice independently at secondary and tertiary levels of health service delivery (Chilopora et al., 2007, Gajewski et al., 2019, Mkandawire et al., 2008, Muula, 2009, McAuliffe et al., 2009b, Bradley and McAuliffe, 2009, McAuliffe et al., 2009a). At hospitals, COs are deployed to various departments/units depending on the areas in which they specialised during their training. At the district and central hospitals, the COs provide various services, including orthopaedics, physiotherapy, HIV/AIDS and TB treatment, family planning, paediatrics, surgery, radiology, pharmacy, laboratory, and antenatal services. As of 1980, when the first locally trained COs

started to practice, there was a handful of medical doctors in Malawi (Muula, 2009, Thetard and Macheso, 2004). Most of these medical doctors were expatriates practicing in Malawi for fixed periods of time (Palmer, 2006). For almost two decades after 1980, most of the administrative and clinical tasks conventionally designated for medical doctors were performed by COs (Broadhead and Muula, 2002, Muula et al., 2016, Thetard and Macheso, 2004).

## *Stress and Restructuring*

The Occupational Safety and Health Administration (2014) describes hospitals as workplaces characterised by high levels of stress. Dousin et al. (2019), Shanafelt and Noseworthy (2017), Bellagamba et al. (2015), Ilić et al. (2017) and Baylina et al. (2018) concur that working conditions at health facilities are inherently stressful. There are negative effects of OS and burnout on health workers. OS and burnout negatively affect the quality of personal life of the health workers themselves and their performance on the job (Gosseries et al., 2012, Goetz et al., 2015). OS and burnout "can reduce the enjoyment in life, cause hypertension, cardiac problems, reduce immunity, contribute to substance abuse, lead to frustration, irritability and reduce the overall status of mental and physical wellbeing" (Bhatia et al., 2010). OS and burnout are also associated with gastric complaints, nervous disturbances, chronic fatigue, headaches, sleep disorders, breast cancer, stroke, and increased consumption of tranquillisers and sleeping tablets (Lin et al., 2014, Pikó, 1999, Rivera et al., 2020, Wichert, 2002).

Changes in the workplace – such as the implementation of functional reviews, increased overtime work, and shift work – are associated with high levels of OS and burnout among health workers (Mathisen et al., 2017, Day et al., 2017). However, changes in the workplace are inevitable (Day et al., 2017, Leka and Lavicoli, 2017). A study on nurses conducted by Hertting et al. (2004) established that fundamental changes in the workplace through restructuring are connected with persistent mistrust towards management and doctors, which became a significant source of stress among nurses in Sweden. Quinlan and Bohle (2009), Bourbonnais et al. (2005b)

and Kalimo et al. (2003) identified an association between job insecurity and changes in the workplace, with significant adverse effects on workers' safety and health. In this regard, Loewenson (2001) argues that such adverse effects may be underreported due to job insecurity coupled with high labour turnover that results from the reorganisation of work. Wichert (2002) demonstrates that there was a negative effect of job uncertainty and work intensification on psychological wellbeing.

Dragano et al. (2005) conclude that there is a synergistic effect caused by simultaneous exposure to fundamental changes in organisations and an increase in work-related stress. For instance, Harney et al. (2018) confirm that restructuring is positively related to work intensity, which ultimately has a negative impact on the psychosocial wellbeing of workers, i.e., exhaustion and stress. Furthermore, restructuring can disrupt interprofessional relations, transform the work routine and the demands on workers, and ultimately trigger OS (Bourbonnais et al., 2005a, Ganster and Rosen, 2013). Against this backdrop, there is a tendency for workers to express negative attitudes towards restructuring efforts (Kivimäki et al., 2000). Such pessimism and negativity may lead to mistakes by health workers while on duty (Jones and Arana, 1996).

## *Functional Reviews in Malawi's Health Sector*

One critical aspect of restructuring in Malawi's public sector since the 1990s has been the implementation of functional reviews within government ministries (Durevall, 2001, Chiweza, 2010). In Malawi's health sector, the planning and implementation of functional reviews are coordinated by the Human Resource Planning Section of the Department of Human Resource Management & Development at the Ministry of Health (Malawi Government, 2020, Malawi Government, 2011). The functional reviews are conceived as efforts to establish new structures and functions in the architecture of health service delivery that reflect current needs while shedding some responsibilities that may no longer be relevant (Malawi Government, 2018b, Malawi Government, 2018a, Malawi Government, 2020). The Health Sector Strategic Plan for Malawi (2011–2016) stipulated a series of functional

reviews for the health sector, some of which were conducted by 2017 (Malawi Government, 2011). The Ministry of Health had planned to complete reviews of functional and governance structures in the health sector by 30 June 2021 (Malawi Government, 2018b, Malawi Government, 2018a, Malawi Government, 2020).

## *Theoretical Framework: Job Demands-Resources (JD-R) Model*

In this paper, the job demands–resources (JD–R) model is used to explain OS among COs in the wake of implementing functional reviews in the health sector. The JD–R model describes work conditions that are associated with burnout and motivation (Hu et al., 2018, Demerouti et al., 2001). According to Zablah et al. (2012), Hall et al. (2010) and Hall et al. (2013), the JD–R model is a dual-process framework on how burnout and engagement are influenced by the interaction of job demands and job resources. Job demands are "physical, social, or organisational aspects of the job that require sustained physical or mental effort and are therefore associated with certain physiological and psychological costs" (Demerouti et al., 2001). Job resources are "physical, psychological, social, or organisational aspects of the job that may do any of the following: (a) be functional in achieving work goals; (b) reducing job demands at the associated physiological and psychological costs; (c) stimulate personal growth and development" (Demerouti et al., 2001).

Job demands are considered contributing factors for mental illnesses such as OS and burnout, while job resources tend to minimise OS and burnout (Zablah et al., 2012, Demerouti et al., 2001, Hall et al., 2013, Hu et al., 2018). In contrast, job resources are contributing factors for engagement on the job, while job demands reduce one's engagement on the job ((Zablah et al., 2012, Demerouti et al., 2001, Hall et al., 2013, Hu et al., 2018).

This paper demonstrates that functional reviews being implemented in the health sector constitute additional job demands that contribute to OS among COs at public hospitals. Ultimately, the implementation of functional reviews in the health sector as additional job demands may inhibit COs' engagement on the job.

In this paper, the researcher has exercised the flexibility to apply the JD-R model in a hospital setting in Malawi. Hence, this paper has identified functional reviews as job demands that may interact with job resources at public hospitals in the course of *task shifting* to influence OS and burnout among COs.

## *Contribution of the Study*

A search of the literature on COs that was conducted in this study indicates that there is a handful of nonclinical articles on mid-level health workers in general that are available. These articles were published over seven years ago. Nevertheless, these articles provide important insights related to the work environment for mid-level health workers on which implications on safety and health can be drawn (Bradley et al., 2015, Bradley and McAuliffe, 2009, Dovlo, 2004, Kalata et al., 2013, McAuliffe et al., 2009a, McAuliffe et al., 2009b). Although these articles on mid-level health workers provide some insights related to the work environment for COs and implications for safety and health, there is one shortcoming inherent in these articles. These papers on mid-level health workers did not specifically target COs. The subjects of these studies were COs, medical assistants, technicians, nurses, and midwives, which collectively constitute mid-level health workers in Malawi. The COs, medical assistants, technicians, nurses, and midwives have distinct experiences in terms of work conditions and ramifications for safety and health. It is therefore critical for further research to be conducted on each category of the mid-level health workers to explore peculiar and deeper knowledge of their respective work environment *vis-à-vis* safety and health. This paper attempts to fill this gap.

Despite the limitations (highlighted later), this paper contributes to the emerging evidence supporting the connection between OS and restructuring in the workplace. In particular, this paper adds new information with reference to psychosocial hazards confronting health workers in the wake of implementing functional reviews. This new information can further be explored by other researchers and policymakers to improve the quality of healthcare at public hospitals in Malawi and beyond.

# 3. Methodology

This study adopted a qualitative explanatory research design with a case study as a research strategy. The research was conducted at the following five district hospitals and one central hospital, all of which are state-owned in Malawi: Mulanje District Hospital, Chikwawa District Hospital, Balaka District Hospital, Nkhatabay District Hospital, and Queen Elizabeth Central Hospital in Blantyre. A total of 1,045 constituted the source population (N) of COs employed in the public sector, while 152 constituted the study population (Np) of COs at the four district hospitals and one central hospital. Finally, for the interviews and focus group discussions targeting COs, 25 people (five from each hospital) were recruited as respondents.

Three methods of qualitative data collection were used, namely semistructured interviews, focus group discussions, and document analysis. Due to the COVID-19 protocols, semistructured interviews and focus group discussions were conducted virtually. In addition to the five COs from different departments at each of the five public hospitals, one immediate supervisor or hospital administrator from each hospital was selected for the semistructured interviews. Finally, five semistructured interviews were also conducted with five key informants outside the public hospitals as follows: a policy specialist at the Ministry of Health (1); an official from the Physician Assistants Union of Malawi (PAUM)[2] (1); retired COs (2); and an occupational health physician (1).

As shown in Table 1, in total, 35 semistructured interviews were conducted virtually with COs at the five public hospitals and key informants outside the public hospitals. Furthermore, at each of the five public hospitals, one focus group discussion was virtually conducted with at least four COs representing different departments or units. In total, five focus group discussions were conducted with COs.

Convenience sampling was used to select the five hospitals as study sites depending on the hospital's conditions set for study

2 Physician Assistants Union of Malawi (PAUM) is a trade union that represents clinical officers (COs) in Malawi. It was formed in 2018 as an association and registered as a trade union in 2020.

permissions to be granted. At each hospital, convenience sampling was also used to recruit the COs into the study. A method of data analysis called thematic analysis was adopted. This method involved the transcription of the virtual interviews and focus group discussions that had been recorded. A computer software called Atlas.ti version 9 was used to conduct thematic analysis on the transcriptions as well as the relevant documents that were gathered. These documents included statements, reports, and memos by the Physician Assistants Union of Malawi (PAUM); policy documents, reports, and statements issued by the Ministry of Health; and reports, memos, and charts provided by the hospital administrators. The thematic analysis of the transcriptions and documents involved creating codes, revising the codes, identifying recurring themes, and merging the themes where necessary (Maguire and Delahunt, 2017).

**Table 1:** Semistructured interviews

| **Interviewees** | **Number of interviews at each hospital** | **Total number of interviews** |
|---|---|---|
| Clinical officers from different departments/units | 5 | 25 |
| Immediate supervisors/ hospital administrators | 1 | 5 |
| Key informants | | 5 |
| **TOTAL** | **6** | **35** |

Informed consent and voluntary participation were mandatory for every respondent. Since data collection was conducted virtually, informed consent was obtained orally and captured in the audio recording before the commencement of a particular interview or focus group discussion. The study was approved by the Committee on Research Ethics in the Social Sciences and Humanities at the National Commission for Science and Technology (NCST) in Malawi (Registration No: P 08/21/598) and the Human Research Ethics Committee (Medical) of the University of the Witwatersrand (Registration No: M 210558).

## 4. Results

During interviews with COs and key informants, focus group discussions with Cos, as well as document analysis, it was established that there had been functional reviews in the health sector since the 1970s. The implementation of functional reviews entailed reconfigurations of some structures and the creation of new positions and functions in the health sector, among others. Some of the functional reviews implemented in the health sector are associated with increased risks of OS among COs at public hospitals.

**Figure 1**: Summary of study results

Figure 1 (above) summarises the results of the study. As shown in Figure 1, some functional reviews implemented in the health sector since the 1970s have caused feelings of frustration, depression, fear, anxiety, low self-worth, resentment, and anger among COs at public hospitals. Such feelings ultimately triggered or exacerbated OS among COs.

### *Creation of a 'Clinical Officer' Position*

A new position in the health sector called the *clinical officer* was created in 1976. This was a result of functional reviews that had been conducted in the wake of an acute shortage of medical doctors (Chilopora et al., 2007, Gajewski et al., 2019, Jiskoot, 2008, Mkandawire et al., 2008, Muula, 2009, Grimes et al., 2014, Bradley and McAuliffe, 2009, McAuliffe et al., 2009a). The introduction of clinical officers (COs) in the architecture of healthcare service delivery is a good example of *task shifting*. *Task shifting* is "a

strategy where nonqualified (or less qualified) health workers are given responsibilities normally performed by highly qualified and highly skilled health professionals" (Muula, 2016). The COs were therefore meant to be less qualified health professionals who would be recruited to serve as substitutes for medical doctors (Chilopora et al., 2007, Gajewski et al., 2019, Jiskoot, 2008, Mkandawire et al., 2008, Muula, 2009, Grimes et al., 2014, Bradley and McAuliffe, 2009, McAuliffe et al., 2009a). As of 1980, when the first locally trained COs started to practice after a four-year training (including a 12-month internship at a hospital), there was a handful of medical doctors in Malawi (Muula, 2009, Thetard and Macheso, 2004). Most of these medical doctors were expatriates practicing in Malawi for fixed periods (Palmer, 2006).

> *I can recall that when the 21 of us were licenced to practice as clinical officers in 1980, there were approximately 15 (or fewer) qualified medical doctors in Malawi, including specialist doctors. Most of these were foreign nationals* (Interview, retired clinical officer 01).

In 1991, upon the opening of the University of Malawi's[3] College of Medicine[4], the country started to train medical doctors locally (Broadhead and Muula, 2002, Muula et al., 2016). This meant that until 1991, there was no educational institution in Malawi where one could receive the requisite training and acquire a qualification as a medical doctor. Since 1980, most of the administrative and clinical tasks conventionally designated for medical doctors were performed by COs as substitutes for medical doctors (Broadhead and Muula, 2002, Muula et al., 2016, Thetard and Macheso, 2004). The situation started to change within a few years after the establishment of the College of Medicine in 1991. By 2002, 168 medical doctors had graduated from the College of Medicine in a space of ten years (Broadhead and Muula, 2002, Muula et al., 2016). A total of 112 of the 168 were then working in the country, while 43 were pursuing various postgraduate studies abroad and expected to serve at public

3 The University of Malawi was established in 1965.

4 In 2021, the College of Medicine and Kamuzu College of Nursing broke away from the University of Malawi and merged to form the Kamuzu University of Health Sciences.

hospitals in Malawi immediately after completion of their further studies (Broadhead and Muula, 2002). Most of the locally trained medical doctors were offered jobs in the health sector soon after graduating from the College of Medicine or institutions of higher learning abroad. Most of these positions had been held by COs since 1980, in the wake of an acute shortage of medical doctors in the country.

The increasing number of locally trained medical doctors available for employment in the health sector gradually emerged as a source of tensions, rivalries, and conflicts between medical doctors and COs. Such tensions, rivalries, and conflicts led to sour interprofessional relations between doctors and COs, particularly as more doctors started to take over some key positions previously occupied by COs. During the interviews and focus group discussions with COs, there was a general feeling among COs that medical doctors were generally favoured at the expense of COs.

> *One of the issues that, as a trade union representing clinical officers, we continue to engage the Ministry of Health to address is differential treatment. We have cases of clinical officers and doctors possessing the same highest qualifications, i.e., bachelor's degree or postgraduate qualification. A medical doctor will be given more incentives, such as accommodations and transportation. However, a clinical officer will be denied such incentives. Doctors will be given a higher grade of service, while a clinical officer possessing a bachelor's degree or master's degree, such as a medical doctor, will be given a lower grade. Unfortunately, the key decision-making offices where we submit our grievances at the Ministry are occupied by medical doctors who are beneficiaries in this vice while we are the victims* (Interview, key informant, president of PAUM).

During interviews, COs indicated that senior management positions at the district or central hospital level and the Ministry of Health were dominated by medical doctors. This was corroborated by the president of PAUM, who spoke as a key informant on behalf of COs. Among others, such top positions that we highlighted as being dominantly occupied by medical doctors include the following: director of social and health services, district medical officer, director or deputy director of the central hospitals, and director or

deputy director at the Ministry of Health headquarters. Other top positions include managers for various programmes in the Ministry of Health, such as the National Tuberculosis (TB) Control Program. The president of PAUM, on behalf of Cos, also bemoaned that some COs had acquired adequate work experience and higher educational qualifications suitable for such high positions, e.g., postgraduate degrees, including PhDs. However, according to PAUM, the suitably qualified COs were deliberately sidelined as far as appointments to such high positions were concerned.

The interprofessional conflicts between COs and doctors emanating from *task shifting* led to OS in two ways. Firstly, the interprofessional conflicts provided fertile ground for deep-seated frustration, anger, and resentment among COs against medical doctors. Ultimately, such deep-seated frustration, anger, and resentment exacerbated OS. In addition, interprofessional conflicts also resulted in a lack of support, respect, understanding, and empathy between COs and doctors. During interviews, COs expressed that when interacting with medical doctors, they would develop feelings of low self-worth, fear, anxiety, depression, and insecurity due to poor interprofessional relations. Such deep feelings ultimately cause or aggravate OS among COs. This was corroborated by a retired CO who was a key informant and graduated from the first cohort of locally trained COs:

> *I can tell you that it is not only too much workload that contributes to stress and burnout among clinical officers. The stress and burnout that clinical officers suffer also come from prolonged frustrations, anxieties and depression arising from several issues, such as poor relations between clinical officers and other cadres, particularly medical doctors. Such grievances about poor relations may have nothing to do with the workloads that clinical officers are subjected to* (Interview, retired clinical officer 01).

Secondly, during interviews and focus group discussions, COs reported experiencing occupational violence in the form of verbal aggression and bullying from medical doctors and nurses due to the lower qualifications and clinical competencies of COs. The verbal aggression and bullying by medical doctors against COs manifested through insults, shouting, and outbursts, sometimes over unfounded

accusations. The COs further testified that such verbal aggression and bullying made them feel intimidated, offended, and less valued by the medical doctors. Subsequently, this caused prolonged feelings of frustration, anger, resentment, and alienation among COs. Ultimately, such prolonged feelings became sources of OS among COs.

## *Unfair Distribution of Tasks*

The unfair distribution of tasks was another grievance that COs raised as a contributing factor to interprofessional conflicts with medical doctors in the course of *task shifting*. During interviews and focus group discussions, COs mentioned that at district hospitals, a handful of medical doctors available were often preoccupied with administrative tasks other than clinical duties. This was corroborated by a respondent who was a medical doctor and then served as a supervisor for COs. Two key informants also corroborated this observation. As such, COs were performing most of the clinical duties, some of which were supposed to be undertaken by the few medical doctors at the hospital. As a result, there was growing frustration and resentment among COs over the unfair distribution of clinical tasks at the district hospitals between COs and medical doctors. The COs mentioned that frustration and resentment ultimately exacerbated OS and burnout among COs.

> *You know, we still have an acute shortage of doctors at our hospital. We need more doctors. However, the handful of doctors we have here at the hospital are not performing the clinical duties as expected. It is mostly us, the clinical officers who do much of the clinical duties which these few doctors here were supposed to be performing. That leaves us with too much work to do. In the end, this triggers stress and burnout. Instead, these few doctors here are preoccupied with administrative tasks at this hospital, that is what all they do here. We have been raising this as an issue of concern. Unfortunately, our superiors where we take these concerns happen to be the same doctors we complain against over unfair distribution of tasks* (Focus group discussion 04B).

Interprofessional conflicts between COs and medical doctors were also associated with training and qualifications between the two cadres. One undergoes a five-year Bachelor of Science (BSc) degree course

to qualify as a medical doctor followed by an 18-month internship at the central hospital, while COs as substitutes for medical doctors are trained for three years at the diploma level followed by a 12-month internship (Chilopora et al., 2007, Gajewski et al., 2019, Jiskoot, 2008, Mkandawire et al., 2008, Muula, 2009, Grimes et al., 2014, Bradley and McAuliffe, 2009, McAuliffe et al., 2009a). During interviews and focus group discussions, COs expressed that despite a shorter period of training and a lower qualification, their clinical performance was as good as that of medical doctors. Despite this, COs highlighted that medical doctors regarded them as far less competent in performing the tasks conventionally designated for medical doctors. However, COs had been independently performing the conventional tasks for doctors at public hospitals for decades when there was an acute shortage of doctors in the country. Against this backdrop, COs testified that they sometimes experienced negative attitudes from medical doctors at both district and central hospitals over COs' qualifications and clinical competency. For instance, some COs felt that as a result, there was insufficient recognition and support from medical doctors as supervisors of COs. The verbal aggression, lack of recognition, and lack of support were cited by COs as drivers of OS and burnout, among others.

## *Creation of a 'Clinical Technician' Position*

From 2016-2017, a series of functional reviews were conducted in the health sector that, among others, recommended the creation of a new position called the *clinical technician* (Malawi Government, 2017, Malawi Government, 2018b). The creation of this new position resulted in a split of health workers in the position of CO. The COs who held a university degree maintained their label of *clinical officer*, while the identity of COs possessing diploma qualifications became *clinical technicians* according to the revised nomenclature of the Ministry of Health (Malawi Government, 2018b). While the designation of COs holding diplomas was downgraded to a clinical technician, their working conditions, including emoluments, were not disparaged.

> *The separation of these cadres and starting to call degree holders clinical officers while those with diploma clinical technicians, in my view, is problematic and unnecessary. Because when you look at the nature of their work itself, you will find that technically it is almost the same. There is little difference between the work being performed by the so-called clinical officer and clinical technician. They may have different educational qualifications, but the truth of the matter is that they all belong to the same cadre of health professionals. Take, for example, nurses: a nurse is a nurse although some have degrees in nursing, while others possess diplomas in nursing. The bottom line is that they are all called nurses. Why should the story be different with clinical officers*? (Interview, retired clinical officer 01).

However, the Medical Council of Malawi, which regulates the training and practice of the medical profession (Malawi Government, 1987), did not have in its registry a position called a *clinical technician*. The Medical Council of Malawi continued to issue practicing licences to individuals under the category of a *clinical officer* whether one possessed a diploma or degree. In other words, while the Ministry of Health revoked the designation of a *clinical officer* from diploma holders and started to classify them as a *clinical technician*, the Medical Council of Malawi still recognised them as *clinical officers.* Figure 2 (below) shows a practicing licence for an individual whose highest educational qualification was a diploma. The holder of the licence shown in Figure 2 (below) still used the licence to practice as a legally registered *clinical officer.* This was despite being categorised differently by the employer (Ministry of Health).

MEDICAL COUNCIL OF MALAWI

CERTIFICATE OF REGISTRATION

REGISTRATION NO. MCM/CO/ CERTIFICATE NO:

*This is to certify that*

is this 11th day of December 2019, registered on the

Register of CLINICAL OFFICERS
kept by the Medical Council of Malawi in accordance with the provisions of the Medical Practitioners and Dentists Act, 1987, and the Regulations made thereunder.

**Figure 2**: Licence for practice as a clinical officer issued to a diploma holder. Source: Medical Council of Malawi (2019)

The unbundling of the CO position was implemented by the Ministry of Health without prior consultations with the COs, besides contravening the classification by the Medical Council of Malawi in accordance with the provision of the law (Physician Assistants Union of Malawi, 1 September 2020). The COs who possessed diploma qualifications regarded the unbundling as a demotion when some of them were eagerly anticipating promotions for long service. This was corroborated by the president of PAUM as a key informant who spoke on behalf of the COs:

> *For those of us holding diploma, the Ministry of Health now calls us clinical technicians. It is only when you acquire a degree that the Ministry will refer you us a clinical officer. This is like a divide-and-rule tactic by the employer against our cadre. This new designation of clinical technician makes some of us feel it is a demotion and it is demoralising and frustrating to say the truth. In the end, as you report for duties every day you become stressed* (Interview, 05/CO/05).

The president of PAUM confirmed that the designation of *clinical technician* eventually caused deep-seated disenchantment,

frustration, and depression with functional reviews in the health sector. Such deep-seated disenchantment, frustration, and depression were associated with the escalation of OS among COs. The president of PAUM further mentioned that the COs who held degrees demonstrated solidarity with fellow COs holding diplomas in protesting against the unbundling of the CO position. The common concern among COs holding diplomas and degrees was that they were not duly consulted by the Ministry of Health before the implementation of the unbundling of the CO position. As such, they found it challenging to cooperate in the implementation of a decision that top management in the Ministry of Health took unilaterally without consultation with the COs as concerned parties.

> *The new position of the clinical technician was introduced without seeking the views of the concerned COs. This decision to introduce a new position of clinical technician sounds demeaning. Our stance as a trade union that is endorsed by both COs with diplomas and those with degrees is that this position of clinical technician should be discarded immediately and revert to the original name of the clinical officer. Then, we can have a new position called an associate clinical officer to refer to those holding diplomas who can then ascend to a full clinical officer upon upgrading qualifications to the degree level. Just like at universities where they have an associate lecturer who later becomes a full lecturer after satisfying certain academic requirements. At universities, they also have an associate professor who eventually ascends to full professor, that is what we have been advising our bosses at the Ministry of Health. However, they have not dared to consider our submission on this matter* (Interview, key informant, president of PAUM).

## *Other Functional Reviews*

Due to budgetary constraints confronted by central and district hospitals to effectively deliver healthcare amidst ever-increasing demand, optional paying wings are being established at central hospitals and five out of 29 district hospitals (Malawi Government, 2020). This is aimed at mobilising financial resources for health services at public hospitals (Malawi Government, 2020). 30 June 2021 was set as a deadline to complete the establishment of optional

paying wings at all central hospitals and the five district hospitals that were selected (*ibid.*). Among the central hospitals and five selected district hospitals are three hospitals: Queen Elizabeth Central Hospital, Nkhatabay District Hospital and Mulanje District Hospital (*ibid.*). These three hospitals were study sites for this study.

> *Some reviews have been going on in the health sector and right here at our hospital. We hear about proposals to change some of our roles and responsibilities, including how this hospital should run and be managed. This makes us feel worried and anxious that perhaps one day, we may wake up to hear that the positions of clinical officer and clinical technician have been scraped off just us it happened when they suddenly declared without consultation that all of us with diplomas were no longer clinical officers. That atmosphere causes fear, and it is stressful as you work when you think about what might happen tomorrow with our jobs here* (Interview, 05/CO/02).

Different health facilities are at different stages of functional reviews. While some health facilities are in the planning stage of functional reviews, others have completed the functional reviews. According to Malawi Government (2020), by the deadline of 30 June 2020, functional reviews of health facilities had been completed for Lilongwe's district council and five central hospitals, while the reviews were still in the pipeline for health facilities in other district councils. With regard to the introduction of optional paying wards, only five out of the 29 district hospitals had been selected to commence the implementation of this particular reform by 30 June 2021 (Malawi Government, 2020). According to some COs, such disparities in functional reviews have intensified their fears and anxieties about what will happen to their roles and responsibilities after functional reviews are completed. This was corroborated by the president of PAUM as a key informant who spoke on behalf of COs. The PAUM president indicated that functional reviews may culminate in additional tasks on COs' job descriptions, while their emoluments remain static. Hence, COs further feared that the problem of excessive workloads and long hours of work would be intensified by the implementation of some functional reviews. During the interviews

and focus group discussions, COs associated such heightened fears and anxieties with the exacerbation of OS.

# 5. Discussion

This section discusses the interpretation of the results on how implementation of some functional reviews increased the risk of OS among COs at the five public hospitals. This section also demonstrates at conceptual, empirical, and theoretical levels how the results of the study relate to the literature.

## *Fundamental Changes from Functional Reviews*

Day et al. (2017), Mathisen et al. (2017) and Hertting et al. (2004) argue that workplace changes may involve adjustments in employment circumstances, relocation, and even job loss due to staff shortages, work overload, long hours, and multitasking. The authors further associated changes at the workplace with increased OS among health workers. This is consistent with the results of the study. The results of the study show that changes in the health sector following functional reviews heightened fears and anxieties among some COs about what would finally become of their roles and responsibilities. Such heightened fears and anxieties over functional reviews exacerbated OS among COs.

**Acquisition and Loss of Power *vis-à-vis* Identity Crises.** The implementation of functional reviews in the health sector can be associated with power in terms of acquisition and loss. Power can be viewed as a process that continuously evolves such that among others, it involves acquisition and loss (Anderson and Brion, 2014, Li et al., 2017). In terms of acquisition, Anderson and Brion (2014) argue that individuals perceived to possess superior competence and expertise are accorded power over others. In 1980, graduates among the first cohort of locally trained COs were allocated various key positions of power in the health sector when the number of doctors was negligible and predominantly composed of expatriates. For over two decades after 1980, most district hospitals have not had qualified doctors (Dovlo, 2004). At such district hospitals, COs

were the available health professionals perceived to possess superior competence in clinical practice. Hence, COs occupied key positions of power as substitutes for medical doctors in the course of *task shifting*.

According to Anderson and Brion (2014), contextual factors beyond the control of those holding power may lead to the loss of power. Among others, the implementation of some functional reviews for which COs had no control gradually culminated in the slipping of power from COs to doctors. This is the power that the COs had acquired and maintained since the 1980s. The slipping of power is a situation against which COs feel disenchanted, frustrated, and depressed. This explains why COs feel that doctors currently dominate the key positions of power in the health sector at the expense of COs and other health workers. They feel that, due to the doctors' domination of key positions of power, suitably qualified COs are deliberately sidelined in regard to appointments to such key positions of power in the health sector. This paves the way for doctors who dominate key positions of power to impose certain decisions, such as unbundling of the CO position, despite resistance from COs. Such feelings of disenchantment, frustration, and depression lead to OS among COs.

**Sour Interprofessional Relations.** *Task shifting* that involves the use of COs and substitutes for medical doctors has also brought about sour interprofessional relations between COs and medical doctors. According to Ogbonnaya et al. (2007), one contributing factor to interprofessional conflicts is the unequal relationships between professionals in healthcare teams. Unequal relationships are manifested through differences in educational backgrounds and work experiences and unequal responsibility and authority (Ogbonnaya et al., 2007). A study by Omisore et al. (2017) found that fierce contestation over positions of authority was one of the reasons for interprofessional conflicts among health workers in Nigeria. In this study, by Omisore et al. (2017), three-quarters of doctors felt that teams and overall management at the hospitals should be headed by doctors only, while 90 percent of other health workers perceived the doctors' propositions unacceptable. Contestation for positions of

authority is a source of rivalry and conflicts between medical doctors and other health workers in Nigeria (Omisore et al., 2017).

The architecture for health care service delivery in Malawi places medical doctors at the helm of clinical practice (Malawi Government, 2017, Malawi Government, 2018b). As such, medical doctors occupy a preeminent position in the entire healthcare service delivery. This is why doctors enjoy higher degrees of autonomy, responsibility, authority, and social status than other health workers, such as COs. The results of the study reveal that COs perceive higher degrees of autonomy, responsibility, authority, and social status among doctors as manifestations of nepotism in favour of doctors. In response, the COs react with feelings of frustration and resentment against medical doctors, culminating in the heightening of rivalry and conflicts between doctors and COs. This supports a study by Omisore et al. (2017) in which 70 percent of the respondents perceived interprofessional rivalry as a leading cause of conflicts among health workers in Nigeria.

The results of the study also reveal deep-seated frustrations and resentment among COs that senior management positions at the district or central hospital level and the Ministry of Health are dominated by medical doctors. The COs confirmed that suitably qualified COs were deliberately sidelined as far as appointments to such management positions were concerned. The results of the study highlight the perceived dominance of top managerial positions by medical doctors as a source of interprofessional conflict between medical doctors and COs. This also supports a study by Omisore et al. (2017), which established that contestation over positions of authority was one of the reasons for interprofessional conflicts among health workers in Nigeria.

Interprofessional conflicts hinder the supervision and support that COs require from doctors as their superiors. As a result, COs experience frustration, depression, and anxiety due to poor supervision and support by their superiors. The results of the study further show that ultimately, such frustration, depression, and anxiety lead to OS among COs. This qualifies McAuliffe et al. (2009b), who found that COs did not receive recognition, respect,

and necessary support from doctors and health administrators. Due to sour interprofessional relations between doctors and COs, COs were made to feel unsupported and undervalued (McAuliffe et al., 2009b). The results of the study also support Dovlo (2004), who discovered that mid-level health workers in Malawi did not receive recognition, respect, and necessary support from supervisors and workmates. The results of the study further qualify the finding by Bradley and McAuliffe (2009) and McAuliffe et al. (2009a) that there were tensions, frustrations, and other interprofessional conflicts at hospitals between COs on the one hand and medical doctors on the other hand.

According to Nwobodo et al. (2022), interprofessional conflicts among health workers can involve abusive language (yelling, threats, vulgarity), blame, and disruptive conduct. This is consistent with the results of the study on poor interprofessional relations and occupational violence. The results of the study indicate that COs experienced violence in the form of verbal aggression and bullying from medical doctors because of their lower qualifications and clinical competence. The verbal aggression and bullying by medical doctors against COs were also manifested through insults, shouting, and outbursts.

## *Additional Job Demands*

Drawing from the JD-R model, this paper argues that in the course of implementing functional reviews, some changes emerge at public hospitals that require COs to put in extra effort to adapt. One example of such changes is the creation of a new position called 'clinical techinician', as illustrated in the previous section. Such changes constitute additional job demands. In attempts to adapt to the additional job demands at public hospitals in light of the implementation of functional reviews, COs encounter OS amidst inadequate job resources. Ultimately, such situations exacerbate OS and burnout among COs.

In the course of *task shifting*, COs' experience sour interprofessional relations with doctors and insufficient supervision and support from doctors. Interprofessional conflicts, insufficient supervision and

occupational violence, and loss of power are examples of additional job demands that COs grapple with in the wake of the implementation of some functional reviews. The job resources would be adequate supervision and support as well as good interprofessional relations with doctors, among others. Adequacy of these job resources can minimise OS and burnout among COs. If incidences of OS and burnout are minimised by adequate job resources, engagement on the job among COs can be enhanced. A drastic increase in these job demands (such as functional reviews) can aggravate OS and burnout among COs, leading to disengagement from the job.

However, COs are generally faced with situations in which job resources are perpetually inadequate while job demands are high at public hospitals. Amidst inadequate job resources, COs struggle to cope with high job demands. Subsequently, such a struggle to cope with high job demands aggravates OS and burnout, which negatively affect COs' attitudes on the job. Ultimately, the negative attitudes on the job, aggravated by OS and burnout among COs, may result in disengagement from the job.

## 6. Study Limitations

There are three limitations to this paper. Firstly, this paper is confined to explain how the implementation of functional reviews increased the risk of OS among COs at public hospitals in Malawi. However, there could be other factors that also trigger and exacerbate OS at public hospitals, such as work overload and long hours of work. Secondly, this paper used one theoretical perspective called the JD-R model to explain OS and burnout among COs. However, there could be other theories, such as attribution theory, that can also be applied to explain OS and burnout at public hospitals. Finally, this paper is drawn from a qualitative study, which by design could not illustrate the extent of OS among COs. Hence, the analysis in this paper is based on experiences of OS and burnout among COs. There are, however, tools for quantifying burnout, such as the Maslach Burnout Inventory (MBI), Tedium Measure, and Burnout Measure (Schaufeli and Taris, 2014). Future research should therefore consider interrogating other contributing factors to OS and burnout among health workers beyond

the implementation of functional reviews, broadening the scope by applying other theoretical perspectives in addition to the JD-R model and using quantitative data collection tools to measure burnout.

Nonetheless, the study's subjects were not ordinary people. They were health professionals active in general clinical practice that also dealt with mental health problems. While their perceptions of OS and burnout were based on personal experiences as observers or current or previous victims of OS and burnout, they shared their realities from informed positions as experts in clinical practice. Their submissions concerning the realities of OS and burnout enhanced the authenticity and trustworthiness of the study.

## 7. Conclusion and Practical Recommendations

This paper has demonstrated that the implementation of some functional reviews in the health sector aggravated OS among COs at public hospitals. For instance, the implementation of functional reviews led to the loss of power among COs, while doctors simultaneously acquired power. The process of losing power among COs amidst the implementation of functional reviews ultimately increased the risks of OS among COs. The implementation of functional reviews in the health sector also provided fertile ground for interprofessional conflicts between COs and doctors, and forms of occupational violence by doctors against COs. All these factors resulted in sour interprofessional relations between COs and doctors that caused deep-seated feelings of disenchantment, frustrations, resentment, depression, and anxiety, being undervalued and unsupported among COs. Such feelings ultimately exacerbated OS among COs in the course of *task shifting*. When implementing functional reviews in the health sector, the psychosocial wellbeing of health workers should also be regarded as critically important. Hence, at a practical level, the following key recommendations are proposed:

1. The Ministry of Health, in consultations with employers and workers in the health sector and other relevant stakeholders, should lead in regularly conducting a psychosocial risk assessment

on functional reviews being formulated and implemented in the health sector;

2. Functional reviews formulated and implemented in the health sector should incorporate specific interventions on how to avoid or reduce psychosocial hazards in the course of implementing functional reviews; and
3. The Ministry of Health in consultations with employers in the health sector and trade unions/associations representing health workers and other relevant stakeholders should develop a curriculum and training programmes on intra/interprofessional conflicts for health workers aimed at promoting interprofessional collaborative practice (IPCP), eradicating stereotypes against other cadres, and inculcating a spirit of mutual respect and teamwork.

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## Semi-Structured Interviews

Interview, key informant, president of PAUM. 10 November 2021.

Interview, retired clinical officer 01. 16 August 2022.

Interview, 05/CO/02. 14 December 2021.

Interview, 05/CO/05. 2 January 2022.

## Focus Group Discussions

Focus group discussion, 04B, 13 December 2021.

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## Conflict of interest disclosure

I declare that there are no known competing financial interests or personal relationships that influenced this work.

## Data availability

Data for this study can be made available by the author with permission from the University of Witwatersrand.

## Ethics approval

This study was approved by the Committee on Research Ethics in the Social Sciences & Humanities in Malawi (Reg. No: P.08/21/598) and the Human Research Ethics Committee (Medical) at the University Witwatersrand, South Africa (Reg. No: M210558).

## Subjects' consent

Every respondent was required to give informed consent and voluntarily participate in the study. Informed consent was verbally obtained and recorded.

## About the author

Paliani Chinguwo is a labour specialist who has closely worked with trade unions for over 15 years at the national (Malawi) and international (Southern Africa/Africa Union) levels. He is currently a post-doctoral fellow on the *Health Workforce in South Africa* at the School of Public Health, University of Witwatersrand (South Africa).

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# Evangelical Christianity and Criminal Rehabilitation: A Clinical Sociological Approach to Stigma and Identity Management

Wesley D. Cohoon
Midwestern State University

## Abstract

Crime and religion are social constructs that indicate what society considers acceptable and deviant behavior. The connection is further complicated when considering how the formerly incarcerated integrate back into society after incarceration. This study examines Evangelical Christianity's role in criminal rehabilitation through identity repair. The article utilizes a clinical sociological approach and focuses explicitly on symbolic interactionism. The researcher conducted a case study of five formerly incarcerated individuals from the United States who are now working in vocational ministry settings. The researcher uses qualitative analysis to uncover how the participants explore social interactions and social systems that impact identity construction and criminal rehabilitation. The researcher finds that Evangelical organizations overfocus on individuality in conversion and do not recognize their part in the conversion process. The study also suggests that ex-felons need to manage their expectations and stigma. The implications of the findings suggest that identity formation and restoration is a social activity dependent upon multiple parties. This discovery can help those seeking to impact criminal rehabilitation as they find ways to repair previous identities and live crime-free.

**Keywords:** crime, religion, rehabilitation, stigma, clinical sociology

Society does not offer many ways for ex-felons to break from their stigmatized past and identities to become productive citizens. While the assumption is that recidivism depends on the ex-felon's effort and desire, it naively emphasizes individualistic traits without considering sociological factors. Ex-felons experience many physical


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challenges and practical barriers after incarceration. However, a primary struggle that heavily impacts their response centers on identity. The identity that a person develops and maintains will further influence their attitudes, actions, and decisions.

Identity creation is a social process, not an individual one. Society either validates or withholds a particular identity for an individual. This acceptance or rejection will impact the person's internalization and responses. People who have experienced an event that stigmatized their identity, like a criminal conviction, cannot create a non-criminal identity unless society verifies it.

Religion is crucial in developing meaning, creating identity, and interpreting the social world. Ex-felons who want to move beyond their criminal identity need a vehicle to accomplish this transformation. Religion is a way in which ex-felons can create meaning after incarceration, construct a destigmatized identity, and reinterpret their identity and past mistakes to produce a new one. However, this transformation is not the sole responsibility of the individual, and the religious community has an essential function. This article explores the role of Christian identity restoration after people experience a criminal conviction.

The article uses clinical sociology, which applies sociology and creates solutions that address societal problems. A sociological intervention is needed to understand how ex-felons can develop destigmatized identities and successfully reintegrate back into society. Often, religious ministries lack the sociological insight necessary to contribute effectively to rehabilitation. Likewise, some secular approaches downplay religion's importance in rehabilitation. Providing sociological interventions combines these two elements and positively impacts the successful rehabilitation of the formerly incarcerated. This study contributes to existing research by offering the voice of those formerly incarcerated, and it provides clinical sociological interventions to address the problem.

The article will first review the literature related to crime and religion. Next, the study will provide information regarding the clinical context and setting of the research, along with the methodology used. Two primary themes emerged from the interviews. The first theme

focused on the relationship between criminal rehabilitation and religious redemption through Evangelical Christianity. The second theme emphasized the connection between symbolic interactionism and identity restoration for those formerly incarcerated. Based on the analysis, the study offers two sociological interventions. The first intervention is for Evangelical organizations. It focuses on Evangelicals recognizing their role in identity confirmation and calls for a change in evangelistic practices. The second intervention is offered to ex-felons and includes ways they can manage their expectations and stigmatized identities.

## 1. Crime and Religion Literature Review

Crime and religion are nebulous concepts that can be taken for granted. Durkheim ([1912] 1955) famously defines religion as a moral community that follows the same beliefs and practices that connect to sacred objects and are separated by profane ones. From that definition, the two primary elements of religion are beliefs and practices that unify a group of people. Durkheim defines the religious community as a "church", and he said that it must consist of priests and laity who share the same morality, beliefs, and practices. Eliade (1987) adds to this definition by pointing out that religions will frequently repeat myths to allow people an opportunity to imitate their gods and maintain the sacredness of their reality.

The challenge is that beliefs and practices can be at odds with others. The inconsistency between people's professed religious beliefs does not always match their actions. Cox (2009) suggests that Evangelical Christianity has isolated the concept of faith from belief and that modern Christians judge Christianity based on the belief of theological doctrinal statements. The emphasis on correct belief over correct practice establishes a system where what people say they believe is more important than how they put those beliefs into practice.

Evangelicals can claim that ex-felons can receive forgiveness but simultaneously withhold it from them. Bae (2017) explains this through a difference between involuntary and voluntary cognition, which means people can distinguish between the belief that ex-felons

can be forgiven versus the religious community actually forgiving them. It is crucial to understand and explain how religious people treat the formerly incarcerated instead of relying on what they claim.

An essential part of religion is that it establishes the moral standards for the community, which guides its members' behavior. One way the moral standard is set is by isolating and protecting sacred objects from the profane (Durkheim [1912] 1955). The sacred in religion is treated differently from similar items by its members (Eliade 1987). While profane and sacred are subjective concepts, it is important to understand what makes them blasphemous or holy to a group of people (Weber [1921] 1968).

Religion must maintain the reality of its members, and one way this occurs is through conversion and disassociation between the converted and the unconverted (Berger 1990). The religious community needs to be able to distinguish itself from others. Casanova (1994) suggests that religious fundamentalists do this by requiring sin and apostasy to exist. Therefore, religious fundamentalists define their holy actions by clarifying that others are unholy.

Since fundamentalists need the unholy so they can be holy, some fundamentalists may struggle with how to define or treat those formerly incarcerated. A challenge for those engaged in criminal activity is that the religious community could consider their actions and those associated with them as profane. When that happens, the congregation may assign a value to people and segregate the profane members from the holy congregants. In religion and criminality, attention needs to be given to how and if the profane can become sacred.

The United States (US) has a long and complicated history with religion. Weber ([1905] 1958) shows that Protestantism mixed with capitalism influences the American ethos. Things like frugality, working hard, assigning meaning to vocation, avoiding idleness, and putting ethical significance on wealth are all things that result from the mix of capitalism and religion, and guide American society. Weber identifies that capitalism and religion mix and guide American society. Berger (1990) observes that religion is currently marketed as a commodity because people can no longer impose it.

Mills (1959) suggests employing sociological imagination to understand people and institutions, which means recognizing history, meaning, social position, and false consciousness. Applying this to the US, it is clear that religious and capitalistic principles are always in play. The influence of Protestant Christianity and capitalism is engrained in US society even when it is not overtly recognized. Therefore, the ideas about criminality and moral behavior are rooted in religion. Kaufman (2019) suggests that understanding how religion matters to people and how religious concepts are used will help evaluate its impact on those in the criminal justice system.

People use religion for guidance through difficult circumstances. Religion allows people to make sense of past mistakes and alleviates anxiety about death (Royce [1908] 2017). Religion is often used as a vehicle of transformation for individuals in dealing with tragedy. Needs and desires can conflict, so religion is employed in those decisions.

Religion and crime are similar because both are socially constructed and represent the collective consciousness of a particular society. Durkheim ([1893] 2014) argues that religious law and penal law are connected, and people seek justice for crime because they want retribution for violating ideas or morals that they hold as sacred. Religion and crime establish moral guidelines, have expected practices, prioritize specific values, assign sacredness and profaneness, and connect the collective consciousness.

Crime is any activity that offends collective consciousness, appears detrimental to society, and incites a punishment reaction against the doer (Durkheim [1893] 2014). Criminal acts are contextualized based on a specific culture and can change. Since crime violates social consciousness, people can easily classify criminal acts as immoral. Durkheim ([1893] 2014) clarifies that an action is a crime because it is condemned by society instead of being condemned because the behavior is a crime. Durkheim makes an important distinction because it recognizes societal bias and refocuses the reactive punitive passions to thoughtful rehabilitative approaches.

Crime and religion frequently intersect through prison institutions. In the US, correctional facilities utilize chaplains who

work under a prison administrator (Beckford 2013). The religious goals of chaplains intersect with the institutional objectives of prisons. While the chaplain may seek to convert or have the prisoner develop spiritually, these goals coincide with the correctional goals of increasing inmate discipline and reducing recidivism (Hallett et al. 2019). Correctional institutions may also support religious programming because it is inexpensive and utilizes a mixture of volunteers and paid staff. Stansfield et al. (2019) point out that religious programming may be the only rehabilitative service that inmates receive.

The literature also indicates that redemption connects to successful reentry. Society impacts how people interpret the world and know themselves (Berger & Luckman 1967). Religious people need to understand how their spiritual practices and beliefs influence offenders. When incarcerated people feel forgiven and acknowledged by God, they report feeling comforted (Landman & Pieterse 2020). Experiencing religious forgiveness impacts a person's ability to forgive others, and being forgiven positively impacts offenders (Morton et al. 2019).

There are reentry challenges connected with ex-felons, religion, and redemption. People take many social institutions for granted that are inaccessible to ex-convicts (Wallace et al. 2020). Ex-felons report that religion is a crucial source of resilience and reintegration, but they also experience social structure barriers that challenge their ability to practice their faith (Teti et al. 2012). The literature frequently emphasizes the discrimination ex-felons experience, resulting in a lack of basic needs like housing and employment (Hlavka et al. 2015).

Employers discredit people with a criminal history, and the applicant's ability to overcome the stereotype is frequently related to their criminal offense (Uggen et al. 2014). A different study indicates that hiring managers are more willing to hire those with criminal histories if the applicant shows remorse, apologizes, or offers justification for their criminal behavior (Ali et al. 2017). A criminal record follows an applicant for their entire life, which can leave them always open to employment discrimination or having to explain

illicit behavior from decades prior. In addition to employment and housing challenges, parolees endure extra financial burdens through fees associated with parole, random drug testing, and court-ordered classes, which contribute to reincarceration (Pogrebin et al. 2014).

Congregations may be limited in what they can do to address the physical needs of ex-felons, but they can offer significant support in ways that are aligned with what the organization is already doing. One religious organization assisted ex-felons in developing recovery capital, focusing on finances, social connection, and life skills (Connolly & Granfield 2017). Many churches already offer money management classes and other avenues where their congregants develop relationally and practically.

However, ex-felons could find it challenging to experience social connection through a religious community. Goffman (1959) argues that social exchanges occur through people concealing their desires and acting consistently with the expectations of others. Being part of a religious group involves the pressure of living an expected lifestyle. The challenges faced by many ex-felons are things that most congregants take for granted. For example, one study found that ex-felons with many incarcerations lack the social and economic capital to change, and therefore they continue a cycle of repeat offenses, solidifying public opinion that these individuals are defective (Pogrebin et al. 2014).

An underlying issue for many ex-felons contributing to recidivism is exclusion from social networks, which continues to limit their ability to build social capital (Koschmann & Peterson 2013). To experience the newness and opportunity for change associated with redemption means that many ex-felons need to develop new relationships. They cannot return to their criminal network, and one study found that some family members even expressed difficulty reestablishing relationships post-incarceration (Dolwick-Grieb et al. 2014).

Religious support for ex-felons positively affects reentry success (Stansfield 2017). Religious organizations that were successful with ex-felon reintegration did so in simple ways. For example, Connolly and Granfield (2017) found that ministries that treated ex-felons

with dignity were more successful, and Koschmann and Peterson (2013) found that mentoring the formerly incarcerated helped address hidden recidivism causes.

The final area that connects with redemption and rehabilitation is desistance, which explores how people formerly convicted of crimes live a crime-free life. The process of desistence helps people accept responsibility and fosters a deeper understanding of how to live reciprocally in a community where they give and receive (McKiernan et al. 2013). Religion plays a significant role in desistence because it enables people to shift their narrative and perspective of past crimes, leads people to normative behavior, and encourages desistance (Ellis 2018). It was also found that religion is useful in the desistance process because it offers the opportunity for self-reflection and provides hope for people's future (Said & Davidson 2021).

Religion is integral to desistence because it impacts behavior and aligns people's actions with societal expectations. Desistance includes personal willpower, determination, and social support (Stansfield et al. 2019). Religion formally and informally controls people's behavior by establishing social and moral expectations. Religion allows ex-felons to develop social solidarity and align with the values and expectations of their religious community.

Religiosity helps individuals with impulse control and helps reduce reoffending associated with self-control (Pirutinsky 2014). Furthermore, Brauer et al. (2013) found that compared to nonreligious participants, religious ones had more self-discipline, social support, informal social control, and conservative moral beliefs. An essential part of desistence was attending religious services. One finding showed that religious involvement increased fear of retribution, social bonds, and self-control (Kelly et al. 2015).

There are at least two noticeable missing pieces from existing literature and research. The first is the views of the ex-felons. Most of the current research focuses on attitudes that congregants or the public have about ex-felons. This study provides the perspective and voice of those formerly incarcerated regarding Christianity and criminal rehabilitation.

A second area lacking in the existing research is a clinical sociological perspective on religion and criminal rehabilitation as it relates to stigmatized identities. Clinical sociology seeks to critically analyze and assess beliefs and practices to develop interventions for change and improvement (Fritz 2006). Previous clinical sociological research has not considered religion's contribution and hindrance to rehabilitation and identity repair.

## 1. The Clinical Setting and Research Methodology

I utilized qualitative case study analysis to understand how crime and religion intersect with identity. I received approval from my institution's Internal Review Board and contacted prison ministries to find participants. All the participants signed an informed consent. The criteria for inclusion in the study were having experienced an arrest or conviction, and some exposure to religion during and after release. However, as I interacted with participants, I noticed a theme. All of the people who were interested in participating in the study were currently employed in vocational ministry. Therefore, I adjusted the initial study to explore how these men were clinically rehabilitated through religion and developed new identities.

There were a total of five participants. They all had felony convictions, served multi-year sentences, and are now working in vocational ministry settings. The interviews occurred through Zoom from April 2023 to June 2023. The interviews lasted from 44 minutes to 83 minutes. I used semi-structured interview questions. The interviews were recorded, transcribed, and then deleted. I used qualitative analysis in the transcription to identify themes.

Participant 1 was arrested for violent crimes and drugs. He received his first felony conviction at 17 years old and continued to engage in criminal activity related to drugs and violence. Participant 1 was incarcerated for over 16 years. Participant 1 experienced a challenging childhood. He was raised in a single-parent household with only his mother present. He reports that his life was unstructured, and he grew up with drugs being a normal part of life. He was not raised in a Christian home and seldom went to church.

Participant 2 received a life sentence, of which he served 15 years before being released. Participant 2 attempted to kill someone and was convicted of a murder-for-hire. He describes his childhood as mischievous. His father committed suicide when he was a boy, and his mother raised him. His family were nominal Catholics, and he entered the military between his junior and senior years of high school.

Participant 3 was convicted of the second-degree murder of a two-year-old child. Participant 3 maintains his innocence. He received a 15-year to life sentence and was incarcerated for almost 29 years. He reports that he only received a couple of traffic tickets before his second-degree murder conviction. Both parents raised Participant 3 in an inactive Catholic home. He considered himself an atheist before becoming a Christian, and he served in the military before his conviction.

Participant 4 was convicted of drug charges and other criminal behavior that he engaged in while working with a drug cartel. He received a 22-year sentence and served 19 years in a federal prison. He was raised in a Christian family with both parents present. His religious beliefs rely heavily on the supernatural. While he was not active in church before his conviction, he speaks about supernatural occurrences and experiences he had as a child and throughout his life.

Participant 5 was convicted of sexual assault of a child. Before his conviction, he was a youth pastor, and the child he assaulted was part of his youth ministry. He received a ten-year sentence and served nine and a half years. Participant 5 reports that he did not have any criminal charges before or since this incident. He was raised in a religious home, went to private Christian schools, and started his career in vocational ministry after graduating from college.

There are some differences between the participants in this study compared to typical ex-felons. For example, all the participants in this study are employed in a vocational ministry capacity. Some participants had secular jobs post-release, but they are now ordained or working towards ordination by their faith group.

Another difference is that the participants are entrepreneurial and could build social capital and make significant accomplishments.

Participant 1 reports: "There's nothing out of the ordinary about me that would place me above anyone or anybody else." However, later he reports: "So I was even before becoming a Christian, like I've always had the characteristics and the traits like to stand on my own two feet."

Participant 1 is highly motivated and has always exhibited leadership qualities. He was previously successful in criminal activity and aspired to be the best drug dealer possible. While incarcerated, he also exhibited an ability to develop social capital and leadership qualities among other inmates. After his release, Participant 1 had a job waiting for him in a vocational prison ministry.

Participant 2 was successful in his military career before his conviction. Participant 2 lived in a friend's 7,000-square-foot home when he was paroled. His friend was also a business owner who gave him a job. He was a salesman and ended up working his way up to sales manager, where he oversaw revenues in the millions.

Participant 2 is currently a leader at a ministry and appears to take his leadership and networking skills for granted. An example of this is his advice to inmates seeking employment. He says that ex-felons need to work two jobs if necessary. He advises those searching for a job to cold-call employers and follow up several days later. Many people do not have these skills or know how to conduct this type of interviewing and networking.

When Participant 3 was released, he had a job waiting for him based on a previous connection. He was only initially working 30 hours a week, so his boss contacted others in the industry to get him part-time work. In addition to these two jobs, he also started working odd, physical jobs for people. Networking and word-of-mouth contributed to him receiving additional business and allowed him to support himself.

Participant 4 is extremely entrepreneurial. He utilized his sales and networking skills through his criminal career and business with the cartel. While he displayed a strong work ethic, Participant 4 is also highly motivated. When he could not find ministry employment, he created a ministry, which was an extension of what he was doing while incarcerated.

Participant 5 describes himself as a "super-Type A personality" who does not take no for an answer. After being released from prison, Participant 5 had a job working in commercial real estate. While he knew little about this field, Participant 5 was given the job by a father who previously had a kid in Participant 5's youth ministry. Eventually, Participant 5 felt the need to reenter vocational ministry. His employer continued to pay him his commercial real estate salary, but allowed him to focus on creating a new prison ministry for the next six months. His employer helped him develop a business plan, set up a nonprofit organization, and connected him with investors.

While all five participants achieved a lot, they also experienced a level of privilege that other inmates may not. For example, all participants were white men. Several also commented that they do not look like "a stereotypical criminal". Participant 2 reports that people look at him and think, "'Oh, he doesn't have any tattoos. Oh, he's a white guy like me… Wow. He's just like me.' And the light goes on, and they are like, 'I could serve somebody like that.'" Participant 4 also mentions not having tattoos and expressed an ability to blend in at any business meeting.

Participant 3 acknowledges people's stereotypes about ex-felons by stating, "I don't present as that stereotypical knuckle-dragging, predatory thug when I'm speaking in front of this group, and then all of a sudden, they find out I served 29 years. And they're hit with something that's a total conflict with their beliefs."

The only one who has visible tattoos is Participant 1. While the other participants had limited criminal activity before their conviction, Participant 1 lived a criminal lifestyle. Even though he has tattoos, they are an asset in his current profession. The tattoos are a reminder and provide a bridge between the churches and inmates while showing that he has been in both worlds.

All the participants experienced successful reintegration. However, part of that success is related to their privilege of concealing their criminality and ability to network with others. Racial segregation still prevails in the United States church (Dougherty et al. 2015). So, it is unclear how minority participants would have the same success integrating back into society.

## 1. Criminal Rehabilitation and Religious Redemption

The concept of rehabilitation is essential to criminology because it outlines how an ex-convict reenters society. Evangelical Christianity offers a similar principle to rehabilitation, which is called redemption. From an Evangelical viewpoint, redemption is how someone's past mistakes are corrected. The language people use is essential as it relates to the sociology of knowledge, and people cannot have a sociology of knowledge without a sociology of religion (Berger & Luckman 1967). Both terms cover how past mistakes are dealt with and how people reenter society.

Four of the five participants experienced a religious conversion while incarcerated. Participant 5 was previously a youth pastor, but he still describes his time in incarceration as spiritually formative and significant. All of the participants saw prison in redemptive ways. For example, Participant 1 reports that part of the appeal to religion in prison is belonging. He says, "So, the nature and the atmosphere of prison is like, if you don't belong to someone, then you don't belong to anyone." Participant 4 continues the idea of the redemptive nature of prison by stating, "Prison will either make you bitter or better. I chose not to be bitter."

The first area of redemption and rehabilitation covers redemptive ideas and practices. An essential part of redemption and rehabilitation involves the community. Kewley et al. (2015) argue that redemption is a mutual process that involves at least two parties. For example, the ex-convict does not experience redemption if the religious community refuses it to him. Redemption is not solely the responsibility of the ex-convict, but instead, the religious community and society are equally responsible for the ex-offender's successful reintegration.

The connection with others while incarcerated emerged during the interviews. Participants 1 and 4 both reported a desire to serve the religious needs of their fellow inmates. Participants 2 and 5 discussed how the prison chaplain positively impacted their incarceration. Participant 3 says that being accepted and not criticized when he first converted was a crucial experience. When he asked theological

questions, he received a welcoming response from fellow religious inmates.

In addition to the response by other inmates and prison chaplains, the participants all focused on the importance of being connected to an outside religious community. Participants 1, 2, and 3 became members of churches in the community before being released from prison. Participant 1 describes how this impacted him post-release with the statement about his church, "And it was like when I went there it was like, I wasn't a stranger. Like over the years, they already knew who I was, and that broke down those barriers of awkwardness. And I felt completely welcomed, and I felt loved."

Participant 4 did not have a positive or welcoming experience with congregations or clergy once released. Instead, he experienced skepticism about his religion and qualifications as a minister. However, the religious community still played an instrumental role in his life. Before being incarcerated, Participant 4 had a pastor prophesy over him by stating he would become a minister one day. While Participant 4 did not think much of the experience at the time, he recalled it as part of his biography, and it seemed to solidify his identity and place.

Participant 5 discusses the importance of religious community throughout his interview. He specifically credits his current involvement in a small group at church as a way of connection, accountability, and support. Regarding religious life and connections while incarcerated, he notes:

> *The one thing about the prison church in particular, if you choose to do that, and a lot of people don't. But if you choose to do that, the pretense of you know that I've actually got my life together is obviously gone. Because if your life is together, then why the heck are you sitting in the prison chapel service, you know?*

The religious prison services served as a safe place for the participants to explore Christianity and not be held back by their previous convictions. It offered an opportunity for them to embrace vulnerability and their previous mistakes while also providing hope for the future.

Religious redemptive narratives significantly impact ex-felons because the transformation in identity translates into a change in behaviors (Ellis 2018). Redemption affects how ex-felons interpret their past, understand their current situation, and envision their future. Ex-felons have experienced redemption from their past when they can serve and prevent others from make similar mistakes (Flores & Cossyleon 2016).

One theme that emerged from the study regarding redemptive narratives was the religious education and training they received while incarcerated. All participants received some religious training, and all were involved in ministry while incarcerated. Their training and ministry involvement positively impacted their redemptive narrative and confidence.

Participant 1 earned several theological and ministry degrees, which included over seven years of seminary training and a doctorate. Participant 4 reported having over 20,000 hours in biblical training and received 16 years of religious curriculum and laity training before entering seminary, where he also earned a doctorate.

While Participants 2 and 3 did not earn specific degrees, they underwent rigorous educational programs. Participant 2 reported reading the Bible 10 to 12 hours daily and compared his first four years of prison to a seminary. His church and denomination later ordained him. Participant 3 was enrolled in several religious educational programs, including a Bible institute.

The only one with religious training before their conviction was Participant 5. He graduated with a bachelor's degree in religion and ministry before his criminal arrest, but he also described his incarceration as a time of spiritual growth. Participant 5 compared his spiritual development while incarcerated to when he earned his bachelor's degree in ministry: "My relationship with Lord actually developed during my incarceration much more than it did during the time I was in school, which is interesting."

Redemption is central to Evangelical Christianity, but it is sometimes withheld from ex-criminals. The divide between ideas concerning redemption and redemption being put into practice is seen in one study where 80 percent of respondents believed ex-

felons could receive redemption, but 90 percent thought criminals were too damaged to change (Burton et al. 2020). Redemption is offered, but not freely given. Congregations sometimes struggle with the tension between ideas of redemption and punishment.

Christians can use redemption to serve their own purposes by reserving it for only something they experience. For example, Stacer and Roberts (2018) found that while most religious prison volunteers reported altruistic motives, their responses indicated that a primary reason for volunteering was that it made them feel good. Another study about Christian attitudes concerning the forgiveness of ex-felons discovered that white congregants are less likely to forgive and that black churchgoers were the most empathetic for those labeled as criminals (Jones & Sims 2016). Perhaps one explanation for the willingness of black churches to offer redemption to criminals is that the most significant factor in how people treat ex-felons is if they know someone engaged in criminal activity (Rade et al. 2016). Police disproportionately target the black community, so race and relationships may play a more significant role in ideas of redemption than religion.

## 1. Identity and Symbolic Interactionism

Another vital element of crime and religion is identity. The research primarily focused on stigma and the impact that identity has on behaviors. Stigma is a challenge for ex-felons, and how they conceal and disclose their backgrounds can negatively impact them. The research also focused on how religion provides ex-offenders with a new identity to replace their criminal one.

The concept of identity is rooted in symbolic interactionism because it deals with meaning and is reinforced by social interaction and institutions. Blumer ([1969] 1998) argues that symbolic interactionism focuses on the meaning people attribute to social products as they interact with each other. Therefore, concepts such as identity are not innate, can change over time, and are modified through relationships with others. Therefore, symbolic interactionism is valuable in studying how identity is created, maintained, and restored. There are three primary premises in understanding symbolic

interactionism: humans act based on meaning, the meaning comes from social interaction with others, and the meanings are modified through an interpretation process (*ibid.*).

Ex-felons are frequently stigmatized for their criminal past, but religion offers them a way to reinterpret and establish a new identity. Goffman (1963) famously defines stigma as a discrediting mark that impacts a person's social identity. Stigma is a concept, and stigmatized people frequently engage in stigma management to carefully manage and conceal people's perceptions of them. Denver et al. (2017) discovered that how people are treated reinforces stigma by creating self-stigma.

A theme that emerged from the study was the prominence of the Christian identity for the participants and how it replaced their previous criminal ones. Burke and Stets (2023) argue that the individual and society are interconnected in the concept of identity, and identity is a defining set of meanings that provide people with their roles, membership, social categories, and unique characteristics. All five participants describe their Christian identity as central to who they are as people. While they acknowledged previous mistakes, the participants used their Christian identities to reinterpret past mistakes and used their new identities and previous ones as a framework for serving others.

Foucault ([1975] 1991) argues that society expects people to have a recognizable, fixed identity that falls into a hierarchy. For ex-felons, it is extremely difficult to establish a new identity because the criminal designation stays with them. No matter what they do or accomplish post-prison release, they will forever be reminded of their criminal identity. Identity activation only occurs when others validate it, as the individual spends a significant amount of time carrying out that particular identity's behaviors and activities (Burke & Stets 2023). Once a person is convicted of a crime, it will forever be on their record. A study that focused on the perspectives of parolees found that while they may work hard to develop prosocial networks, they still experience distrust and suspicion from others (Pogrebin et al. 2015). People with a criminal record always have to identify themselves by their criminal identity on job and housing applications.

One meta-analysis study found that successful reentry interventions include reducing stigma and developing interpersonal relationships with others (Rade et al. 2016). Religion provides a second chance for ex-offenders and new interpersonal relationships within the religious community. However, the challenge may be that some ex-offenders do not engage in religious communities after release. Stigma makes it challenging to develop the needed social support because it impacts self-esteem, which then causes people to limit their interactions with others and conceal themselves (LeBel 2012).

Involvement with a religious organization decreases stigma by offering forgiveness of mistakes, reinterpreting biography, and providing social connection. For example, sex offenders involved in religious programming after being released from prison had increased socialization and reduced recidivism (Stanfield et al. 2020). Another study found that involvement with a religious community is crucial for successful reentry (Mowen et al. 2018).

Hlavka et al. (2015) suggest that stigma, shame, and acceptance are primary issues plaguing ex-felons. In addition to navigating stigma from previous criminal behavior, many ex-felons experience stigma from trauma associated pre-, post-, and during their incarceration (Williams et al. 2021). Stigmatization is further experienced by the formerly incarcerated because they may be prohibited from voting and participating in political change (Miller & Spillane 2012). Society expects ex-felons to be rehabilitated after they are released, but the stigma they continue to experience, and the barriers put in place, make it very difficult.

Even when stigmatization is not apparent to society, it is a burden that does not easily leave. Ricciardelli and Mooney (2018) found that ex-offenders can conceal their stigma, but they still feel like they possess an unseen character trait where they worry about being discovered and discredited by society. The internet does not help with stigma because many websites humiliate and violate ex-offenders' privacy, ensuring ex-felons always have an online criminal record (Lageson & Maruna 2018). Ex-felons from a lower socioeconomic background have the extra burden of dealing with

class-based stigma, which can result in a lifetime of internal and self-stigmatization (Loughnan et al. 2014).

The participants echoed the internalization of stigma, and one example is Participant 2's self-disclosure: "And that's one of the internal struggles I struggle with. I don't know if you, as you talked to other formerly incarcerated, but I have this constant weight that I don't belong; that I should still be in prison." Similarly, Participant 3 recalls:

> *I felt inferior to everyone else. Now, I had been taught through my biblical education that, you know, we're all sinners and we're all equals, but I didn't feel it... Despite the fact that no one treated me inferior, I felt it myself. And it's something I still battle with.*

Rituals help ex-offenders change their identity and combat stigma (Snedker 2016). Religion provides rituals that reinforce a religious identity. Even with a new identity brought on by rituals, it is difficult for people to lose their old ones. For example, Goffman (1963) suggests that people who move beyond their stigmatized category are still considered representatives of their previous group by others. So, an ex-felon who begins his religious identity after engaging in criminal behavior may always be viewed as an outsider by the religious community they seek to join.

The second part of identity with religion and crime is reframing and establishing a new identity. How someone views themselves is essential to their identity and reality construction. Berger and Luckman (1967) suggest that subjective meaning translates into objective facts and that identity is socially constructed, changes, and is decided by language. So, if a person always views themself as a criminal, they are likely to continue criminal behavior. Likewise, when someone identifies as a religious person, they are more likely to adhere to the moral guides established by their religion.

A common theme for all the participants is how they interpret their ex-felon identity. When asked about being an ex-felon, Participant 3 reported that it was not defining for him and, "It's almost a weird badge of honor – not to have been imprisoned, but to have been in prison and be doing okay now." Likewise, the other

participants viewed their ex-felon identities as an opportunity, a redemption story, just part of their past, and subordinate to their Christian identity.

While some participants shared stories of discrimination, they used their Christian identity as a coping mechanism. They interpreted their discrimination and sometimes rejection in view of their religious identity. Identity verification is the process where others confirm the person's proposed identity. When a stigmatized identity is verified by society, it limits the person's opportunity to develop a positive new identity by reinforcing negative internalizations (Burke & Stets 2023). The participants sought other forms of identity verification that reinforced their religious identity, like through self-talk or serving others, to confirm their Christian identities.

Mills (1959) connects social problems with how biography and history intersect with social structures. Therefore, successful reentry depends not only on religious affiliation but also on how ex-convicts view themselves and their past. The ability to begin a new identity and use past mistakes as a growth opportunity will enable ex-convicts to overcome many social problems. Ex-offenders can use religion to shed their criminal identity and establish a new religious one (Kewley et al. 2017).

Religion is seminal in offering the formerly incarcerated hope, forgiveness, and purpose. The way religion accomplishes this is through reframing past criminal behavior and creating a new identity. Ex-felons report that they can reframe their past and that colloquial religious sayings like "everything happens for a reason" offered a different way of seeing their history (Teti et al. 2012).

Miller and Vuolo (2018) suggest that people who spend time building a religious identity may not want to jeopardize losing their investment by engaging in criminal acts. In this way, group solidarity can encourage someone who makes a religious decision to continue living a religious lifestyle. Religious conversion gives the offender the benefits of a new identity while encouraging them to conform to the system (Algranti 2018).

Each participant experienced opposition and skepticism concerning their religious conversion. Participant 1 was called a "fake Christian"

even one year after his conversion. Participants 2 and 5 discuss how people confronted their wives about their marriage decisions and dissuaded them from continuing their relationship. Participant 3 is estranged from his adult child. Participant 4's sexuality was called into question when he maintained celibacy. A local newspaper found out about Participant 5's past, so they did a story questioning if he should be allowed to work at a church with adults because he had a previous conviction of sexual assault of a child.

Self-esteem reinforces identity through a person's self-talk. People's self-esteem is impacted by the success level of their expectations. Therefore, even a high level of success can be viewed as a failure if the person has even higher expectations than what they achieve (Burke & Stets 2023). This dynamic helps explain how people can internalize and feel like a failure even when others view their actions as successful. Participant 4 recalls his expectations with the church after being released:

> *I'm going to be accepted in the church, and they're probably going to give me some sort of position, and we're going to launch prison ministry because at that point I'd already launched a prison ministry behind bars... And I know I'm going to be accepted because I paid the price. That wasn't the case. Just the opposite was the case. They wanted me to sit on the pew. They wanted me to prove myself. They wanted to assess me*.

Crime and religion intersect with identity. Society assigns a lifelong, negative identity to those formerly incarcerated. Religion offers a way for ex-felons to reinterpret their identity and reintegrate into society. Those trying to repair and restore a damaged identity encounter discouragement when their experiences do not align with their expectations. If a new identity is not supported, individuals can abandon their efforts and focus on an identity that received previous support (Burke & Stets 2023). Religious organizations, nonprofits, and governmental agencies must find ways to encourage ex-felons to form new identities.

# 1. Sociological Interventions

A clinical sociological approach is needed to help ex-felons achieve successful rehabilitation. Ex-felons who experience a religious conversion while incarcerated can find it hard to maintain their conversion and live a crime-free life. One of the primary reasons for this is that Evangelicals overemphasize the individual's role in religious identity creation. Churches have a prominent function and a responsibility to validate the new convert. This final section will propose two sociological interventions to address the problem of clinical rehabilitation of identity for ex-felons. Therefore, a clinical sociological approach is needed to evaluate the social norms, relationships, structures, and patterns to address current dysfunctions (Rebach 2001).

At the center of criminal rehabilitation is the concept of identity. Previous clinical sociologists have explored the impact of stigma on developing new identities, but the challenge is that sometimes past identities become intertwined with self-identity and behaviors (Robinette & Straus 2002). Changing identities is not a matter of willpower; instead, the transformation relies upon the social institutions and interactions people experience. Clinical sociology allows a transition from individual choice to intersocietal relationships (Fritz 2006).

As discussed in the previous section, symbolic interactionism is well-suited to address identity creation and restoration. One crucial symbolic interactionism element is the role of meanings and social interactions in developing the concept of the self. A clinical sociology approach that utilizes symbolic interactionism frames this problem regarding how people view and interpret their situations and interactions with significant others (Glassner & Freedman 1979).

Evangelical Christianity provides incarcerated people with a framework of hope and meaning. It also helps them establish new relationships with other religious believers. This new relationship within a church is frequently called a "spiritual family." Therefore, the interactions ex-felons have with their "church family" when released can make a significant impact and help them understand their identity, situation, and future.

The first sociological intervention involves churches recognizing and capitalizing on their role in identity reconstruction, resocialization, and meaning-making institutions for ex-felons. I propose that Evangelical churches and organizations do this by not converting those who are incarcerated or formerly incarcerated. Currently, the emphasis for many Evangelicals is conversion, but there is little or no follow-up. Since inmates and ex-felons are highly stigmatized and vulnerable, they should not be converted unless the religious community can make an ongoing and long-term commitment to the ex-felon post-release.

A normative social practice of Evangelical Christianity is to evangelize non-Christians by having them repeat the "Sinner's Prayer." This prayer is a formulaic expression that emphasizes an individual decision through the confession of personal depravity, belief in the substitutionary atonement and deity of Jesus, and commitment to follow Jesus personally. This codified practice of the "Sinner's Prayer" is the first step in creating the Christian identity for many churches. After this decision, the person engages in the symbolic act of baptism, where they reenact the death, burial, and resurrection of Jesus as their public declaration of faith.

Repeating the "Sinner's Prayer" and the subsequent baptism is a facilitative mechanism that encourages social support and identity within the Evangelical community. At the same time, this personal confession and baptism also serve as a limiting mechanism. While it is designed to establish identity and social solidarity, the practice exaggerates personal choice, where the burden of fulfilling the commitment is primarily on the new convert. If the new Christian does not fulfill these expectations, the religious community may not provide the needed interactions to support, encourage, and confirm the new identity.

Evangelicals may not want to limit proselytizing because most see it as a cornerstone of their faith and a divine commandment called the "Great Commission." However, engaging in evangelistic activity with no plan to follow up is irresponsible, harmful, and selfish. The current Evangelistic model pushes the responsibility for

maintaining a religious identity primarily on ex-felons and inmates, who are already at a disadvantage.

Identity verification by others produces within the individual a positive emotional reaction, and the factors that impact the solidifying emotions for identity are the level of commitment, frequency, verification by intimate relationships, and social structures (Burke & Stets 2023). When someone is highly committed to an identity, they will put more weight on how or if others verify it. Similarly, the regularity with which an identity is confirmed or ignored impacts the individual's conversation with themselves.

The relationship of the person verifying the identity impacts the individual – denying an identity from a loved one can have a more damaging effect. Lastly, a person's relationship within a social structure can affect how they feel and reinforce their identity. Burke and Stets (2023) suggest that those at the bottom of social hierarchies may be more negatively impacted and not have other resources to cope with identity rejection.

Resocialization is an essential part of identity formation and restoration. Human life constantly changes as people transition through life, receiving new roles, statuses, and responsibilities (Robinette & Straus 2002). The nature of being released from prison is a transitional status where an individual is struggling with roles, statuses, and responsibilities. Christianity provides a moral framework that builds solidarity and conformity to social norms, laws, and expectations. As Participant 1 notes:

> *Before I became a Christian, I'm the victim, right, and it is me against the state. You know, I didn't take ownership of my offenses and my sins, and I just thought that they were wrong. That, just leave people alone, let them live life however they want to, right. Now, after being a Christian obviously that went the opposite direction – just taking ownership of my sin, repenting, and knowing that all authority is given by God for a specific reason, as laws that he gives to us through these authorities.*

Resocialization is a common clinical sociological intervention (Rebach 2001). It is needed when individuals go through major life transitions, and it allows them to internalize new social norms,

values, and identities. Evangelical churches and organizations can positively contribute to the resocialization of ex-felons, and they need to recognize that identity creation is an ongoing process, not a conversion event.

The last area in identity restoration is meaning-making. People constantly interpret social interactions and assign meaning to objects and the behavior of others (Blumer [1969] 1998). As it relates to identity, this meaning-making process is a collective event. In addition to the intentions and actions of the group and other individuals to the ex-felon, there is also the ex-felon's internalization of themselves that impact identity. Identity is a social occurrence, so the focus needs to be on helping ex-felons reframe their past identities and reinterpret previous mistakes.

People desire to feel important and crave meaningful roles that help them make sense and interpret their lives (Du Bois & Berg 2002). People want to be the hero of their own story and the leading actor in their lives. When they experience a stigmatizing event, they need new ways to reframe their mistakes to maintain or reclaim their hero status. Evangelical Christianity provides a stage where people can be heroes by reinterpreting past events and starting over.

Evangelical Christianity can serve as a facilitating mechanism for transformation and newness. Likewise, it can be a limiting mechanism by focusing on that change and contributing to people feeling stigma for not adapting fast enough. Therefore, a successful rehabilitative approach will emphasize acceptance of the ex-felon in their current situation and allow them to change at a slower pace than what the congregation may expect.

The second sociological intervention is for ex-felons to manage their stigma and expectations. Identity is socially constructed, and it is the responsibility of society and the individual to engage in the process. The way that ex-felons manage their stigma and expectations will impact how they interact and interpret their identity and place in the religious community. Unfortunately, this means that ex-felons should expect that there will be people who reject them despite their good deeds or religious conversion, redefine their ideas about success, and actively address and manage their stigma.

A normative social practice for ex-felons who experience a religious conversion while incarcerated involves making certain assumptions. Ex-felons can speculate that religious redemption gives them a second chance at life, freedom begins once their sentence or community supervision is over, and others will notice and accept them and their transformation. Ex-felons have these three assumptions because they have engaged in codified practices from Evangelicals who have told them that these three things are not only possible, but they should be expected through conversion, belief in the religious doctrine, and living a Christian life.

Evangelicals utilize symbolic practices that impact the expectations of ex-felons. For example, Participant 5 recalls an experience with a pastor at a church who addressed the congregation about this participant's criminal past: "So, they covered it and said, 'You know about this.' And he made this statement, he said, 'The one thing that I urge everybody in this church to remember is the ground is still level at the cross.' And I never forgot those words."

The pastor's words served as a symbol that communicated acceptance and commonality regarding mistakes and the need for forgiveness. While the symbol meant a lot to Participant 5, it practically does not happen, especially with more stigmatized offenses. Later in the interview, this same participant recalls about his criminal past and conviction: "there are certain people that define me by my offense, and there is nothing I can do about that."

The criminal justice system also sets ex-felons up for unrealistic expectations about successful reentry through symbolic practices. For example, when someone finishes their prison sentence, it is commonly said that they have "paid their debt to society". This language implies that the person is starting afresh, and the offense is not held against them anymore. The problem is that a criminal conviction follows the person, and their debt is never canceled.

A facilitative mechanism is stigma management. All the participants navigated stigma management and presentation by being upfront. Participant 2 reports that he experienced churches as welcoming and attributed that to being upfront with them about his criminal past. Similarly, Respondent 5 says:

> *I think a lot of times previously incarcerated people go, man, let you get to know me first. And once you get to know me, the truth about my past, it won't be as hard. I just think it's backwards. I really think it's a backwards approach. I think you're better off with a fast no than a very slow and protracted yes.*

Presenting the stigma can help facilitate support and allow for the ex-felon to frame the narrative and experience. However, it is also a limiting mechanism for ex-felons because it can lead to further discrimination and stigmatization. Congregants without a criminal history enjoy a level of privilege that is not experienced by ex-felons. The average congregant can hide previous and ongoing mistakes and present themselves as faithfully religious. Ex-felons, conversely, must decide to immediately and fully self-disclose past mistakes, knowing that it may impact their current and future relationships.

A facilitative mechanism that the criminal justice system provides those formerly incarcerated is the label of "ex-felon". The intention behind this is to encourage community support and place the criminal offense in the past. However, it also serves as a limiting mechanism. While the language intends to emphasize the "ex," the focus is usually more on the "felon" part of the term, which continues to lead to social exclusion and stigma.

Ex-felons need to adjust their expectations. A person's self-talk and level of expectation will influence how they interpret success and failures (Burke & Stets 2023). While churches need to accept ex-felons and look past their mistakes unconditionally, ex-felons need to do the same for the shortcomings and biases of congregations. Unfortunately, the expectation of ex-felons needs to be that they will experience opposition, skepticism, barriers, and restrictions. Participant 3 notes:

> *There's a reality we live in – folks have parole restrictions. So, if someone's got a sex crime, especially, there are restrictions, and the church has to be prepared for that... The church has to set that up. They have to be prepared for that, and they have to be able to do it in a manner that's not degrading as possible to the individual. But the individual also has to accept that, hey, this is life; you have restrictions. It's not all on the church. It's got to be on the parolee as well. I refuse*

> *to put it all on the church… People getting out of prison have to understand there's going to be restrictions. You've got to be realistic about it.*

Just like Christianity allows ex-felons to reframe their previous mistakes, ex-felons need to use that same reframing when it comes to ideas and expectations about successful reentry. When the ex-felon has high expectations that are not met, their previously damaged identity can resurface.

Despite experiencing success, some of the participants who were incarcerated for an extended time expressed negative self-feelings when they compared themselves to others in their age bracket. This evaluation contributed to negative self-talk and internalized stigma because it is not a fair comparison. These participants' lives were put on hold for sometimes decades due to incarceration, while people their age were building families and careers. While the participants could have been more successful than others incarcerated for a similar time, their self-interaction reinforced negative feelings.

## 1. Limitations, Future Research, and Conclusion

One limitation of this research is the case study method, which only included five participants. The study participants also do not represent the average ex-felon, because they were all white males employed in Christian ministerial positions. Many participants expressed their ability to blend into congregations with their criminal past unnoticed. While this study allowed an in-depth qualitative analysis, another study with a more diverse group of participants who displayed traits that align with common stereotypes of ex-felons could be insightful in highlighting these differences. This second study could also explore how other religions and those not identifying as religious manage stigma and create new identities.

Additional research that will focus on governmental agencies and correctional institutions is needed. This study centered on Evangelical organizations and inmates. While those two groups are vital, uncovering how correctional institutions help and hinder identity rehabilitation could be useful. Some governmental and secular agencies could downplay the importance of religion in

meaning-making, interpreting life, and building identity, so it would be fascinating to see how they handle these issues.

Individuality is a crucial component of Evangelicalism. It manifests through things like a personal faith decision and personal responsibility for moral behavior. While the individual does play a part in the equation, the social responsibility of the religious organization is often overlooked. A sociological perspective is needed regarding conversion and restoring previously damaged identity. By using a clinical sociological approach and highlighting elements of symbolic interactionism, the article provided interventions for Evangelical organizations and ex-felons that will assist in criminal rehabilitation through identity management.

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## About the author

Wesley D. Cohoon is an Assistant Professor of Sociology at Midwestern State University, a Certified Clinical Sociologist, and has a Ph.D. in Sociology. Previously, he earned a professional doctorate, a Doctor of Ministry, which focused on application-oriented research to address organizational problems. He also has two master's degrees – an M.S. in Sociology and a Master of Divinity.

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# Voice Recognition in the Era of Virtual Reality: Disruption of Normative Social Meaning-Making

Grace Khunou
University of South Africa

## Abstract

The teaching and working world has been disrupted by developments known as the Fourth Industrial Revolution. As we grappled with the COVID-19 pandemic, the world saw massive disruptions in how and where we work, teach, learn, and socialize. As moves to continue social interactions via virtual platforms increased as a result of COVID-19 restrictions, we saw disruptions in everyday social meaning-making. This article, via reflections from personal observation and conversations with colleagues, engages with the idea of voice recognition as an important social cue in virtual interactions. The article shows how taken-for-granted social markers of engagement can be rendered useless in a context where the only connector to the people you are interacting with is their voice. The article challenges us to engage with the following questions: What impacts does the move to virtuality have on social engagements that allow us to humanize each other? What can we do to maintain the important social cues important for meaning-making in the context of teaching, counseling, and consultation as we see many of these roles move to the virtual space?

**Keywords:** Voice Recognition, Online Teaching/Meetings, Social Meaning-Making, Virtual Reality

## 1. Introduction

Virtual reality caught many of us by surprise and continues to disrupt normative ways of social meaning-making. Meaning-making happens in our effort to make sense of our environment. This process is undertaken because the world seems to be complex, thus we find ways to classify things, people, animals, plants, and


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biological processes so as to cope with this complexity (Dobbin 2009, Pariyadath, & Kline 2016, Satar 2016). As a social scientist and someone who thrives from social engagement, I have found this new normal a challenge. I started working for a new organization at the beginning of 2021, thus most of my interactions with my new colleagues had been online, until recently. My first move to online teaching and engagement happened when South Africa introduced the lockdown in March 2020. In retrospect, I realize that I had a lot of anxiety about the move to online teaching, which involved recorded lectures and the setting up of and managing of WhatsApp groups. My anxiety was a result of the unknown. I loved face-to-face interactions, and I considered myself good at reading the room and getting my students to engage to address perceived confusion resulting from reading their bodies, their sighs, and facial expressions. The physical context played an important part in how I made meaning not only in my teaching but in my everyday interactions with friends and colleagues.

For example, when meeting a new person, I would use lessons from my earlier interactions to position the person. These lessons included assumptions about their dress style, their make-up or lack of it, how they carried their body, and where they sat in conference/meeting room settings. These are referred to as social cues. In clinical sociology, for example, engagement for mediation in counselling and consultation processes has also been done and built on physical interaction cues. These cues are being eroded in online contexts. In defining clinical sociology, Fritz (2020) builds on the conception of sociological practice, which has a long history in South African sociology, especially during the struggle against Apartheid. Fritz (2020, p. 5) goes on to argue that clinical sociology is one form of sociological practice which is "creative, humanistic, rights-based and interdisciplinary and seeks to improve life situations of individuals and groups in a wide variety of settings". Interaction/ social cues play a fundamental role in how mediation and casework are facilitated. Thus, the move to online engagement has an impact on these settings and calls for creativity for clinical sociologists as suggested by Fritz.

This article provides a reading of online engagements in the higher education context in South Africa. The move to online teaching and virtual working took the world by storm which started during the COVID-19 context and is continuing to influence teaching and work beyond COVID-19. The article is divided into four sections, all informed by personal observations and conversations with colleagues as we try to deal with the changes brought on by remote teaching and working.

## 1. Engaging with the Disruption of Virtuality

The physical contextual space served me well in my efforts to make social meaning of my space and to characterize who I was interacting with via normative identifiers like how they dressed, their smell, facial reactions, and how they carried their body in different spaces. I know that the same identifiers were used for those who encountered me. However, since the COVID-19 pandemic, I have found myself lost – I have been forced to rely largely and at times solely on voice to characterize myself and others. Klaus Schwab (2016) writes about how the current technological revolution is transforming humankind. In this article, I concern myself with the same idea in terms of how, since the COVID-19 pandemic, we are forced to identify with a factor I have known to be significant in the digital space – voice recognition.

My initial interaction with the term *voice recognition* was in the context of software applications for smart technologies. In an article by Ionita (2008), the term voice recognition is referenced in the context of human-computer interactions, not in human-human interactions. According to Scardina (2018: p. 1),

> "voice or speaker recognition is the ability of a machine or program to receive and interpret dictation or to understand and carry outspoken commands... Voice recognition systems enable consumers to interact with technology simply by speaking to it, enabling hands-free requests, reminders, and other simple tasks".

This use of technology has become a feature because of advancements in *"Artificial Intelligence (AI) learning and the subsequent development of*

*intelligent assistants such as Amazon's Alexa, Apple's Siri, and Microsoft's Cortana" (Scardina 2018).*

In August and September 2021, I had the privilege of first-time face-to-face (physical) interaction with a few of my "new" colleagues. I had already met many of these colleagues virtually over the first seven to eight months of 2021; I had briefly seen some of their faces as we tried to humanize our virtual interaction. One of the current etiquettes of online meetings has been to briefly switch on your video to show your face so that the people we are interacting with can at least be introduced to us. I have, however, found that these attempts are a bit futile as the few seconds that one shows their face fails to offer the information one gathers on who one is interacting with when such a meeting is physical. Again, our underdeveloped technological infrastructure in South Africa has also meant that we are unable to effectively use the video feature in most of our online platforms, thus making it hard to match the voices to the faces of our colleagues. Research shows that infrastructure for digital engagement remains a challenge in South Africa because of "insufficient spectrum and inadequate access to favorable low frequency spectrum" (Bhandari 2020: p. 12). As a result of this infrastructure problem, sometimes when videos are turned on, the flow is slowed down, or the connection gets lost.

What I observed in my first face-to-face interactions is something I never thought would be significant in my social interactions – voice recognition. As indicated earlier, I have learned over the years to read the room, the faces of those around me, the multiple shifts of the body, and the multiple expressions in everyday interactions to make social meaning, including to read their individuality presented by how they carried themselves. As social beings, our interactions in the workspace and other social spaces are influenced not only by how we speak and sound, but we also send multiple cues to communicate, including our facial expressions and body language. Having access to these characteristics of face-to-face interaction provides important cues for social interaction and communication practice. The research argues that the ability to read each other's body language facilitates social connection and meaning-making (Dorr-Bremmer 1990,

Hunsinger 2008). These cues are completely lost in a context where voice becomes the only marker of what is being communicated.

Until recently, many of us have never had to meet a lot of people and share daily experiences and personal experiences without multiple markers of who they are in terms of their faces, fashion sense, and other normative markers of physical identity. The virtual work mode is disrupting how we develop individuality, how we share it, and thus our influence on how others read us. I am writing this to illustrate how virtuality is not only disrupting where we work but also how our tendencies for certainty through stereotyping are limited. This stereotyping is achieved by how we read and link certain bodies to certain voices, tones, positions, and behaviors. The virtual reality of work and teaching and learning challenges us to broaden our parameters of communication – so that we do not rely only on physical features to help us in meaning-making. In a brief reflection on how moving to online teaching has impacted social interaction, Professor Peace Kiguwa[1] shares the following thoughts:

> So, for example, in class before COVID, I could read my students' body language and guess when there was a sense of discord or lack of understanding. Or even just who they were (so, I was VERY shocked recently to discover that one of my postgraduate students this year is a Muslim young woman who wore a hijab. I did not pick this up because her video was always off). Maybe it matters in terms of what/how I interact with her and the class, but I think in online engagements, we do work with assumptions in our minds of who the other person is. And so, because I did not have that, I did not engage in a way that I would have face-to-face, even if just by engaging with aspects of her culture to enhance our discussions. Also, what I also noticed as a result, was her silence – something I think had to do with not knowing how to engage with me and the group about some of our conversations on gender and sexuality, especially given that I was unable to bring her into the conversation because I was unable to read that the class might have had diverse students with diverse backgrounds.

1 Professor Peace Kiguwa is Associate Professor in Psychology at the University of the Witwatersrand.

Prof Kiguwa indicated that, because of the virtual space, she lost an important aspect of face-to-face interaction in the classroom which she had previously taken for granted – making meaning via dress. As a result, she was unable to bring one of her students into the discussion. She argued that, as a result, she felt that she lost something important. In the process something was learned, we must reimagine how we teach and interact to make the virtual experience more human and inclusive.

The same has been true for me. I realised that I had to work hard to change my teaching and interaction practice so that it did not rely on these kinds of cues. I had to activate the students and myself to interact with the world differently. for example, telling them before we discuss concepts, that everyone must bring in a real-life example of something happening in the world that speaks to what we are discussing. So, lectures became less theory and more practice oriented. In them, by discussing their examples and objects and their feelings about them, I could get a sense of their politics and positions. Pillay and Agherdien (2021) indicate that, in remote teaching and learning, it is much harder to develop the social connection and social presence that is required for effective pedagogy. In addition, they illustrate that many of the effective social cues usually used to humanize the classroom experience are lost in online engagement.

Physical interactions are usually determined by time and space, which also determines the rules of engagement and, thus, facilitates how one positions oneself. This is with regards to dress code, how to speak, turns in the conversation and acceptable disruptions. According to Dorr-Bremmer (1990: p. 381), "in order to locate and identify the social context at the moment, participants in an interaction seem to take into account the time and place of the scene at hand and especially the actions of others present". In the virtual context, we have had to deal with bringing together in one platform multiple times, spaces and thus a disruption of normative rules around dress code and what are deemed appropriate disruptions. I have sat in online meetings where colleagues would be disrupted by children crying or asking for something from the parent as they just switched on to present or make a point during a meeting. For

example, in Lesego Plank's[2] reflections on her experiences of the merging of the virtual world and her home, she found that she experienced new pressures, including having to remind her Gogo that when she is in her room, she is working and thus should not be constantly disturbed. She shares her experiences thus: "She will enter the room whilst I am teaching, and I would raise my hand to indicate that I am in the middle of a class."

As we have been forced to work together as we sit in our different homes due to lockdown, we have seen the merging of home and work. On the one hand, virtuality and the merging of multiple times and spaces have lifted the veil of perfectly curated work lives characterized by suits, clean-shaven faces, made-up faces, salon-prepared hairstyles and nails. This new reality has led many to reevaluate their lives completely, which has resulted in a more relaxed stance on multiple issues, including long commutes to the office. Recent debates on work have begun to suggest the importance of blended possibilities, where both options are provided. In the teaching and learning space, the question of digital e-learning has challenges, given the inequality in access to e-learning infrastructures in South Africa.

Another major challenge has been accessing electricity, mainly for the already marginalized. South Africa started implementing electricity load reduction processes called load-shedding in late 2007 (Rathi 2022). Periods of load-shedding can take anything from two hours once a day to periods of four hours twice or thrice a day. What is also worth noting is that load-shedding affects areas in the country that are supposed to be the economic hub, that is the Gauteng Province. It is also important to note that even though this is the case, the poorest of the poor are still largely more impacted as it is difficult to organize individual alternatives like solar electricity which has been grown as an alternative for those who can afford it. As I am writing this on the seventh of October 2021, 9:33 pm, my area has just experienced load-shedding. I am using my phone to cast light on my keyboard, and luckily my laptop was charged earlier in

2 Lesego Plank works as a part-time lecturer at the University of Johannesburg and is also a PhD candidate.

the day. This is a luxury that many do not have. I know of colleagues, students, and family members who live in Soweto and have gone for months without electricity.

These experiences with electricity make it hard to see the possibilities that proponents of the Fourth Industrial Revolution (4IR) emphasise; how do I play where the playing field is made unequal by continuing oppressions of the past? On electricity and virtual teaching, Lesego, a PhD candidate who lives in Diepkloof, Soweto, had the following reflections to share"

> My laptop and phone are always on the charger; this is because I experience both load-shedding and load reduction throughout this year as I live in Soweto. I had to buy Magneto rechargeable LED lantern lights because every week our lights are switched off either from 5am until 9am or 5pm until 10pm. I have made it a norm to always charge the lights, because we were spending so much on candles but also with candles it was not as conducive as compared to the electric lights.

Lesego works as a lecturer during the day and does most of her PhD writing work at night. This has not happened as planned, as she is forced to be constantly catching up with work that she would usually do during the day because of electricity access challenges. Even though Marwala (2020) suggests that mastering previous developments from the first three industrial revolutions is not necessary for one to understand the 4IR, he is silent on the main issue which is the fact that challenges with access to electricity impacts the ability to engage fully and effectively in both the use of these new technologies and, most importantly, on the potential to develop context-specific 4IR technologies. As indicated earlier, many experience internet disconnection during load-shedding. Lesego shares the following experience: "Look at the disconnection of internet when there is no Wi-Fi, how in many cases most home modem/router are connected to the electrical socket, then there is disconnection to the social world".

As a result of the country's inability to fully use technologies and tools of the first three industrial revolutions, and especially with the electricity challenge, our potential to develop context-specific

4IR technologies remains limited. Unequal access to electricity is not a new phenomenon (Khunou, 2002); the Eskom, Soweto cost recovery issue is one that has continuities from the past. In a context like Soweto and other townships there is systematic non-payment for electricity and other municipal services dating back to the call to make the apartheid state ungovernable. As a consequence, municipalities put measures in place to recoup costs for use of these services. These measures usually include cutoffs of services. Hlatshwayo (2021) rightly contends that the issue of access to infrastructure is an economic justice question as its potential denies the already marginalized access to economic opportunity, and I would like to assert the power to determine how one is represented and defined. One of my PhD students, who is also a junior lecturer at the University of Johannesburg, has been unable to draft most of the work he had in his plan due to lack of electricity in his area in Soweto. He first experienced load-shedding and then an issue with an exploded community electricity transformer that Eskom refused to replace because Soweto residents are in arrears. This has been going on for over eight months, which is basically most of the year. Electricity issues in Soweto are not a new challenge. In 2002 I engaged in a study that showed how Soweto residents experienced unequal access to electricity and resorted to illegal connections and other equally dangerous access mechanisms to electricity (Khunou 2002).

Another important point raised by Marwala (2020: p. 61) in his discussion of the electricity issue in South Africa is the lack of appropriate skills by municipalities to generate and transmit electricity, including the inadequacies of professional engineers and engineer technologists. The question, then, is: how will we develop appropriate AI technology to address our electricity and other social challenges, when we have been unable to leverage skills of the previous revolutions?

In cases where video engagement is not supported by the infrastructure, it has redefined our fellow colleagues and collaborators as voices behind a dark screen with a name as the only identifier of who we are interacting with. Consequently, making them into voices without the other social cues that go with face-to-face interactions

makes the interaction incomplete. The e-connection infrastructure is also a challenge for ease of use of these technologies. Lesego reflects that she has found herself dealing with new inconveniences; instead of her historical challenges resulting from transport infrastructure challenges, she now has e-connection challenges. She shares her experiences thus:

> But now, over one year and nine months, I have not boarded the Rea Vaya or taxi to campus, I have not walked over the UJ bridge, I have not said, "sorry I am late, I was stuck in traffic", or "the bus got stuck" or "there was a strike". Instead, now it's "sorry, I can't log in because of my poor network connection" or the now classical "sorry I can't hear you properly you might have poor internet coverage".

Our move to virtual teaching, learning, and work has come with what looks like new challenges; however, when one uses the lens Lesego provides in her reflection, underdeveloped infrastructure continues to be our challenge. Hlatshwayo (2021) alerts us to the reality that the South African state has failed to provide access to the infrastructural and technological developments of the first three revolutions and it seems from our experiences thus far that they will continue to fail in this regard. Will Africa ever lead in any of the upcoming socio-economic revolutions? Without the power to define provided by ownership of capital, the answer to this fundamental question is a resounding "no". Are we able to participate fully in this revolution, or has the train already left? Marwala (2020) argues that his intentions as an advocate for the significance of the 4IR are to make sure that we are not left behind. The evidence might be indicating that his call is a few industrial revolutions too late.

## 1. Virtuality and the Centering of Voice Recognition

The physical workspace can be argued to be a context rich with multiple opportunities for meaning-making, which have influenced our understanding of employer-employee relations, productive vs reproductive work, and the formation of formal relations and rewards. These meaning-making processes influence who is promoted, who is ignored, who gets the corner office, and who sits at the back.

However, in the virtual world, reality or realities are influenced by different factors, for example, "virtual reality typically incorporates auditory and video feedback, but may also allow other types of sensory and force feedback through haptic technology" (https://en.wikipedia.org/wiki/Haptic_technology).[3]

As one reads the multiple cues in physical social interactions, one is also able to regulate the interaction. This is particularly important in the context of the classroom and in running administrative and academic meetings. However, in the recent new normal, we are all redefining what it means to be in class and in a meeting. The cues available to regulate are completely absent in the virtual space, especially where the video mode present in the multiple virtual platforms is not effective in the South African context where the online infrastructure is not fully supported. As a result, most of our interactions with students and colleagues are without video mode, thus we are forced to interact with the voice. Even though language is argued to be a significant cue for social meaning-making, I personally have not found it as a central marker for identifying people I know.

Knowing someone I work with or someone I teach has involved multiple modalities including their bodies and their gestures (including how their mouth shifts when they smile, frown, or when they are shocked). I am now grappling with a new reality where voice recognition is becoming a significant identifier for those I have met recently. This is throwing off the stereotypical connections we make for certain bodies with regards to how we think they should sound, for example the assumption that black women are loud. Online engagement, therefore, means that we must work harder to know our colleagues/students. We can no longer rely on easy cues. But, on the other hand, it may also make us lazier. For example, in my engagement with my "new" colleagues[4]. I observed this stereotype

3 According to Wikipedia, haptic technology refers to, "any technology that can create an experience of touch by applying forces, vibrations, or motions to the user". https://en.wikipedia.org/wiki/Haptic_technology

4 I started my current position at the beginning of 2021 and have only recently met most of my colleagues. From the beginning of the year, I have interacted with them virtually – via voice connection mainly.

when I met for the first time a colleague with a strong commding voice – I assumed from her voice that she must be big and intimidating. However, when I met her physically, I reacted to the misalignment between the familiar voice and the "strange" body that carried it. She had to repeat my name before I could acknowledge that I knew the voice. My ability to recognize her voice could not be trusted as my normative recognition of those I know, have never only been from their voice. The misalignment between the voice I recognized and the "strange" body was because she was smaller in stature and had a soft face – these were at odds with my assumptions of what type of body and face should carry a voice like hers.

On recognizing that an unintimidating body carried the big voice, I realized how social face-to-face cues might easily lead to stereotypes that might be completely off in terms of the intentions of the individual. I had to contend with the question of how I might have been stereotyping those I have interacted with because their bodies suggested weakness or because their voices suggested strength. The virtual realities we find ourselves in are an opportunity to reevaluate old ways of doing and relating.

From the beginning of August 2021, I met a few colleagues in the corridor and would greet them, and then the colleagues would laugh and shift their energy at recognizing my voice. I felt the same with a few colleagues who, when they started speaking, would be shocked as I recognize their voice. My shock was a result of the fact that I had built a very different sense of who they were from our online engagement; some voices were sweet and soothing, others rough and unimpressive. In my reflection on these shifts, I realize how the online space might be useful in reducing the normative characterization of who we like and who we hold prejudices against. This article seeks to engage with how the virtual workspace is centering new ways of identifying with each other and how those have the potential to shift normative prejudices that influence how we interact and who we interact with.

It is important to note that, where multiple physical markers of meaning-making are removed in the virtual space, one still uses the same assumptions to typecast those we interact with. This is

because one of the reasons we are stereotyping in our engagement with others is a result of our need to simplify what we consider to be a complex social world (Pariyadath & Kline 2016). As critical race and gender scholars, we have recognized how this move to simplify often creates challenges for the marginalized. These challenges emerge due to stereotyping and discrimination, often made possible by our need to use old assumptions to typecast individuals we might be meeting for the first time.

## 1. Absent Bodies, Multiple Times and Spaces: Re-imagining Normative Social Cues

Moving to the virtual space has meant that there are significant changes in how we interact, which influences the diversity of cues present in physical interactions. Thus, meaning-making is shifted from the multimodal cues present in physical interactions. Research shows that, in online communication, all semiotic resources "are integrated in unprecedented ways, enacting new interactional patterns and new systems of interpretation among web users" (Sindoni 2013: p. 2). Therefore, it can be argued that face-to-face communication theories may not always be sufficient or appropriate when interpreting online multimodal communication (Satar 2016). In my personal observation, I tend to agree with the views shared by Satar (2016) that virtual engagement removes multiple cues usually present in face-to-face communication. These cues include non-verbal communication, body gestures, and emotional expressions, among others (Swartz 2000). These cues make for rich data for meaning-making. In their absence, what are we left with to make meaning of our social interaction?

My earlier reflections suggest that we can use our old understandings, or we can use new conceptions – that is if we allow ourselves to reflect on the possibilities provided by the new online world. A challenge for communication has been opened. In further reflections, Prof Kiguwa asks, "Do I need to see you to know you?"

This is an important question, as it relates to how those without visual impairment assume that seeing is believing. However, the

vision is not the most important marker of interaction for many individuals. Prof Kiguwa further observes:

> My visually-impaired student said to me the other day: "Now, you will all have to work with imagination the same way I always have!" And I realise that all this time, she has worked with voice recognition to make sense of her world. But her idea of working with imagination is a good one. We will have to imagine differently the other person sharing our screen.

This reflection suggests that it is important to integrate multiple ways of knowing. Is this providing an opportunity to do away with social cues linked to discrimination? Is it possible that, when online, we engage with more compassion towards our coworkers than we do when in face-to-face interactions? Or is it possible that we call on the same cues used to discriminate in face-to-face interactions? However, discourses of virtuality state that, our already existing interaction modalities facilitate the possibilities presented by the virtual world. I refuse the notion that there are no possibilities for justice work to use these tools to reimagine existing inequalities. Pillay and Agherdein (2021) suggest that justice in teaching and learning in the context of e-learning will require more cooperation to ensure various methods are used to encourage participation and connection with colleagues and students.

## 1. Presence in Absence: Virtuality and Dis/engagement

Literature on communication technologies and virtuality illustrates the importance of understanding conceptions of presence in absence. Communication technologies, including print media, cellphones, and most recently smartphones, computers and their myriad communication applications like WhatsApp, Zoom, Teams, WeChat, and others, should be considered "as powerful contributors to absent presence" as they allow people to communicate at a distance (Gergen 2002). The idea of presence/absence is one we can draw from in thinking about meaning-making in online engagements. In a newspaper article I penned for the Sunday Independent titled "Fourth industrial revolution: possibilities for thinking of simultaneous father absence and presence" (Khunou 2018), I make the argument

that virtuality has the potential to bridge the divide between physical absence with its ability to provide virtual presence in the case of migrant parenthood and non-residential parenting. Can similar ideas be used to make the e-class room more present?

The absence of physical bodies in virtual meetings and lecture halls has resulted in a new dilemma. Are the historical controls for making sure the students write their exam without assistance possible? During private meetings, how do you know uninvited guests are not sitting in, listening in where they should not be? These are significant ethical questions for virtual engagement. How do you determine that an issue on the agenda is fully engaged during online meetings? I have observed loud silences in my first online classes. I could not see the students, or determine that I had their full attention. My questions would go unanswered, and my usually effective prompts for engagement with concepts I teach seemed to have lost their power to inspire conversation. I was also unable to feel the room to gauge if there was confusion, irritation, and a need to change tack and/or pause. I found the same silences to be true during virtual staff meetings, senate meetings, and other committee meetings – it seemed like nobody was present or that the speaker had been relegated to a monologic speaker. Gergen (2002: p. 229) argues that, with monologic communication technologies like radio, television, and films, the audience can easily switch off or relegate the message to background noise. Is it possible that the silences experienced during these online meetings and classes mean that the audience is logged on but disengaged?

Even though I could see who had logged into the meeting or lecture hall, I was unable to determine who was present. I realized that in the virtual, digital world, we must contend with a new phenomenon of absence in presence. Gergen (2002: 227), in his engagement with the absence in presence created by communication devices, argues that "increasingly these domains of ulterior meaning insinuate themselves into the world of full presence – that world in which one is otherwise absorbed and constituted by the immediacy of concrete, face-to-face relationships". In the context of virtual teaching and learning and virtual work, space has been opened to

make presence absent. This absence-in-presence dilemma is a result of these technologies' ability to blur boundaries (Kraemer-Mbula & Mazibuko-Makena 2021) through the merging of multiple times and spaces into what historically was the home, workspace, or lecture space. In such a boundaryless context, is it possible to be concretely present in all three spaces at the same time? How do we then define "now"? In this context, one's attention is simultaneously pulled into multiple domains – thus rendering it as non-existent.

## 1. Conclusion

COVID-19, and the rapid move to virtual work engagement that it facilitated for South Africa and many parts of the world, has multiple implications for where and when we work. It has forced us to identify characterizations far removed from the historical norm where one was represented by more than their voice. Social meaning-making about who individuals are is now being forced to be made without the multitude of information present in physical social settings. This article illustrated the signifying of voice recognition because work is now identified with a virtual space rather than the norm in physical workspaces. This article is important for clinical sociologists who have moved the bulk of their work with individuals and communities online. It will help them think about what they might be missing and, thus, how to make the interactions more human.

We are left with the following questions: does virtual interactions provide the possibilities for social justice and the reduction of prejudice? With AI capabilities growing , virtual meaning-making will continue to morph in ways that will influence social interactions in unprecedented ways. For clinical sociologists, this article offers a starting point for other research into how online engagement, like counselling and mediation consultations, are impacted by these shifts and how those might be perpetuating already-existing exclusions and how they can be resolved.

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## About the author

Grace Khunou is a professor and currently Director of Scholarship Change in the Department of Leadership and Transformation, Unisa. She engages in research with a focus on the Black condition. She writes creatively and academically and has published numerous articles and book chapters in national and international publications. Her Google Scholar citation index is currently 15 with over 700 citations. She has supervised over 40 research students and was awarded the 2020 UJ Humanities Post-graduate Teacher Award. **Orcid ID**:000-0001-9164-8379

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# Clinical Sociologists as Guardians *ad Litem*

Yvonne Vissing
Salem State University

Eric Knudsen
Salem State University

## Abstract

This article posits that clinical sociologists have ideal expertise to serve courts as guardians *ad litem*. It explains what these court-appointed representatives provide the court, their qualifications, and how they can advocate for the best interests of children in divorce, custody, shared-time, and other caregiving situations. Often, decisions are made by judges with an adult-focused legal lens. Clinical sociologists have a background in both macro and micro issues that impact the wellbeing of children. They are able to contribute and integrate their scholarly and practical knowledge to make better informed decisions that the court can use. Common challenges that guardians *ad litem* face are identified, with insights on how clinical sociological expertise can overcome them.

**Keywords:** guardian *ad litem*, GAL, clinical sociology, courts, best interest of the child, child rights

## 1. Introduction

A guardian *ad litem* (GAL) can play an important role in the safeguarding of children in court proceedings by providing the court with objective information that the court can use, directly impacting the living arrangements and future wellbeing of children. Guardians *ad litem* vary in qualifications and background. Many are lawyers and, while their legal background is certainly valuable, they may not have expertise in child development or family dynamics that may allow them to make recommendations that are in the best interest of the child. This article affirms that clinical sociologists have skills and knowledge that make them valuable assets to the court when they


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are in positions as guardians *ad litem*. This article explains what GALs are and why clinical sociologists have superior skills that allow them to make effective recommendations to the court. It also identifies common challenges that GALs confront and why their expertise as clinical sociologists can help them to overcome them.

## 2. Definition of Guardian *ad Litem*

A GAL is an attorney or specially trained professional who is temporarily appointed by civil, juvenile, and family courts to advocate for the "best interests" of vulnerable populations. These populations include children, adults with intellectual disabilities, people who experience physical or emotional disabilities, or older people who are in need of assistance (Aneiros & Prenkert 2022; Boumil et al. 2011; Federle & Gadomski 2011; Fraser 1977; Legal Information Institute 2022; Whitcomb 1988). In the United States (US), GALs are appointed in cases involving child abuse and neglect (Child Welfare Information Gateway 2021a) and are central to custody disputes in family and juvenile courts (Boumil et al. 2011). GAL designation is not to be mistaken for legal guardianship, which grants one person the power to make medical, financial, and care decisions on behalf of someone else (Crowe 2018). At its core, a GAL is an investigator with an "independent voice" (Boumil et al. 2011; Whitcomb 1988, p. 1).

Confusion about the GAL role persists because there is no internationally agreed-upon definition, and GAL duties and qualifications vary by state (Bilson & White 2005; Crowe 2018). In the US, GALs are conflated with a similar role known as a court-appointed special advocate (CASA). While both GALs and CASAs are tasked with advocating for the best interest of the child, there are some key differences (Child Welfare Information Gateway 2021a; Crusco 2008; Orozco 2019). A GAL is a paid attorney, works on a variety of family law cases, and may have up to 30 cases at a time. A CASA is typically a part-time volunteer with legal training, works on one to two cases at a time, and typically serves on cases involving abuse and neglect. While it is technically possible for a child to have both a GAL and CASA, this is not common (Connecticut CASA 2023). GAL and CASA requirements and appointments vary based on US

jurisdiction. Some states permit a CASA to stand in for a GAL, using the two titles interchangeably (State of Maine Judicial Branch 2023).

GALs and CASAs are primarily funded by state and federal budgets. CASA programs also receive donations, and in divorce proceedings that involve child custody disputes, one or both parents may be ordered to pay for the GAL's services (McDuffey 2023). The CASA program is authorized by the Violence Against Women Act (VAWA) to receive approximately $12 million in federal funding each year and is administered through the Office of Juvenile Justice and Delinquency Prevention (OJJDP), a division of the US Department of Justice (National CASA/GAL Association for Children 2023f). States also receive federal funding for their CASA/GAL programs through the Crime Victims Fund, established by the 1984 Victims of Crime ACT (VOCA) (National CASA/GAL Association for Children 2023e). In 2020, the Crime Victims Fund, which consists of fines from federal crimes and forfeitures, dispersed more than $83 million to 500 state and local CASA/GAL programs (National CASA/GAL Association for Children 2023e).

A GAL is distinct from an acting attorney and is not "bound by the child's directives or objectives" (Dane & Rosen 2016, p.13). Crowe (2018) clarifies the different attorney roles on behalf of the American Bar Association:

> *Attorneys, whether they are personally obtained or court appointed, are there to zealously advocate for their clients' wishes, whatever those wishes may be. The attorney's view of the situation does not matter; they are there to represent their client. This differentiates an attorney from a guardian* ad litem*. A guardian* ad litem *is there to represent the respondent's best interests. The "best interests" standard is a subjective one, based more on what the respondent may need than what they may want.*

All 50 States and the District of Columbia appoint legal representation to children in cases of abuse and neglect, and approximately 41 states appoint a GAL to represent the child's best interests. In 16 of these states, the GAL must be an attorney. Eight states require a child to have both an attorney and a GAL. In other states, volunteers who are not attorneys, such as CASAs, may serve as a GAL (Child

Welfare Information Gateway 2021b). Other GALs may be trained as professional social workers, psychologists, clinicians, or those with high-level child development expertise. There are 939 state GAL and CASA organizations in 49 states, comprised of nearly 98,000 volunteers who serve 242,000 children annually (National CASA/GAL 2023b). North Dakota is the only state without a CASA program (National CASA/GAL 2023d).

Internationally, articles 3 and 12 of the Convention on the Rights of the Child (CRC), an international human rights treaty adopted by the UN in 1989 and since ratified by all of the 196 United Nations member countries with the sole exception of the United States, require nations to protect the "best interests" of the child and to ensure that the child's views are heard in public law cases (Office of the High Commissioner for Human Rights 2023a, 2023b). Although the CRC does not explicitly state the appointment of a GAL, member nations have developed various ways to advocate for children in both public and private law (Bilson & White 2005). For example, in the Netherlands the GAL plays a significant role in custody disputes and is a "behavioural expert with expertise in child abduction cases and cross-border arrangements" (Leuftink 2020). In the United Kingdom (UK), a GAL is known as a Children's Guardian and represents the rights of a child in addition to their best interest, and is tasked with appointing their solicitor (lawyer) (Cafcass 2017).

## *Duties of a Guardian ad Litem*

A guardian *ad litem* is broadly described as the "eyes of the court" (Crowe 2018) and is principally an investigator who first collects and consolidates information on the case from people close to the child and family – including parents and therapists – and then drafts a report for the court (Boumil et al. 2011). The report is supposed to be objective and based on the research findings the GAL obtains. GALs generally have immunity from lawsuits alleging they have failed to protect children if they are acting within the scope of their duties. However, GALs may risk losing that immunity if they become active litigants, for example if they sue child protection workers (American Bar Association 1998).

Forty-two states plus the District of Columbia (DC) list specific GAL duties (Children Welfare Information Gateway 2021b, p. 4) which include:

- meeting face-to-face with the child on a regular basis, including before all hearings;
- conducting an independent investigation of the circumstances of the case;
- attending all hearings related to the case;
- monitoring cases to ensure that court orders for services have been fulfilled;
- submitting written reports to the court; and
- making recommendations to the court about specific actions that would serve the best interests of the child.

Crowe (2018) reviewed GAL statutory duties of all states and listed the most common additional responsibilities:

- advising the respondent of their rights (four states);
- interviewing the respondent prior to the hearing (12 states);
- informing the respondent orally or in writing of the contents of the petition for guardianship (seven states);
- recommending whether the respondent should be represented by legal counsel in the proceeding (four states);
- eliciting the respondent's position concerning the proceedings and the proposed guardian (three states);
- inquiring of such person's physician, psychologist, care provider (three states); and
- interviewing prospective guardian by telephone or in person (four states).

Twenty-nine states and DC require the GAL to report the child's wishes to the court, while in 16 states and Washington DC, a separate counsel may be appointed to represent the child's wishes (Children Welfare Information Gateway 2021b). In states where a CASA is appointed in addition to a GAL (p. 5), duties typically include:

- investigating the case to provide independent, factual information to the court;
- monitoring the case to ensure compliance with court orders;
- determining whether appropriate services are being offered to the child and family; and
- preparing regular written reports for the court and parties to the case.

The best-interest advocacy model developed by National CASA/GAL (2023c) incorporates the following five tasks:

- learning all about the child, their family and life;
- engaging with the child during regular visits;
- making recommendations for the child's best interests, including their placement, and necessary services;
- collaborating with others to ensure that the child is provided with necessary services; and
- reporting observations and other information to the court.

At least five states – Idaho, New Mexico, South Carolina, Alabama, and Delaware – blur the line between acting attorney and guardian *ad litem* by assigning both roles to one person, which has the potential of posing an ethical dilemma (Crowe 2018). Most courts, however, do not permit the dual role. For example, a New Jersey appellate panel held that a GAL could not also function as a mediator on the same case, and could not both represent the best interests of the child and mediate finances (Crowe 2018). In an article by Boumil et al. (2011), authors identify conflicts of interest that can arise when the court appoints a dual child's attorney and GAL to represent both the child's wishes and child's best interests. For example, a child's attorney has client privilege, whereas a GAL does not, and anything shared with a GAL could be presented to the court. The authors recommend ethical considerations such as informing the child that their conversations are not confidential. This is important because children could present information that could put them at risk of parental rage when divulged.

Similar findings are reflected in children's reports of their experiences with GAL services. In a qualitative study of interviews with 47 children between the ages of 7 and 16 from counties to the north and south of London, United Kingdom, Ruegger (2021) found that children were dissatisfied that the guardian would share private information, such as how they felt about their biological parents, and were unhappy about the court not being able to influence their choice of placements. They were also disappointed with gradual loss of contact with family members. The authors suggest that GALs could do a better job at explaining the rationale to children, or including their voice in the decisions. Overall, the children were very satisfied with the service, and perceived the GAL's responsibility was to listen to them and explain court proceedings.

Advocacy groups have sought to expand the GAL role and apply the concept to other legal circumstances and environments. The American Academy of Pediatrics (2000) recommended that a medical GAL be appointed in cases of suspected child abuse when Life Saving Medical Treatment (LSMT) is in question, due to two conflicts of interest. Caregivers suspected of child abuse may want to forgo LSMT to avoid charges of manslaughter or homicide; and prosecutors may choose to forgo LSMT to support the same charges. The Academy asserted that "the primary consideration in forgoing LSMT ought to be the best interest of the child, after carefully weighing the benefits and burdens of continued treatment" (p. 1151). In a radical departure from the traditional GAL role, Aneiros & Prenkert (2022) propose a model for a corporate GAL to "ensure that the best interests of children are considered in the development of corporate strategy and decision-making" (p. 2).

## *History of Guardian ad Litem*

The concept of guardianship in the United States is historically rooted in the protection of wealth and the English common law doctrine of *parens patriae*, or the idea that monarchs and the state are obligated to protect vulnerable people (Whitcomb 1998). Federle & Gadomski (2011) trace Western concepts of guardianship to medieval England courts, modeled on Roman law, that appointed a curator *ad*

*litem* to litigate only on behalf of children who inherited property. Children without land did not have legal protection, and poor laws from sixteenth century England permitted the courts to assume guardianship of orphans and place them in apprenticeships. This two-tiered system of guardianship persisted in American colonies, where poverty was inexplicably linked with neglect and court intervention. Although the concept of parental rights was established in the early 1800s, entitling parents to "the services and labor of their children" (p. 343), courts could remove children from their homes and place them in the care of another "when the parent was deemed neglectful, incompetent or had failed to provide for the child" (p. 346). The doctrine of "parental absolutism" or near-limitless parental control over children, began to erode in the early twentieth century (Fraser 1977, p. 26). Ray (2021, p. 6) explains how the notion of the "best interest" of the child evolved out of custody disputes:

> First, children were considered property; therefore, custody favored fathers, as women could not own property. This view then shifted to the since-abolished "tender years doctrine" in the early 1800s, which preferred maternal custody if the child was young. Finally, the courts arrived at a more gender neutral, child-centered approach in the mid-1800s, known as the best interest of the child doctrine.

In 1912, Rule 70 of the Federal Equity Rules permitted legal guardians to sue on the behalf of children and people deemed incompetent, and to appoint a GAL if none existed (Aneiros & Prenkert 2022). This provision was then included in the 1938 Federal Rules of Civil Procedure (Aneiros & Prenkert 2022; Legal Dictionary 2015; United States Courts 2022). However, guardians were not routinely appointed to represent the best interests of the child, and by mid-century, the "unfettered discretion and inevitable fallibility" of judges was questioned, as was the lack of due process (Federle & Gadomski 2011, p. 347).

The 1970s presented significant legal shifts in the evolution of the GAL from an adversarial role to that of an advocate today (Fraser 1977; Whitcomb 1988). The "best interest of the child standard" (Dane & Rosen 2016) was proposed in the Uniform Marriage and Divorce

Act (UMDA), also known as the Model Marriage and Divorce Act, a 1970 statute created by the National Conference of Commissioners on Uniform State Laws to define marriage and divorce (Uniform Law Commission 2023). Ray (2021, p.6) explains how the UMDA determined the best interest of the child:

> The court analyzes a custody decision based on: the desires of parents, the wishes of the child, the child's interactions with each parent and other related parties, the concerns related to the child's home or school environment, and the mental and physical well-being of all involved parties.

Although it was only adopted by six states (Uniform Law Commission 2023), the UMDA is remarkable because it introduced the no-fault divorce and the equitable division of assets, two concepts that forever changed divorce proceedings around the country (Levy, 1991). In 1963, Colorado became the first state to mandate a guardian *ad litem* in child abuse cases (Fraser 1977), and in 1967 the Supreme Court ruled in *re Gault* that children require legal representation in juvenile delinquency cases (Aneiros & Prenkert 2022). In 1974, the federal Child Abuse Prevention and Treatment Act (CAPTA), signed into law by President Nixon, provided funding to states with the purpose of identifying and preventing child abuse and neglect (Whitcomb 1988). The legislation required states to appoint GALs as a condition of receiving funds. Section 4(b)(g) of Public Law 93-74 (1974) decrees "…in every case involving an abused or neglected child which results in a judicial proceeding a Guardian ad litem shall be appointed to represent the child in such proceedings." CAPTA did not specify standards or qualifications of the GAL, however, and due to economic cost of hiring lawyers, and lack of additional funding from CAPTA, states decided to employ volunteers or people without legal experience in the position (Davidson 1981). In 1977, Seattle juvenile court judge David W Soukup established the first CASA/GAL program of trained volunteers (National CASA/GAL 2023a), after which the program gained national endorsement.

## *Qualifications of a Guardian ad Litem*

In 1980, the National Legal Resource Center for Child Advocacy and Protection sponsored the first national policy conference on GALs that included "over 20 experts in a variety of fields related to child welfare, including judges, attorneys, social workers, academicians, researchers, GAL program directors, and child advocates" (Davidson 1981, p. 21). The group reached consensus on the following GAL qualifications (p. 23):

- The child's appointed representative should always be a separate person from the individual representing the state, county, agency, or parent (or be appointed to represent the child's interests exclusively).
- If the GAL is not a lawyer, he or she must have access to an attorney or independent legal resource.
- The child's independent representative should have the benefit of specialized training. Every GAL and GAL program or system should have multidisciplinary support, both for training and ongoing technical assistance.
- GALs should not be appointed by the court before their roles and responsibilities are defined for them.

Despite these recommendations, today GAL qualifications vary across states. According to the Child Welfare Information Gateway (2021b), 46 states and DC address training or qualifications for people who represent children in child abuse and neglect cases. Sixteen states require the GAL to be an attorney, and 14 states require that attorney GALs receive specific training. Approximately 37 states allow a CASA to be appointed to a court case, and 16 states permit the CASA to serve as the GAL. CASAs are required to have 30 hours of training before serving in their position, and 12 hours of continuing education annually (National CASA/GAL 2023c). Perhaps the greatest qualifications for GAL service – time, experience, and passion for advocacy – are the least official. In a qualitative study of GAL motivation, Cooley et al. (2019) found that life transitions such as retirement was the greatest factor for GALs to enter the

field, followed by an interest in advocacy for children and families, personal fulfillment, and personal experiences with abuse or neglect.

## 3. Clinical Sociologists as Guardians ad Litem

Clinical sociology provides a useful framework for professionals to use when they serve as guardians *ad litem*. What are clinical sociologists? Clinical sociology "is a creative, humanistic, rights-based, and multidisciplinary specialization that seeks to improve life situations for individuals and groups in a wide variety of settings" (Fritz 2020, p. 4), that can include courts. As sociologists, they are trained in macro, meso, and micro issues, all of which directly and indirectly impact the lives of children and families. Clinical sociology's integrative framework and approaches are used by scholars, policymakers, and courts to address problems in many different situations, including family, school, and community. Clinical sociologists benefit from training that allows them to have extensive knowledge about issues including housing, health, education, economic, social, and psychological factors. They can bring to the court clinical analysis which allows for the critical assessment of beliefs, policies, or practices with an interest in improving a situation. Intervention is based on continuing analysis; it is the creation of new systems as well as the change of existing systems (Fritz 2020, p. 4) and includes an emphasis on prevention. A clinical sociological approach allows professionals to assess situations and prevent, reduce, or solve problems through a combination of analysis and intervention. Many clinical sociologists provide direct therapy with individuals and families. They are also familiar with social systems and resources and can make recommendations for actions that can serve children's best interests. These are valuable skills that they can bring to courts as they serve in a guardian *ad litem* role.

Most clinical sociologists are not attorneys. While many may be knowledgeable in law and court proceedings, they may lack detailed knowledge about specific cases and particular protocols that lawyers naturally have because of their training. This may make it difficult for clinical sociologist GALs to trump what a lawyer may say or demand. In the education and power hierarchy, while PhD clinical

sociologists may have more education than lawyers, in a court of law attorneys may wield power that clinical sociologists do not. There are also ethical boundaries that may occur while allowing the GAL to do their job. For instance, if an attorney demands to sit in on interviews with their parent-client, it influences what is divulged, but it is challenging to tell the attorney that they cannot be present. But when an attorney demands to observe the interview with the children, this is inappropriate because the child will likely feel vulnerable to divulge their actual feelings or experiences. This is an example of an area where the clinical sociologist must rely upon the power of their profession to ensure that good data will be collected, while safeguarding the rights of children, whose rights may not always be the attorney's priority.

## *Children as Human Rights Holders*

Courts have historically advocated for parent and adult needs and rights over those of children. But courts are used to address situations of child abuse, child maltreatment, and decisions over where a child should live, who they should have contact with, and other sensitive issues pertaining to their wellbeing. Children's human rights is an area of study that fits perfectly into a clinical sociological framework (Gran 2020; Vissing 2023). Child rights as a field concerns global, national, community, and family levels of both policy and intervention. The UN Convention on the Rights of the Child focuses on issues of provision, protection, and participation (Office of the High Commissioner of Human Rights 1989). A clinical sociological perspective views children's lives as dynamic; its open-systems approach sees complex systems as interrelated. For instance, children's lives are simultaneously impacted by the operation of economic, education, health, transportation, recreation, religious, gender, racial, and political institutions. A change in one influences the other. A child rights perspective recognizes young people as human beings with agency who both act and are impacted here-and-now, as well as human becomings whose future life trajectories are shaped by the opportunities and challenges afforded them when they are young (James & Prout 1997).

## *Benefits of Clinical Sociologists as GALs*

As a guardian *ad litem* for over 25 years, I have found that my background in clinical sociology has made me an effective guardian *ad litem*. Sociology provides theoretical frameworks to help us to conceptualize why things are the way things are. Conflict theory is of enormous value in examining court decisions and the influence of power, politics, and agenda-staking inherent in the court process. Symbolic interaction theories are essential for GALs for they impact our understanding about the complex dynamics that occur within families. Families and courts are full of expectations about how people are "supposed" to behave; norms, values, culture, and traditions all impact what people do and how their actions are perceived.

The sociological emphasis on research methodology, data collection, and analysis of findings all influence what clinical sociologists may do in their GAL role. It is important to collect unbiased data so the court can make good decisions. Our recommendations to the court can only be as good as the data we collect. In a typical custody case, this requires reports from teachers, counselors, medical practitioners, as well as interviews with each parent and the child or children. I always try to meet with people individually, with no outsiders to influence them. This is especially important when dealing with sibling sets, since one sibling may influence what another may say or refuse to divulge. Usually, parents will want GALs to interview their relatives, friends, or neighbors, but a clinical sociologist must be careful since they are selected because they likely are perceived to be advocates for a particular perspective.

Report writing is critical because the court needs to have all information documented about both the methodology used and the relevance of the findings. Sometimes I use written surveys that I can attach as documentation of what I learned. Other times, that kind of submission is difficult to secure. Because of the conflictual nature of court hearings, some people will be hesitant to divulge all that they think or know. This is especially the case when it pertains to child testimony. In most cases, children are not present at court hearings, nor do they have private conversation with a judge in chambers. If

a child does speak at a hearing, they could be questioned by both attorneys and this poses a very stressful situation for the child.

Synthesis of data is essential, since before a report can be written there are multiple sources of qualitative, and sometimes quantitative, data to make sense of. The court wants the bottom line view of the GAL, whose job is to make sense out of multiple types of information or data. Cases that arrive at the court in which a GAL is needed indicate that there is disharmony and issues that are beyond the capability of parents and their attorneys to resolve. Parent or lawyer anger, hostility, and conflict are overtly and covertly a part of many court proceedings in which GALs may be appointed. GALs become the eyes and ears of the court and can bring forward insights for judges to consider that would otherwise be unavailable to them.

Objectivity and rational decision-making that is focused on securing the best interests of the child are often very hard to find in hotly contested court proceedings such as child custody. Use of good communication to help ascertain what is going on behind the scenes in the family is a gift that clinical sociologists can bring to the court process. Because clinical sociologists have been taught to utilize both macro and micro data, they are able to develop recommendations and advocate for solutions that could save the situation that children may find themselves in. Clinical sociologists don't just figure out what is going on – they use that information to identify best practices for what to do in order to move forward. Table 1 showcases key skills that clinical sociologists bring to the court when they serve as guardians *ad litem*. The skills include research and analytical expertise, good communication skills, therapeutic expertise, and the ability to synthesize a multiplicity of factors into a coherent, cogent problem-solving recommendation that serves to advocate for the best interest of the child.

**Table 1**: GAL Clinical Sociologist Skills

| |
|---|
| Good methodology background |
| Assessment and research skills |
| Understanding underlying theoretical frameworks |
| Analytical skills |
| Objectivity |
| Listening skills |
| Good communication skills |
| Familiarity with the law |
| Knowledge of the psycho-social world |
| Knowledge of child development |
| Understanding of family dynamics and family systems |
| Knowledge of gender and power roles |
| Understanding of culture, norms, values, and traditions |
| Analysis of social systems and resources available for support |
| Advocacy and problem-solving skills |
| Knowledge of the community resources |
| Best interests of the child focus |
| Therapeutic identification of the etiology of the problem |
| Ability to recommend appropriate strategies for child safety and wellbeing |
| Advocate for short- and long-term solutions for best interest of the child |
| Ability to recommend appropriate strategies for family interventions |

## 4. Methodology

Data for this article was collected in a triangulated methodology (Denzin 1962). One form of data was obtained through direct observation over a decade when I served as a guardian *ad litem* in

Strafford County and Rockingham County courts in New Hampshire. Most of my appointments as a court officer were in family courts dealing with custody, visitation, abuse, mental health, and relationship issues. I served in cases that had single parents, two-biological-parent families, stepfamilies, grandparents as guardians, estranged parents, and families with adopted children. While some cases pertained to only one child, usually there were multiple children's needs to consider, including twins. Actual abuse or abuse allegations were common. Parenting plans were almost always necessary to be constructed. In this article, examples from some of these GAL cases are provided to show the complexities that families face and how a clinical sociology-trained GAL can be helpful to both families and the courts.

The goal of the GAL court reports was to provide a set of observations that I felt the court should consider pertaining to the wellbeing of the child, along with recommendations for actions. My reports were thorough and described the methodology used to make my assessments and recommendations. They typically included: meeting with each parent individually; meeting with each child individually; meeting with school representatives; discussion with therapists, counselors, or other social service providers working with the child and family; discussion with extended family, friends or neighbors, and others as identified to have insights useful to the case. Each lawyer provided me with information that they deemed relevant. Sometimes there were additional legal personnel with whom to meet, as in the murder case that I was GAL in, in which the father murdered the mother, forced the son to move and bury her body, and threatened harm to him if he told. This research process was absolutely necessary because, given time and investigation, initial assumptions of what was going on in the family were often re-evaluated, as sometimes first impressions could be completely incorrect.

The second form of data was obtained through my membership in MAGAL, the Massachusetts Association of Guardians ad Litem. MAGAL provides peer-based resources and support by the GALs to other GALs. They hold regular workshops, conferences, an email chain,

and Zoom support meetings. The shared conversations from dozens of GALs have been helpful in confirming whether my experiences and perceptions of GAL work were consistent with those of other GALs. Through attending these events, I have gained perspective of what other GALs encounter and have learned that my GAL experiences are normative. The conversations shared have ranged from how to interact with families, lawyers, and the courts, ethical dilemmas that GALs face, to legal procedures that GALS should follow. While these conversations are not showcased in this article, they have provided confirmation that what I observed as a GAL is similar to that which others face.

The third source of data was obtained through a detailed review of the literature on Guardians *ad litem* in the United States. This included a history, review of qualifications, benefits, and challenges. This literature has been used in the introduction of this article. Together, these data provide a keen understanding of the role of GALs. This lays the foundation for explaining why clinical sociologists are trained to bring to this role a superb understanding of dynamics that can assist the court in making good decisions.

## 5. Research Pressures

Being a GAL is akin to being a doll made out of rubbery, stretchy material that can be molded this way or that, depending on how their arms or legs are pulled. Everyone has an agenda for what they think the GAL should do or decide, and the respective players pull and push to have their views seen as the correct ones. The pressures to give GALs access to people or information that the lawyers or parents think may support what they want to see happen in their case are significant. For instance, parents will give names of family or friends who they think will say that they are good parents and that the other parent is less adequate. These types of individuals do provide a window into the life of the child and family – but the windows are colored by filters of what they know, and what they do not. Finding a neutral observer who is not biased and has only the best interests of the child in mind can be challenging. This is why meeting with school personnel or people who know the child

(not the parent) as the primary unit can be quite helpful. Physicians, psychiatrists, social workers, and other clinicians are also valuable contacts because, typically, they operate under a code of ethics that should put the wellbeing of the child first. This means that getting releases of information so that the professionals can speak is important.

Understanding that parents feel caregiving, economic, occupational, legal, social, and reputational concerns is useful in order for the GAL to be sensitive to the nature of the pressures they face. They will transfer the pressures they face onto the GAL, who they may see as the vehicle to relieve them. There are pressures from each attorney, who by design is supposed to "win" the case for their client. There are pressures from the court to have the reports completed in particular formats and in designated timeframes. There are also pressures from the children themselves. Unless they are quite young, children know when trouble is afoot at home, and they are typically being overtly or covertly manipulated by even well-intended parents.

Clinical sociologists are trained in how to identify good research and analyze data. As professionals, we understand the importance of methodology and how to design data collection systems. We understand how theoretical frameworks may alter how someone perceives a situation. As Howard Becker (1967) reminds us, we must always consider whose side we are on; in court proceedings, each attorney is advocating for their client. A GAL must have as their primary consideration the rights and wellbeing of the child. This means that our theoretical positions and our use of data must be focused on the children. Holding steady and not being swayed by the maneuvers of each attorney can be supported through our theoretical and methodological stances.

## *Challenges Obtaining Data from the Child*

Judges in courts do not usually talk directly with the child. There is a concern that if the child talks privately with the judge that each lawyer will want to be present. If a child testifies in court, then they often legally may be asked questions by each of the lawyers. This is a

scary and intimidating situation for the child, especially as they look out and see the faces of their parents. As a result, most of the time children are not asked to testify in court proceedings, especially in cases of divorce.

Obtaining accurate information from children is often challenging. The main reasons stem from their developmental ability to say that is going on in the home, and the other is their willingness to divulge information that they feel could jeopardize them or put them at risk. Young children may not have the verbal or cognitive skills yet to divulge what is going on. They may perceive what is going on in their lives as normal, since they may not have a broader view of what is appropriate and in the best interests of the child. Children may not realize when they are in a dysfunctional situation, and they may think the experiences they have had may be normal, so they don't say anything about them to the GAL.

When conducting interviews with children, if children divulge information that they fear may be used against them if their parents learn what they said, they may be hesitant to talk. Children are dependent upon their parents for love, attention, and resources. Parents are disciplinarians and children may fear their parent's physical, verbal, emotional, social, or financial retaliation if they say or do something that displeases their parents. This puts children in a vulnerable situation when dealing with court representatives. They may not know who to trust, and feel it is safer not to trust anybody.

They also know that parents may pressure them to take sides and prefer one parent over the other. Parents may say disparaging things about the other parent which may bias the child. In most cases, children want to have a positive relationship with both parents and they are afraid to say anything that could make their parent less loving or generous to them. Children understand their dependency role within the family and act to protect what they identify are their best interests.

As brief examples, a five-year old girl talked about how she and her daddy would take a bubble bath together and play with boats while both of them were naked. In another case, a little boy and his father slept together in the same bed with no clothes on. In the former case

there was no sexual abuse but in the latter there was. Both children had learned that nakedness with parents was something all children did. In both cases, the other parent felt this was highly inappropriate behavior when they found out. In the first case, parent education was needed for the father to learn appropriate boundaries, and he readily complied with this newfound instruction. In the second case, we learned that the little boy tried to initiate sex with other little boys at a child's slumber party, having learned this behavior through contact with his father. Court actions and therapy had to be undertaken to protect the boy. The context in which a parent-child behavior occurs is vitally important for the court's determination of a child's safety.

In another case, when a boy indicated that he had been hit by his stepfather and this was reported to the court, the boy ended up with a broken arm and black eye – allegedly from "an accident". He was forbidden to talk with the GAL or social workers again in order to curb any further information he might reveal about his treatment in the home. This example demonstrates what I observed many times – that children who speak their truth about how they are being treated may put themselves at even more risk if they do.

Clinical sociologists know how to interact with children and modify their style to help increase comfort for the child to be willing to talk, while they maintain their professional role of objectivity. One strategy that I have found useful with young children who do not understand why they have to talk to yet another person about what is going on in their lives is to contextualize myself as their advocate. They undoubtedly know that their parents each have attorneys and I tell them that while I am not an attorney, I will act as their advocate, sort of like their lawyer who will represent what they need or want, or to think of me as their guardian angel who is watching out for them and who will tell the court what I think is best for them. This soft-peddling of my role helps them to see the GAL as someone who could help them. But it is also important not to promise the child anything except that you will do what you can to help them – GALs do not have magic wands they can use to make certain things happen in court.

It is also essential to let the child know that what they divulge may be known by the court who can help them. They need to know that this also means that their parents may find out what they say. It is inappropriate to let the child think that their parents may not know what they say. If there are distinct concerns that the child will be harmed as a result of what they say, the court needs to know that and to make decisions on how to protect the best interests of the child. The ethics of working with children must always be respected. Ethical considerations are engrained into our work as clinical sociologists.

## *Pressures Proving Child Maltreatment*

GALs are mandated reporters, and as court officers, they are obligated to reveal when abuse has occurred. There is a delicate line to walk on how best to protect children who are in potentially risky situations. Parents (and typically their lawyers) are trying to shine the best light on themselves and vehemently deny abuse allegations when they arise, and may respond by saying that it is the other parent who is abusive. I typically work with outside professionals (social workers, therapists, teachers, medical personnel, etc) who provide input. In some cases, it seems clear that there is no abuse occurring. In other cases, it appears that abuse has occurred. But sometimes, it is hard to tell. As a GAL, who knows we are being manipulated by all parties to some degree, we have a predicament – do we indicate that the child is being abused when no abuse has occurred and face the wrath of indignant parents OR do we buy the parent's line that no abuse has occurred when the child has actually been maltreated, and thus inadvertently put the child at risk for future abuse?

In one case I worked on, the father alleged that the mother was suicidal and had put sleeping pills in pudding that she planned to serve the children – thus implying that she was planning to kill the children. There was no proof of this, but the mother had attempted suicide before. The father, who was a skilled attorney himself, painted a picture of the mother as being mentally ill and dangerous. However, in the course of my investigation I found that while the mother had some issues, she was in therapy and that it was the

father who was abusing both her and the children. The belligerent father had hired an aggressive lawyer to represent him, while the submissive mother had hired a passive lawyer. I pleaded to the court to assign an outside intervention team from Harvard to do an external assessment because I was so concerned about the children and I felt my recommendations for action were not being taken seriously. My request for the external assessment was denied. A few months later, it was learned that the father had killed the mother and engaged in extensive abuse of the children. The oldest child witnessed the murder and was forced to drag their mother's body to their car and drive with the father to a secluded area in Maine where they dug a hole to bury her.

My sociological training in research helped me to figure out what had happened. In particular, knowing about Type 1 and Type 2 errors led to my publication of an article on how, when in doubt, it is always our professional responsibility to advocate for children's safety, even when parents and other caregivers may deny the incidence of harm (Vissing 2018).

| | **Null HY is True (No Abuse)** | **Null HY is False (Abuse)** |
|---|---|---|
| Reject Null HY | Type 1 error<br>Predict abuse when child is not abused | Correct Outcome<br>Predict abuse when child is abused |
| Fail to Reject Null HY | Correct Outcome<br>Child is not abused and no abuse is predicted | Type 2 error<br>Child is abused and child is not predicted to be abused |

**Figure 1:** Child Abuse Determinations

Figure 1 provides a simplistic explanation of this issue. A null hypothesis assumes that a child is not being abused. An alternative hypothesis would assume that the child is abused. Statistics help us to make decisions about the truthfulness of those assumptions. If a child is not being abused and a decision is made that the child is safe, all is well. If a child is actually being abused and a decision is made that abuse has occurred, then the correct call has been made and

action can be taken to better protect the child. So, half of the time, correct decisions can be made.

The other half of the time, it's more complicated to make accurate decisions. A Type 1 error, or alpha error, occurs when a null hypothesis is rejected. It is the process of incorrectly rejecting the null hypothesis in favor of the alternative. This would mean that the child is not abused (null hypothesis), and yet there is an allegation of abuse. A Type 2, or beta, error occurs when a false null hypothesis isn't rejected. If the null hypothesis states that the child is well-treated (no abuse) when the child is actually being abused, but the worker doesn't catch this and suggests that the child is fine when the child is abused, this is a Type 2 error.

If a correct decision is made, everyone is happy and feels that justice has been achieved. If a child is not abused and there is no substantiation of abuse, then the family and court agree that no abuse has occurred. If a child has been abused and the investigation substantiates that abuse has occurred, then the court feels the GAL has done a good job by documenting that fact that abuse has indeed occurred. This is what the GAL strives for – a clean determination of abuse when it is present, and a clear indication that a child isn't abused when it is actually well-cared for. The problem occurs in the other two cells of the model. When a Type 1 error occurs during child abuse investigation, the investigator makes a judgment that there is abuse when none has actually occurred. When a Type 2 error occurs, the child is abused but the investigator has insufficient information to make that determination. In either case, the parent feels outraged that the GAL hasn't done a good job.

While parent upset may occur, acting on behalf of the protection of the child is the top priority for a GAL. The court can make the determination of what to do. From the GAL's perspective, it is better to risk wrath from the parent and safeguard the child rather than make a decision that placates the parents but puts the child at risk of harm. Understanding Type 1 and 2 errors is part of a clinical sociologist's training – not something that lawyer GALs may know about. This is another example of how clinical sociologists may have superior training as GALs than many attorneys.

## *Other Challenges GALs Face*

Common challenges facing GALs include not just research pressures, pressures from parents, pressures from lawyers and the court, and pressures about how to handle information from the child, but other challenges as well. Submitting the report can be difficult for non-attorney GALs. For instance, some courts will only accept reports when they come through a designated portal that typically only attorneys can access. I submitted a report over a dozen different ways and found that the court would not accept it because it didn't come through in the portal that I could not access. Another problem that most GALs face is getting paid. While parents may be willing to pay their attorney, they are more likely to do so because a) they usually have a choice of lawyer and b) without the lawyer, their case would not be presented by counsel. GALs are appointed by the court. In some cases when parents demonstrate financial hardship, the court may agree to pay the GAL fees. But in most courts that I am familiar with, the reimbursement rate is far lower than what most GALs normally charge. Attorney GALs tend to charge attorney rates, which could be either side of $350/hour, while many courts pay only $60/hour. Non-attorney clinical sociologist rates typically fall somewhere in between.

For private-paying clients, it is recommended to get a retainer ahead of time. GALs have to list time as a lawyer would, with increments of time listed. It is usually easy to get the retainer first, but harder to be paid after a report is filed – especially if it is not in support of what the parent wanted to have happen. There are occasions when GALs have to take the parent to court in order to be paid. Clinical sociologists may find it helpful to create a contract for services with parents and attorneys when they begin a case, to ensure that all parties understand how the GAL will be paid.

Another major concern is for the safety of the GAL. This is particularly important after the GAL makes a recommendation that may be antithetical to parental desires. Most GALs I know have received threats that are designed to intimidate them, particularly around their own safety, the safety of their family, or the security of their property. While actual occurrences of harm seem relatively rare,

"safety first" is a good motto to embrace at every point of the GAL process. The issue of threat was confirmed through conversations with other MAGAL guardians *ad litem*; many of them have also received personal threats, intimidations, manipulations, and have worried about being stalked, physically attacked, or confronted with weapons. Some have discussed how clients have attempted to soil the reputation or credibility of GALs when the clients didn't get what they wanted in a court proceeding. It is as though, because they paid for the GAL services, that the GAL is obligated to do what the client wants. But GALs are not baristas at Starbucks; we have the responsibility to do what we believe is in the best interest of the child, whether the parents or attorneys agree or not.

There are ways to offset potential danger. These include using a business email and a post office box for correspondence, not a personal email or home address. Keep a copy of all correspondence for future reference. When face-to-face meetings are held, find a neutral office or meeting space. Do not use your in-home office for meetings with parents. Libraries often have meeting rooms that GALs can use for free. Meeting where there are other people nearby is wise. Meeting at the office of one of their attorneys is unwise, because it makes it seem as though you are already aligned with that particular attorney/parent. After a contentious court hearing, it is a good idea to watch the other parties leave first, or to have someone escort you to your car.

There may be time pressures in cases. The court may need immediate information that is challenging for the GAL to obtain. This could be because the GAL has a booked schedule, or because the people the GAL needs to meet with are busy or won't make time for the assessment. It typically takes time to locate the right people and to coordinate schedules – GALs aren't the police and cannot just barge in and demand immediate access in most situations. Time can be an issue in another way. Getting a court hearing can take weeks or months in overloaded courts. In the meantime, the child may be in limbo. The child may need interventions, and the GAL wants to see some court action on behalf of the child, but the court is unable to fit them in unless it is a dire emergency. Parents or their lawyers can

petition for the hearing to be delayed, which can also put the child in limbo. Clinical sociologists – who act as teachers, grant writers, researchers, and who write materials for publications – are often under deadlines. We understand the importance of time management and the importance of flexibility in developing our schedules.

## 6. Conclusions

Being a guardian *ad litem* is not easy work. It is fraught with conflict and challenges. Yet it is a very important task in advocating for the safety and wellbeing of the child. The future of an individual child may rest in the hands of the decision that a court makes.

GALs are in a position of opportunity to advocate for the court to make decisions that will enhance a child's life in both the short and long run. Clinical sociologists come from different theoretical, conceptual, methodological, and pedagogical frameworks than do attorneys. If clinical sociologists want to do court-appointed work such as acting as GALs, it is incumbent upon them to acquire legal knowledge and skills so that they can be effective in the work. While attorneys in the two states that I studied, New Hampshire and Massachusetts, are likely to be GALs, it is important for the court to identify the limitations of lawyer GALs and the benefits that a clinical sociologist GAL can bring to the court.

It is recommended that clinical sociology as a field create more opportunities to train applied and clinical sociologists in elements of law. Knowing how court procedures operate and how to file motions and testify are important skills to acquire. It is also recommended that the field of clinical sociology do more to make the fields of criminal justice and law more aware of the valuable skills that clinical sociologists can bring to the court. We have the research and practice knowledge, systems awareness, and human rights underpinning that help to improve social justice.

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## About the authors

Yvonne Vissing is a Professor of Healthcare Studies and director of the Center for Childhood & Youth Studies at Salem State University in Massachusetts, and author of 20 books.

Eric Knudsen studies social work at Salem State University in Salem, Massachusetts. He expects to earn his master's degree in December 2023. Eric is also a Fellow with the Center for Childhood and Youth Studies at Salem State.

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# Building a Strong Clinical Sociology Program through Accreditation

Amitra Wall
SUNY Buffalo State University; USA

Norma Winston
University of Tampa; USA

## Abstract

This article focuses on the work of the Commission on the Accreditation of Programs in Applied and Clinical Sociology (CAPACS). The authors describe the reasons why graduate and undergraduate sociology programs as well as programs in related fields that have a clinical sociology concentration or track should consider accreditation of their clinical programs. Accreditation by the Commission of programs in the United States and other countries can increase the marketability of graduating sociology students.

**Keywords**: program accreditation, clinical sociology, Commission on the Accreditation of Programs in Applied and Clinical Sociology

## 1. Introduction

Characteristics of quality higher education institutions and programs include a clear and shared mission; high standards and expectations for all students; effective school leadership that monitors student progress and needs; as well as the alignment of curriculum, teaching, learning, and instruction with standards of quality control. Accreditation, the process to measure quality control in higher education, can be at the level of the institution and at the program level. At the core is the maintenance of high educational standards.

This article will focus on the work of the Commission on the Accreditation of Programs in Applied and Clinical Sociology (CAPACS), an accrediting body based in the United States. Specifically, the authors describe the reasons why domestic and international sociology programs should consider accreditation of their programs


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through CAPACS. The need for agreed-upon standards is due to the recognition that increasing numbers of sociology graduates are pursuing professional jobs. Overall, sociology students are deemed to be at a disadvantage when compared to students graduating in such areas as psychology, social work, and marriage and family therapy; because these fields are often regulated by professional groups and occupational associations, and not open to sociologists. Hence CAPACS is an important solution for increasing the marketability of sociology students in clinical and applied programs.

## 1. The Commission on the Accreditation of Programs in Applied and Clinical Sociology (CAPACS)

Formerly known as the Commission on Applied and Clinical Sociology (CACS), CAPACS was established in 1995 as a joint initiative of the Society for Applied Sociology (SAS) and the Sociological Practice Association (SPA). Its purpose is to develop, promote, and support quality sociological education and practice through the accreditation of programs in sociological practice (e.g., clinical sociology, applied sociology, engaged public sociology, translational sociology, forensic sociology, and rural sociology).

The Commission on Applied and Clinical Sociology (CACS) changed its name to the Commission on the Accreditation of Programs in Applied and Clinical Programs (CAPACS) in 2010 to convey its focus and work more accurately, which is to train students and qualify them to be competitive in the nonacademic and professional marketplace. Programs are accredited in the United States and internationally at the bachelor's, master's, and doctoral levels. In addition to accreditation, CAPACS acts in an advisory capacity and as a resource provider to sociology departments interested in developing programs in sociological practice, and also advocates for sociologists in areas of professional certification and licensing (Fleischer 1998, cf. Fritz 2012, Perlstadt 1998).

## 1. CAPACS Accreditation Standards

CAPACS accreditation provides both the standards against which quality higher educational programs in sociological practice are measured and a monitoring system to ensure that accredited programs continue to meet the standards. The result is highly trained graduates in the substantive content and applications of sociology, auguring well for their future employment.

CAPACS developed standards for clinical sociology; the standards highlight the application of the sociological perspective to the analysis and design and intervention for positive social change at all levels of social organization. CAPACS standards are based on learning outcomes that specify what students can do upon completion of a program. The standards cover the use of sociological theory, research methods, professional orientation, and ethics. In addition, students must complete a meaningful practice experience, such as an internship, for a program to be accredited.

After programs demonstrate and explain how preconditions are met, CAPACS Commissioners review programs for full compliance, partial compliance, or non-compliance. CAPACS standards are divided into five broad categories:

- Institution: the resources of the university, college and department that house and support the program;
- Programmatic Structure: the program's mission and goals; administrative structure; services to students; faculty characteristics and development; and public service;
- Practice Experience: the program's internships, practicum, field experiences and/or experiential learning, as well as student's involvement in the professional activities of sponsoring organizations;
- Student Learning Goals and Outcomes: student integration of sociological knowledge and skills; acquisition of a professional identity and ethics as practicing sociologists; work with diverse populations in diverse settings; understanding of the limitations imposed by the social, political, and contextual factors of their

employment; and dedication to their continued professional development; and

- Monitoring and Quality Control: the program's use of appropriate mechanisms to monitor, evaluate and document its administrative procedures and practices, and assessments of student learning as well as continuous quality improvement.

Sociology programs that have a specialization or concentration in clinical sociology must (1) identify student learning goals and outcomes for each area of specialization or concentration; (2) provide evidence that there are faculty members with special qualifications in the area of specialization or concentration; and (3) provide a practice experience that is directly related to clinical sociology.

The goal is to provide opportunities for students to integrate sociological knowledge and skills. Doing so, these students will develop a professional identity, demonstrate a capacity for leadership, and adhere to a set of ethical standards in their practice endeavors. Students will learn about the field and engage in critical analysis and application. CAPACS relies on outcome-based assessment and the creation of learning environments. Adequate training in sociological theory, sociological methods, skills, practice experience, and ethics are the key to the accreditation of clinical sociological programs.

Students graduating from an accredited clinical sociology program will be able to engage in activities in which they can make written, oral, and graphic presentations to appropriate audiences; understand group processes and decision-making; identify, locate, and retrieve information relevant to the practice of sociology; and link these skills with their area of specialization or concentration. A clinical sociology program integrates academic studies with occupational realities through a practice experience. Sociology students become competitive in the market as their experience enables them to:

- demonstrate the ability to utilize theory, methods, and skills in their practice experience;
- recognize the individual, group, and/or organizational processes within a specific practice setting;

- adhere to professional norms and demonstrate appropriate behavior regarding work assignments;
- realize the influence of their personal values and perceptions as related to other individuals and groups in practice settings;
- function as an effective member of a work team or group in a specific practice setting; and
- demonstrate additional learning outcomes in their area of specialization or concentration relevant to their practice experience, if appropriate.

It is important for clinical sociology programs to emphasize ethics as well as the standards and values that guide sociological practitioners in their work. Students in an accredited program would have the opportunity to:

- acquire and maintain a professional identity as a sociological practitioner;
- comply with the codes of ethics of the Association for Applied and Clinical Sociology, the American Sociological Association, and/or another relevant professional association;
- recognize the social, political, and ethical constraints on sociological practice;
- understand the procedures for the protection of research subjects and the privacy of client records; and
- demonstrate a professional and ethical orientation in their area of specialization or concentration.

## 1. The "How To" of Accreditation

The key to accreditation is the preparation of a program self-study that shows how the program meets the accreditation standards (see https://www.capacs.net for standards for programs in clinical and applied sociology and Guidelines for Completing the Self-Study Report). While the self-study does take some time because of the "back and forth" between the program and the commission, the feedback and support provided assists programs so that the commission standards for accreditation are satisfactorily met. After

the self-study has been accepted, two members of the commission (so called "site visitors") will visit the program on campus to verify information and prepare a recommendation for accreditation. The time needed to complete this process ranges from approximately six months to considerably longer (see https://www.capacs.net for Accreditation and Reaccreditation Process: Suggested Timeline).

## 1. The Advantages of Accreditation

CAPACS accreditation contributes to the professionalization of sociologists by preparing them to compete in interdisciplinary fields such as public health and administration; the civil service; organizational and community development; research; dispute and conflict intervention; as well as in occupations such as marriage and family therapy and professional counseling. Hence it serves to broaden students' opportunities for job and career placement.

CAPACS accreditation unites faculty around a common set of standards and goals, thereby improving the quality of sociological education for students. Furthermore, since the maintenance of high standards requires needed resources, CAPACS accreditation ensures the allocation of needed college and/or university resources to the program.

CAPACS accreditation of programs in sociological practice affirms that the program is committed to the highest standards of postsecondary education and training in sociology as well as peer review of the program. As such, it enhances the marketing of the program by bringing status and recognition to the program and, if the program is in a public college or university, can help the college or university attract government funding.

## 1. Conclusion

CAPACS works collaboratively with interested program faculty and staff in different countries to professionalize the discipline. A clinical sociology course or program that is being developed should consider reviewing the CAPACS standards. An existing clinical sociology program, whether it is the department's only program or

is a track within a department's program, should consider applying for accreditation. For additional information, please consult the CAPACS website https://www.capacs.net and/or contact Dr. Michael Fleischer, CAPACS Chair, at mfleischer@capacs.net.

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## About the Authors

Amitra A. Wall is a professor in the Department of Sociology and has served, since 2018, as Associate at SUNY Buffalo State University (USA). She is a certified applied sociologist and is a member of the Association of Applied and Clinical Sociology as well as the International Sociological Association; she serves as a Commissioner for the Commission on the Accreditation of Programs in Applied and Clinical Sociology and as a Middle States peer reviewer. Her email is hodgeaa@buffalostate.edu.

Norma A. Winston retired from her position as Professor of Sociology at the University of Tampa (USA) in 2018. She holds current memberships in the Association of Clinical and Applied Sociology as well as the International Sociological Association; she is Vice-

Chair of the Commission on Accreditation of Programs in Applied and Clinical Sociology. Her email is winston.norma6@gmail.com.

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