Perspectives on Social Work

The Journal of the Doctoral Students of the
University of Houston
Graduate College of Social Work

Volume Seven, Issue Two
Spring 2009

Table of Contents

From The Editors
Elena Delavega

From the time we published the last issue of *Perspectives on Social Work,* the world changed under our noses. We in social work, are probably not surprised with the state of our very globalized planet, for we have seen what comes to pass when social workers and social work values are excluded from the development of social and economic policy and regulation. By this time, it is clear that the neo-liberal policies of the last eight years have produced a very large world-wide crisis. This is, however, the time for us to remember that the word crisis comes from the Greek κρίσις, change or turning point, and this has been taken to mean opportunity. As social workers, we cannot let this opportunity for positive change and influence to pass us by, we cannot lie dormant by the sidelines as the world convulses. This is the time to take charge, to live and work by our values, and to become truly and bravely involved with the development of new social and economic policy. This crisis, this bright and new opportunity, is ours to take or not. Writing and publishing are very important elements in our commitment to involvement, and we are very proud to be able to provide an outlet for emerging social work scholarship, particularly in these critical times.

We thank all of our contributors, their commitment to writing about the issues that they care about, that show they will not stand passively by as our world shudders and changes. We would also like to thank our invited reviewers, without whom we could not bring *Perspectives on Social Work* to life and whose dedication and commitment to the Journal are a shining beacon of light and hope in these dark times: Betul Balkan, Darla Beaty, Ada Cheung, Roberta Leal, Grace Loudd, Thang Luu, Joy Malbrough, Karen Mukoro, and Josephine Tittsworth.

The time has come to ask ourselves if we are to observe the change around us, or if we are to participate in the creation of change. We trust our readers will find our efforts through *Perspectives on Social Work* fruitful.
Best regards,
Editorial Board

Call for Papers

We invite submissions for

Perspectives on Social Work
Volume 8, Issue 1

The submission period is open from
April 15, 2009 to July 15, 2009

See submission guidelines at the end of this issue

The CV Builder
University of Houston, Graduate College of Social Work
Perspectives on Social Work congratulates the following doctoral students on their
accomplishments for Fall 2008

Darla Beaty has had a poster accepted for presentation at the Poster to be presented at 19th
IAGG World Congress to be held in Paris, France in July 2009.

Elena Delavega has presented a paper at the 35th Annual Meeting and Educational Leadership
Conference of the Association of Gerontology in Higher Education, in February-March, 2009.

In Addition, **Darla Beaty** and **Elena Delavega** have had a presentation accepted to the
16th International Symposium, International Consortium for Social Development,
Monterrey, Mexico.

Ada Cheung has two presentations accepted to the 16th International Symposium, International
Consortium for Social Development, Monterrey, Mexico, and two presentations accepted to the
International Conference on Social Work and Counseling Practice, Hong Kong in June of 2009.

Nadia Kalinchuck recently created a collaborative with Baylor International Pediatric AIDS
Initiative through the Clinton Global Initiative University Commitment and also attended the
53rd Commission on the Status of Women at the United Nations. She blogged for the event!

Larry Hill has become a member of the Advisory Board of Hope Worldwide, Houston Chapter,
and of the Board of Directors of Collective for Orphan Care and Education.

Love, S., Koob, J. & **Hill, L.** (2008) The effects of using community mental health practitioners
     to treat children: *Implications for Child Welfare Planners, The Scientific Review of
     Mental Health Practice, 6*(1), 31-39.

Josephine Tittlsworth has had two papers accepted at the International Conference on Social
Work and Counseling Practice, in Hong Kong in June of 2009, and has published the following
article:

Erich, S., **Tittsworth, J.**, Dykes, J., & Cabusas, C. (2008). Family relationships and their
     correlations with transsexual well being. *Journal of GLBT Family Studies, 4* (4), 419-
     432.)

Venus Tsui has been awarded the CSWE-SAMHSA Clinical Fellowship (CSWE-Minority
Fellowship Programs), and presented two juried papers at the CSWE APM in Philadelphia in
October 2008. Ms. Tsui has two presentations accepted to the 16th International Symposium,
International Consortium for Social Development, Monterrey , Mexico and International
Conference on Social Work and Counseling Practice, Hong Kong in June, 2009.

Cheung, M., Leung, P., & **Tsui, V.** (2009, In Press). Asian male domestic violence: Services
     exclusive for men. *Journal of Family Violence.*

Perceptions: The Story of a Working Mother
Stephanie Scott, Doctoral Candidate
The Catholic University of America

Introduction

As the term "working mother" becomes a customary part of our everyday language it has become increasingly important for us to understand these women as they strive to perform their many roles: wife, mother, and worker. Therefore, the primary research question for this effort is what is the perception of a working mother?

Women continue to increase their participation in the labor force due to the economic climate and with the stresses of modern day life there has been a great deal of interest in the social sciences research community to begin exploring the challenges of women in their attempts to manage their public (work) and private (home) spheres. According to Berke (2003), there have been extensive changes in our society's economic, social, and demographic realms, which have altered both the family and the workplace. Managing the pressures of both the work and family spheres has forced people to identify new ways to balance both their employment and home lives. Also, those who work at home face a unique set of challenges and boundaries that impact one's ability to manage both personal and professional. Berke (2003) states,

> …there are two different boundaries that home-located producers confront and negotiate. These include the management of boundaries between the household and the outside world [external boundaries] and the organization of boundaries among activities conducted within the household [internal boundaries].…home or work roles intrude on the time and space that is equated with the opposite realm's roles, particularly for women. (p.515)

> Home is often a place of unpaid work for women, especially with respect to nurturing, caring, and expending emotional labor. Because of the gendered nature of household regimes, under certain circumstances, woman may perceive paid employment at home as affording them power and control. (p.517)

The experience of females as mothers and workers in interaction with home and work responsibilities is very different from men's experiences. Where men are more likely to see home as a place for respite, women tend to view home as additional work—a place of stress, demands, and prohibiting a private place for leisure time (Grant, 2000). As social workers, this area of study becomes increasingly important to our profession because if we are to understand and provide services to the working mother population it behooves us to get a sense of the stresses they face, their feelings regarding the challenges, and their perceptions of their various roles. From a social policy perspective, we must comprehend the challenges, barriers, and nuances of this population in order to advocate for and assist in developing policies and programs which are more worker/mother familiar.

Overview of Design

Grounded theory was the chosen methodology for this qualitative research study. This methodology was the most appropriate in the effort because the researcher wanted to approach data collection from an inductive perspective and wanted to identify and compare what themes, such as gender roles, familial support, and familial expectations that were offered by the research study participant's responses to the interview questions. According to Padgett (1998),

One of the most commonly used methods of coding is constant comparative analysis, a technical associated with grounded theory (Strauss & Corbin, 1990). In practice, it is iterative, beginning as inductive, then becoming deductive, then returning to an inductive approach. As themes emerge from the initial coding [inductive phase], one goes back over the data to ensure that it is coded in accordance with these themes [deductive phase]. As one combs back through the data, new codes often emerge [inductive phase]. (p.77)

Due to the fact that the research effort was to understand the perceptions of a working mother, grounded theory using an inductive approach in order to identify themes is the most appropriate methodology at this time. The sample chosen for this effort was a working mother with a young child (seven years old). The interview took place at a local coffee shop in the mid-afternoon. Unfortunately, due to the participant's time constraints the interview only lasted a half of an hour.

The measures included in the interview covered the domains of work, family, and personal attributes and experiences. These measures were chosen in order to glean from the participant themes that would provide evidence of feeling empowered by work, possibly challenges in obtaining work-life balance, and themes regarding support from family members. In analyzing the data, I used open coding to identify themes for further investigation using grounded theory in order to identify the major themes and this served as the framework for data analysis.

Report of Findings

The most interesting findings from the interview was the strongest theme Based on the interview, we learned that the study participant is comfortable serving in the more traditional role of wife and mother, which is evidenced by the interaction between the me as the interviewer and the participant,

> I: So, does your husband view women and work as the same as you do?
> S: Kind of… (pause), he definitely wants me to bring in some sort of income. But, he is traditional in that I clean the house, cook, do the laundry… (pause), you know the regular household chores.
> I: Does he contribute to maintaining the household?
> S: Oh sure, he mows lawn and helps with my daughter.
> I: Is that enough for you?
> S: It's no problem. He works so hard…sometimes 70 some odd hours a week. (pause), I guess if I worked outside of the home I might feel differently. But, we manage. Though, we just moved to a bigger house…so I have a lot more to do around here. But XXXX (daughter) is getting to the age where she can help me some… (laugh) especially keeping her room clean.

This statement suggests that study participant is comfortable with the role she plays. However, based on the fact that her professional life is in the home, it is curious as to whether or not she would feel the same way if she worked outside of the home. In fact, she questions that herself. In addition, the study participant seems to have been able to balance work and home life, which is evidenced by five instances of work-life balance in her statements and four instances of work satisfaction. The study participant states,

I: How do you feel that this type of work [medical transcription] adds to your life?

S: I need to think about that one. (pause)…well, it is fast paced, which I enjoy and it changes everyday. I guess I just feel like I am adding to someone's wellbeing when I am supporting the doctor. (Laugh) That is at least until I can get back to college.

I: Can you tell me a little something about your challenges of trying to balance work and family life?

S: Well, it seems to change from day to day. (pause). See my daughter also has ADHD and so a lot depends on where she is on any given day. If she is in a good mood, then all is well…if she is having a tough day…it can be hell to get things done. (laugh) And if that is not challenging enough…she is really smart. So if she is wired…then it is constantly a struggle. (sigh) But, somehow we manage through it (laugh). I guess it is a lot easier for me than most women because I work at home and can do my work at midnight if I need to. (pause) So, I guess I can't complain. It isn't like I have to be at an office at a particular time everyday, which helps.

What is an interesting finding from this interview is that the participant appears to be quite content in her role as mother and worker. The study participant offers that this is somewhat a new concept for her because she had such non-traditional, strong female role models in her life growing up where her father was responsible for the majority of the household duties, as suggested by:

S: Well, I come from a family of strong women who have always worked… (pause)…not just in everyday jobs, but as professionals. So, I guess…like me she has been exposed to strong women. I always tell her [daughter] she can do anything she wants.

I: Can you tell me a little bit more about the working women in your family?

S: Well like I said, my mother was an insurance professional and always seemed to enjoy her work. I remember her being like the men in the workplace and (laugh) I guess at home to. You see, my dad did all the cooking and grocery shopping and my mom paid all the bills…you know kinda a non-traditional family. And my grandmother in (pause), I guess it was the 70s decided she wanted a business for herself. So, (laugh) instead of doing more traditional work…she started a garbage company… (laugh) and my grandfather and uncles started working for her (laugh). So, I guess I didn't know any better to think that girls couldn't achieve anything they wanted. (pause), So, I guess I have kind of passed that onto my daughter.

Though, the study participant seems to be comfortable in her role as mother and worker, she was able to articulate equality for women and the concept that women are capable of doing equal work as men:

I: Do you feel that woman should be able to have the same jobs as men and that men should carry some of the burden of the responsibilities at home?

S: (laugh) Of course, I do. I think my parents were equal partners and so, I don't really know any better. In fact, my mom made more money than my dad and (laugh) couldn't cook a meal if life depended on it. I really think that they were fifty/fifty partners. I mean, heck, just because men and

women are different doesn't mean that we can be as smart and do the same kind of work. Uh, except maybe the hard physical type of work.

I: Do you think companies are moving in the direction of giving equal pay and benefits to women and men?

S: Well, I really don't know about the pay part. But, I do know that my husband in his job is allowed to take time off to take my daughter to school or to the doctor if I can't do it. As for my job, I don't know we are all women, so I have nothing to compare it to. I do think that we are making some headway. (pause) I mean now a days it takes two paychecks to keep a family going. So, I don't think it is realistic to think that we can go back to the days of Ozzie and Harriet. I mean if you want to provide a decent quality of life for your children…it takes two jobs.

Based on the data analysis and the supporting vignettes presented, though much of the research has shown that women have greater struggles balancing work and family there are those who are satisfied with their roles. Moreover, the results of this effort beg for further study if this comfort level is due to the strong female roles that women give their daughters or if it is a product of being able to have both your public and private spheres within the home.

Discussion and Conclusion

Since this effort had only one participant, it cannot be assumed that there is significance in the findings. However, the results do pose additional research questions regarding the influence of strong female role models and the impact on work-life balance and further inquiry regarding the blurring of the public and private spheres. Furthermore, there would be much to gain by understanding the male perspective on work-life balance and the assignment of household and child rearing responsibilities. The perceptions learned in this study are that there are women or at least one woman who is satisfied in her role of wife, mother, and worker and is upbeat and positive regarding her life's direction.

References

Berke, D.L. (2003). Coming Home Again, The Challenges and Rewards of Home-Based Self Employment. *Journal of Family Issues, 24*(4). 513-546.

Grant, J. (2000). Women Managers and the Gendered Construction of Personal Relationships. *Journal of Family Issues, 21*(8). 963-985.

Padgett, D.K. ((1998). *Qualitative Methods in Social Work Research*. Sage Publications, Inc.: Thousand Oaks, CA.

PTSD in contemporary Veterans: The impediments to VA care

Sharon L. Young, L.C.S.W.
Fordham University

The modern Veterans Administration (VA) system, traditionally resourced to meet the needs of aging veterans, is struggling to keep up with current demand for PTSD and other mental health services. Despite new policies designed to streamline and expedite VA mental health services, the bureaucracy of the VA is slow to respond to the dynamic demands of changing warfare (Yano, Simon, Lanto, & Rubenstein, 2007). The warfare experienced by soldiers in the Global War on Terror is very different from previous wars (Hoge, Castro, Messer, McGurk, Cotting, and Koffmann, 2004). Returning service personnel have experienced improved battlefield medicine and advanced body armor leading to fewer deaths, but a greater number of traumatized survivors has resulted (U.S. Government Accountability Office, 2008).

The Impact of the Global War on Terror

The ratio of wounded to killed in action for soldiers in Iraq is seven to one (Fisher, Klarman, & Oboroceanu, 2008). This is compared to casualty ratios of roughly two to one in World War II and three to one in the Korea and Vietnam wars (Fisher, Klarman, & Oboroceanu, 2008). More soldiers are returning from battle bearing wounds reflecting the logistics of a modern battle tactics and improved body armor. Rates of traumatic brain injuries, for example, have increased due to the use of strong, but lightweight Kevlar helmets, which prevents wounds but not the jarring physiological damage a bomb causes to the brain (Okie, 2005).

The sequelae of neoteric warfare has led to an unprecedented overall rise in patient enrollment at the VA, precipitated by a dominance of poly-trauma including traumatic brain injury and posttraumatic stress disorder (Yano et al., 2007). According to the Rand Corporation Research Brief (2008), 18.5 percent of veterans returning from the Global War on Terror currently have PTSD or depression and 19.5 percent report having a traumatic brain injury. A study of 3,863 soldiers who found in the Iraq war, 16.6 percent met screening criteria for PTSD one year following deployment (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). Comparatively, the rate of PTSD in the general population is between two and four percent (Hoge et al., 2004). PTSD, though present in the general population, is much more pervasive in those returning from active combat duty. Hoge et al. (2004) found nine percent of soldiers at risk for mental disorders before deployment, and 11-17 percent at risk following deployment. Due to experiential variations in the theaters of operations, soldiers returning from Iraq had significantly higher rates of mental disorders, falling closer to 17 percent, than soldiers returning from Afghanistan. Of all the mental disorders measured by Hoge et al. (2004) (depression, anxiety, and PTSD), PTSD rates increased the most following deployment. The modern battlefield presents new challenges for the VA as soldiers return home. Despite the mental health policy changes VA had made, there are many barriers, which impede the ingress of veterans to treatment.

<center>Barriers to Care</center>

Soldiers returning from war with PTSD face many obstacles to receiving care. One of the most notable is the reluctance of veterans to seek treatment. Hoge et al. (2004) found that those who were most in need of mental health counseling were the most resistant to receive it. This study of infantry tropes found those with a higher degree of mental health symptoms identified more strongly to the list of barriers to care. Some of the items on the list of barriers include: a mistrust of mental health professionals, difficulty in fitting treatment into the work schedule, social stigma of seeking help, being seen as weak for seeking mental health treatment, and the perception of the ineffectiveness of mental health treatment (Hoge et al., 2004). Only 23 to 40 percent of soldiers in the Hoge et al. (2004) study sought treatment for their mental health issues. A more recent study of returning soldiers also found roughly half of those with mental health needs seek treatment for it (Rand, 2008).

Looking specifically at disability benefit applicants, Sayer and colleagues found only roughly half of all PTSD disability claimants were receiving treatment for it (Sayer, Clothier, Spoont, & Nelson, 2007). Though seeming advantageous for a disability claimant to seek treatment for his or her debilitating PTSD, barriers to care were cited to explain the low number of care seekers. The barriers to treatment from Sayer et al. (2007) echo those from the Hoge (2004) article. Possible barriers offered by Sayer and her colleagues included: fear of stigmatization, difficulty in accessing care, and doubt of the utility of mental health counseling. The Sayer et al. (2007) study found that there were certain demographic groups who were more likely to seek treatment during their claims process. These protective factors included: being

married, being younger, and being on public insurance. They found no relation between problem recognition or the degree of functional impairment to an increase in seeking mental health treatment at the VA. The Rand Corporation Research Brief (2008) study of both VA and Department of Defense mental health provision concurred with the aforementioned barriers to care studies. The Rand Brief also described structural as well as personal, organizational, and cultural factors which limit the access of mental health services to returning soldiers.

VA Systemic Barriers

Over the past century, the VA has evolved into an enormous health care system, the largest in the United States (Ibrahim, 2007). There are not many "out of network" opportunities for VA care. Otherwise uninsured veterans generally have no choice of where they receive services. They must utilize the VA clinic that is within driving distance from their home. Receiving mental health services exclusively from the VA creates many barriers to care for veterans. Frequently veterans experience long wait times for initial appointments. The U.S. Government Accountability Office (2007) reported follow up appointments for PTSD at Veterans Administration programs can by delayed by 90 days. So burdened is the VA with veterans from previous wars, the VA asked their medical facilities to give Iraq and Afghanistan veterans priority appointments (U.S. Government Accountability Office, 2007).
Obtaining care becomes a double albatross for rural veterans who often do not have ready access to VA facilities. The process of attaining benefits, sometimes driving long distances to a center, and then perhaps being put on a waiting list creates many obstacles to receiving care. Adding to this labyrinth are the VA benefit seekers, who are seeking a PTSD assessment and care while concurrently applying for benefits. The VA is forced to serve a dual role of gatekeeper and care giver which can alter the basic therapeutic relationship between the veteran and VA care provider. Compensation-seeking veterans with PTSD may experience a mutual atmosphere of distrust at the VA (Frueh, Grunbaugh, Elhai, & Buckley, 2007; Kato & O'Malley, 2007).

PTSD and VA Disability Benefits

The concept of PTSD being a disability has evoked controversy in the veterans' community. Much of this controversy is tied to the way the VA determines its priority system providing access to health care and cash disability benefits. Veterans claiming a PTSD disability can qualify for a priority one, two, or three access to care (Veterans' Administration, 2008). Qualifying for a PTSD disability not only allows veterans to gain more expeditious medical care, but also provides for disability benefits. The policy of proving PTSD disability to receive access to medical care and benefits creates an environment of presentiment from both the veterans seeking care and providers. The negotiation of the complex VA process and feelings of powerlessness associated with filing a disability claim can lead to veteran mistrust in the VA (Kato & O'Malley, 2007). Undergirding the mistrust by VA staff is the supposition that disability payments incentivize pathology and discourage recovery. According to Frueh and colleagues (2007), many VA clinicians are suspicious of veterans with PTSD complaints because they assume they are trying to access or maintain disability payments. Department of Veterans' Affairs figures demonstrating an increase in PTSD disability payments of 79.5 percent from 1999 to 2004 has brought PTSD disability compensation to the forefront (Frueh et al., 2007). This dramatic increase in PTSD claims is compared to payments for other disabilities which rose only 12.2 percent (Frueh et al., 2007). Frueh and his colleagues point to fraud and misrepresentation by veterans as an explanation of the disproportionate rise in PTSD claims. According to Frueh et al. (2007), the majority of veterans who sought mental health treatment for PTSD concurrently applied for disability benefits. He and his team examined the role of

symptom overreporting during the disability claims process. Kashdan, Elhaj, & Frueh (2007) found that overreporters were more likely to express a greater level of anhedonia than non overreporters. This malingering depression was seen as an advantageous symptom to misrepresent, increasing the perception of an inability to work. The premise of this research is that unqualified people will apply for PTSD related disability because they can receive a sizable salary from the disability claim. Further, if they remain sick, they will continue to get paid.

Contradictory evidence has been presented by other researchers which challenges the accuracy of research on misrepresentation of PTSD. Looking at prior studies on symptom exaggeration, Dohrenwend, Turner, Adams, Karestan, & Randall (2007) found discrepancies were due to differences in PTSD definitions published in subsequent editions of the Diagnostic Statistical Manual. More recent research found claimants' psychiatric status did not improve nor did they drop out of treatment following disability claim determination (Sayer, Spoont, Nelson, Clothier, & Murdoch, 2008). An additional study by the same group found that, although psychiatric symptoms increased during the disability claims process, they reverted to the pre-examination level following claim determination (Spoont, Sayer, Nelson, Clothier, Murdoch, & Nugent, 2008). These symptomatic changes were related to income level, employment status, and negative expectations of the disability claim process. The increase in psychiatric symptoms during the change process was attributed to the stress of the claims process itself (Spoont et al., 2008). Increased symptomatology was demonstrated in an independent setting outside of the claims process. The authors claimed there were no incentives for the subjects to overreport to an independent researcher. Therefore, the increase in symptoms was attributed to actual stressors and not manufactured to increase benefits (Spoont et al., 2008).

This mistrust by VA staff might be caused by the high number of veterans who seek PTSD treatment concurrently with filling a disability claim. A high percentage, between 69 and 94 percent, of those seeking care for PTSD are also applying for disability benefits (Frueh, Elhai, Gold, Monnier, Magruder, Keaned, & Arana, 2003).   This high percentage of claimants who are concurrent-care seekers demands further examination.   Only half of disability claimants seek care for PTSD, of that half, 73 percent of those seek care from the VA. These numbers suggest that even though most of the veterans being treated for PTSD at the VA are benefits seeking, they are roughly 36 percent of the total number of disability claimants. Thus, the VA is providing treatment for a small percentage of veterans who claim to be disabled by PTSD. They are serving an even smaller number of non-benefit seeking veterans with PTSD. Clearly, the VA is not effectively reaching the majority of veterans suffering from PTSD.

<div align="center">Conclusion</div>

The VA has designed its modern system to serve the most disabled and impoverished clients. Access to services for working veterans who have not been classified as disabled is blocked by waiting lists and sometimes co-payments. The structure of the VA impedes a rapid response to policy changes. The Veterans' Administration continues to provide mental health services through its hospital system. This limits the accessibility and quality of mental health care. Although there have been some quality improvements in VA treatment for depression, treatment for PTSD is only in process (Rand, 2008). Only half of those receiving mental health services for PTSD received only minimally adequate care. In that half, those receiving evidence based care for PTSD represent just a small portion (Rand, 2008). The VA continues to struggle to provide quality care which is supported by research outcomes. Keeping up with the changes and increasing demands of returning soldiers is a daunting task given the size and structure of the VA. Unlike active military personnel who have a managed care system where they have many

choices of where to seek care, disabled and poor veterans can generally only rely on the VA hospitals and clinics. This bureaucratic behemoth is ill-equipped to expand and react to the ever changing needs of veterans returning from this protracted Global War on Terror.

It its most recent report, the Rand Corporation Research Brief (2008) recommended that the VA increase the amount of and access to quality mental health services. According to the Rand Brief (2008), policies should include a plan to encourage veterans to seek PTSD care. Currently, the VA is serving only a small percentage of PTSD-afflicted veterans. Veterans are reticent about receiving care for their PTSD due to negative attitudes about therapy or concerns about the consequences of seeking care. Many seek care only when their PTSD symptoms are severe enough to render them disabled. However, PTSD is associated with chronic interpersonal, legal, occupational, and health problems. Veterans with PTSD tend to be heavy service users and suffer from a wide range of co-morbid psychiatric and physical problems (Hoge et al., 2007). If the VA fails to reach out to engage those resistant to PTSD treatment, it will continue to be burdened with caring for the physical and other psychiatric needs of these veterans.

References

Dohrenwend, B., Turner, J., Adams, B., Karestan, C., & Randall, M. (2007). Continuing controversy over the psychological risks of Vietnam for U.S. veterans. *Journal of Traumatic Stress*, *20*(4), 449–465.

Fisher, H., Klarman, K., & Oboroceanu, M.J. (2008, May). American war and military operations casualties: Lists and statistics. Congressional Research Service, (Order Code RL32492) Retrieved from the Congressional Research Service web site, http://www.fas.org/sgp/crs/natsec/RL32492.pdf

Frueh, C., Elhai, J., Gold, P., Monnier, J. Magruder, K., Keaned, T., & Arana, G. (2003). Disability compensation seeking among veterans evaluated for posttraumatic stress disorder. *Psychiatric Services*, *54*(1), 84-91.

Frueh, C., Grunbaugh, A., Elhai, J. & Buckley, T. (2007). U.S. Department of Veterans Affairs disability policies for posttraumatic stress disorder: Administrative trends and implications for treatment rehabilitation, and research. *American Journal of PublicHealth*, *97*(12), 2143-2145.

Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D. & Koffmann, R. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *The NewEngland Journal of Medicine*, *351*(1), 13-22.

Hoge, C., Terhakopian, A., Castro, C., Messer, S., & Engel, C. (2007). Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *The American Journal of Psychiatry, 164*(1), 150-153.

Ibrahim, S. (2007). Editorial: The Veterans Health Administration: A domestic model for a national health care system? *American Journal of Public Health, 97*(12), 2124-2126.

Kashdan, T., Elhaj, J., & Frueh, B. (2007). Anhedonia, emotional numbing, and symptom overreporting in male veterans with PTSD. *Personality and Individual Differences*, *43*(4), 725-735.

Kato, K. & O'Malley, K. J. (2007). Relationships between the eligibility process, trust in the U.S. health care system, and patient satisfaction with the Houston Veterans Affairs Medical Center. *Military Medicine*, *172*(8), 818-23.

Okie, S. (2005). Traumatic brain injury in the war zone. *New England Journal of Medicine*, *352*(20), 2043-2047.

Rand Corporation. (2008). Invisible wounds: Mental health and cognitive care needs of America's returning veterans. *Rand Corporation Research Brief Series*, Santa Monica, Ca. Retrieved May 1, 2008, from Rand Corporation web site, http://veterans.rand.org

Sayer, N., Clothier, B., Spoont, M., & Nelson, D. (2007). Use of mental health treatment among veterans filing claims for post traumatic stress disorder. *Journal of Traumatic Stress*, *20*(1), 15–25.

Sayer, N., Spoont, M., Nelson, D., Clothier, B., & Murdoch, M. (2008). Changes in psychiatric status and service use associated with continued compensation seeking after claim determinations for postraumatic stress disorder. *Journal of Traumatic Stress. 21*(1), 40- 48.

Spoont, M., Sayer, N., Nelson, D., Clothier, B, Murdoch, M., & Nugent, S. (2008). Does clinical status change in anticipation of a PTSD disability examination? *Psychological Services*, *5*(1), 49-59.

U.S. Government Accountability Office. (2007, March). *Testimony before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives. Challenges encountered by injured service members during theirrecovery process* (Publication No. GAO-07-606T). Retrieved April

20, 2008, from the U.S. Government Accountability Office web site,
http://www.gao.gov/new.items/d07589t.pdf

U.S. Government Accountability Office. (2008, February). *Testimony before the subcommitteeon national security and foreign affairs, Committee on Oversight and Government Reform, House of Representatives. Preliminary observations on efforts to improve care management and disability evaluations for service members* (Publication No. GAO-08-514T). Retrieved April 20, 2008, from U.S. Government Accountability Office web site, http://www.gao.gov/docsearch/abstract.php?rptno=GAO-08-514T

Veterans' Administration (2008). *All Enrollment Priority Groups.* Retrieved April 20, 2008, from Veterans Administration web site,   http://www.va.gov/healtheligibility/eligibility/PriorityGroupsAll.asp

Yano, E., Simon, B., Lanto, A. and Rubenstein, L. (2007). The evolution of changes in primary care delivery underlying the Veterans Health Administration's quality transformation. *Journal of Public Health*, *97*(12)*,* 2151-2159.

Expanding Our Vision in Child Welfare:
Child Neglect from a Structural Violence Perspective

Mohan V. Krishna, LMSW, MA
Graduate Center - City University of New York

Child neglect is the most prevalent type of child maltreatment in the United States (Allin, Wathen, & MacMillan, 2005; Roditti, 2005; Petras, Massat, & Essex, 2002). Children who experience neglect comprise more than half (59.2%) of all child maltreatment victims (Roditti, 2005). Child neglect is the most lethal form of child maltreatment, leading to more than a third of all child fatalities compared with 25.6% for victims of abuse (Roditti, 2005). Despite this widespread prevalence, child neglect has received limited attention in the health and social sciences literature compared to child abuse (Allin et al., 2005; Roditti, 2005). Child neglect emerges through a variety of factors, including family systems issues, parent-child interactions, individual pathologies of parents, and interactions between the parent and the environment (Petras et al., 2002). Despite this complexity, the problem of neglect has generally been framed and addressed in narrow terms. Policymakers, researchers, and practitioners have often viewed neglect through personal and gender-specific terms, most often as the failure of mothers to carry out their mothering responsibilities (Swift, 1995). As a result of all of these factors, effective practice models for working with families affected by child neglect are lacking (Petras et al., 2002).

In this paper, I will examine recent shifts in child welfare policy and their impact on families affected by child neglect. Using Structural Violence Theory, I will discuss what these shifts reveal about recent definitions and responses to child neglect and about the tension in child welfare policy between child protection and family preservation. One way in which values and ideology infuse practice is through theory, both theories that are used to shape practice and theories implicit in practice. Ideology, according to Therborn (1980) (as cited in Garvin and Lee, 2003), sets boundaries by defining what exists, what is good and what is possible. Using examples from the theoretical and practice literature and principles of Social Democracy, I will explore how Structural Violence Theory can expand our vision for child welfare by advocating for the fundamental human rights of all families and the eradication of inequities which undermine the conditions necessary for families to not only survive, but to flourish.

Recent Shifts in Child Welfare Policy and Practice

Child neglect has been categorized into different subtypes including physical, emotional, medical, educational, environmental, and psychological neglect. Dubowitz, Black, Starr, and Zuravin (1993) define neglect as an act of omission rather than commission that occurs when children's basic needs are not adequately met. Defining neglect as the absence of particular

actions or conditions leaves room for much interpretation in the investigation, assessment, and diagnosis of families. Gordon (1988) claims that historically, the notion of child neglect has been a "container for residual anxieties about child-raising which [do] not fit any of the more precise definitions of family problems" (p. 118).

Several themes emerge when one examines the history and evolution of child neglect from the early nineteenth century. Definitions and responses to child neglect have been inextricably linked to prevailing norms about childhood and about the proper societal roles and functions of the family. A second theme is that the construction of child neglect as a social problem has helped shape and has been shaped by prevailing attitudes towards women and mothering and have over time taken the form of mother-blaming, particularly towards poor women of color. Third, there has often been confusion among the populace and among child protection officials between child neglect and the effects of poverty on child and family well-being.

In 1997 lawmakers passed the Adoption and Safe Families Act (ASFA). Through ASFA, for the first time in the history of child welfare in the U.S., federal law mandated the timeline and conditions for states to file a termination of parental rights for children in foster care. ASFA stipulates that if a child has been in out-of-home care for fifteen of the past twenty-two months and the state is not moving towards returning the child to her/his biological parent(s), the state must file to terminate the parents' rights over the child. By reducing funding for preventive services, shortening time frames for families to complete reunification service plans, reducing barriers to terminating parental rights, and providing incentives to states to promote adoption of children in foster care, ASFA marked a shift away from family preservation and toward concurrent planning and adoption. The primary goal of concurrent planning is to achieve timely legal permanency for children by providing reunification services to the child's biological family while simultaneously developing an alternate plan in case it is needed (Katz, 1999).

These policy shifts have had a particularly powerful impact on families charged with neglect. Due to reduced time frames and pressures on agencies to seek adoptions for children, there has been a greater tendency to not only pathologize families more severely, but to use these pathologies as grounds for severing the ties between a child and her family. Child neglect and the conditions associated with it are seen not only as deficiencies, but as sources of imminent danger from which a child must be protected. Krane and Davies (2000) describe this shift in focus from child well being to risks as a "rhetoric of concern" (p. 38) for the welfare of children. Shortened time frames for reunification have had dramatic effects on families affected by mental illness (McWey, Henderson, & Tice, 2006) and substance abuse (Karoll & Poertner, 2003). McGowan and Walsh (2000), in an analysis of the combined effects of welfare reform and ASFA legislation on families in the child welfare system, critique "quick-fix solutions" (p. 11) that have scapegoated poor women and children and have polarized the dual objectives of child protection and family preservation.

Current debates about how best to respond to families charged with child maltreatment often result in battles between protecting the "best interests of the child" and preserving the rights of parents. What functions are served by perpetuating this dichotomy? Second, to what extent do definitions of child neglect help social service providers understand the distinctions between neglect and poverty and promote conditions for the well being and growth of all families? Structural Violence Theory offers an alternate lens through which to view the functions of the family as a social institution and the relationships between the state and the private lives of families. In the next section, I will highlight key tenets of Structural Violence

15

Theory and examine the implications of these tenets for how child neglect might be viewed and responded to as a social problem. I will also explore the potentials of Structural Violence Theory for developing a broader vision in child welfare policy and practice, one that promotes social and economic justice for all families.

<div align="center">Structural Violence Theory and Child Neglect</div>

Structural Violence Theory holds an expansive view of human nature, one in which people are inherently proactive, reactive and creative (Gil, 1998). Society, through a structural violence framework, is seen as a site of conflict. This conflict manifests in different forms of violence. People are considered fundamentally nonviolent, but are prone to react against violent conditions. The family, from a structural violence perspective, is a site of both harmony and conflict and both growth and destruction. Families have the right to social, economic, and political security. In the absence of this security, familial relationships, including the parent-child relationship, can become inhibited, diverted, subverted, and sometimes destructive (Farmer, 2004; Gil, 1998).

 Social problems, from a structural violence perspective are manifestations of social conflict. A social conflict model questions who profits from the existence of social problems and claims that the eradication of social problems requires equalizing social structures (Parillo, 2002). Thus, social policy is a history of conflict, accommodation, and agreement (George & Wilding, 1985). In terms of the role of the state, Structural Violence Theory demands that the state play a central role in alleviating suffering and creating just, humane, and nurturing conditions for all. Consequently, the term "child neglect" is inherently problematic in a structural violence framework, in that it narrows the lens on the deviant behaviors of the caregiver towards the child. In so doing, the term frames a highly complex social and political issue as a "clinical concern" that demands an investigation, assessment and diagnosis. A structural violence lens makes central the question as to why certain families and communities become more likely to be investigated by child protection officials, a question that has taken on even greater meaning in the current discourse on racial disproportionality in the child welfare system (see Roberts, 2008; Rivaux et al., 2008). Anglin (1998) views social and governmental policies that valorize particular family forms, withdraw help, and impose disciplinary techniques as violence in the guise of social stability and order. Furthermore, U.S. adoption practices, she claims, are sites for perpetuating gender-based hierarchies, ideologies of kinship, and practices of domination.

Several authors have offered interpretations of structural violence that are useful for analyzing child maltreatment and child neglect, in particular. Violence against children, according to Korbin (2003), can be individually perpetrated acts of maltreatment, collectively perpetrated cultural rites that prescribe violent acts towards children, and structurally perpetrated assaults, such as the devastating effects of poverty, famine and lack of opportunity on child well-being. Gil (1998) asks to what extent the environment meets the needs of families, in terms of their circumstances of living, relative power, quality of social relations, and overall quality of life. The lack of or inadequate care for a child is an expression of intrapersonal violence within the family (see James et al., 2003) and a form of counterviolence against inequitable social, economic, and political conditions that hinder parents and families from opportunities for life-enhancing activities and from fulfilling their potential (see Gil, 1998). Counterviolence is an expression of blocked developmental energy in the form of destructive and self-destructive behaviors (Gil, 1998).

Social Democracy and Child Welfare

Structural Violence Theory reflects the social democratic view that societal institutions (such as the child welfare system) are inherently political, skewed, and often unjust (Eitzen & Zinn, 1998). These institutions create norms that give rise to a false sense of consensus, ultimately leading to certain individuals and groups being alienated. Social democracy advocates for challenging institutional norms in order to reorganize faulty societal systems (Parillo, 2002). Social democrats also acknowledge that the current economic system is not designed to meet human needs (Pilisuk & Tennant, 1997). Structural Violence Theory reflects social democracy's focus on the fulfillment of human needs and its insistence that the state has the responsibility and opportunity to create conditions for social, economic and political equality (Mullaly, 1997).

Several examples illustrate how adopting social democratic thought to address child maltreatment can bridge the gap between the personal and the political, and between the individual and the communal. Roditti (2005) proposes the use of social network mapping to examine the community of caregivers for neglected children. In so doing, Roditti offers a way of transforming the process of assessing situations of neglect into an opportunity to challenge prevailing norms of child-rearing and to seek ways of strengthening communities. McGowan and Walsh (2000) similarly advocate for *differential* responses to the wide range of families who come to the attention of child protection agencies and for a commitment to incorporating both social services *and* economic development in poor communities. Reduction in inequalities, according to Mullaly (1997), reduces feelings of isolation and alienation among those who have been marginalized.

Inherent in Structural Violence Theory is a vision of transcending dichotomies between the personal and the social and between the individual and the collective. This tenet mirrors the social democratic ideal of promoting fellowship and collective responsibility over competition and a narrow view of human rights (Mullaly, 1997). Such a perspective can potentially help us rise above polarizing debates between the rights of the child versus the rights of the family and provide children, families, and communities the justice and care they deserve.

Conclusion

Analyzing child neglect through the lens of Structural Violence Theory can provide practitioners and policymakers with a more nuanced understanding of social work's response to child neglect. At the heart of these complexities lie some of the most fundamental aspects of human experience: childhood, the relationships between parents and their children, human rights, and the enormous potential within individuals, families, and communities. Nurturing this potential requires reflective policy and practice, innovation, and embracing multiple perspectives on social problems and their solutions. The children and families we serve deserve no less.

References

Allin, H., Wathen, C. N., & MacMillan, H. (2005). Treatment of child neglect: A systematic review. *The Canadian Journal of Psychiatry, 50*(8), 497-504

Anglin, M. K. (1998). Feminist perspectives on structural violence. *Identities, 5*(2), 145-152.

Brooks, D., & Webster, D. (1999). Child welfare in the United States: Policy, practice and innovations in service delivery. *International Journal of Social Welfare, 8*(4), 297-308.

Dubowitz, H., Black, M. M., Starr Jr., R. H., & Zuravin, S. (1993). A conceptual definition of child neglect. *Criminal Justice Behavior, 20,* 8-26.

Eitzen, S. D., & Zinn, M. B. (1998). Deviance. In *In conflict and order: Understanding society* (pp. 154-185). Boston: Allyn and Bacon.

Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology, 45*(3), 305-325.

Garvin, T., & Lee, R. G. (2003). Reflections on the "policy-relevant turn" in research. *Social Justice, 30*(4), 40-53.

George, V., & Wilding, P. (1985). State, society, and social problems. In *Ideology and social welfare* (pp. 1-18). London: Rutledge and Kegan Paul.

Gil, D. G. (1998). Fostering peace in families by ending social structural violence. *The Justice Professional, 11*, 143-157.

Gordon, L. (1988). *Heroes of their own lives: The politics and history of family violence*. Boston, MA: Penguin Books.

James, S. E., Johnson, J., Raghavan, C., Lemos, T., Barakett, M., & Woolis, D. (2003). The violent matrix: A study of structural, interpersonal, and intrapersonal violence among a sample of poor women. *American Journal of Community Psychology, 31*(1/2), 129-141.

Karoll, B. R., & Poertner, J. (2003). Indicators of safe family reunification: How professionals differ. *Journal of Sociology and Social Welfare, 30*(3), 139-160.

Katz, L. (1999). Concurrent planning: Benefits and pitfalls. *Child Welfare, 77*(1), 71-87.

Korbin, J. E. (2003). Children, childhoods, and violence. *Annual Review of Anthropology, 32*, 431-446.

Krane, J., & Davies, L. (2000). Mothering and child protection practice: Rethinking risk assessment. *Child and Family Social Work, 5*, 35-45.

McGowan, B. G., & Walsh, E. M. (2000). Policy challenges for child welfare in the new century. *Child Welfare, 79*(1), 11-28.

McWey, L., Henderson, T., & Tice, S. (2006). Mental health issues and the foster care system: An examination of the impact of the Adoption and Safe Families Act. *Journal of Marital and Family Therapy, 32*(2), 195-214.

Mullaly, R. (1997). *Structural social work: Ideology, theory, and practice*. Toronto: McClelland & Stewart.

Parillo, V. N. (2002). The sociology of social problems. In *Contemporary social problems* (pp. 14-25). Boston: Allyn and Bacon.

Petras, D. D., Massat, C. R., & Essex, E. L. (2002). Overcoming hopelessness and social isolation: The ENGAGE model for working with neglecting families toward permanence. *Child Welfare, 81*(2), 225-249.

Pilisuk, M., & Tennant, J. (1997). The hidden structure of violence. *ReVision, 20*(2), 25-32.

Rivaux, S. L., James, J., Wittenstrom, K., Baumann, D., Sheets, J., Henry, J., & Jeffries, V. (2008). The intersection of race, poverty, and risk: Understanding the decision to provide services to clients and to remove children. *Child Welfare, 87*(2), 151-168.

Roberts, D. E. (2008). The racial geography of child welfare: Toward a new research paradigm. *Child Welfare, 87*(2), 125-150.

Roditti, M. G. (2005). Understanding communities of neglectful parents: Child caregiving networks and child neglect. *Child Welfare, 84*(2), 277-298.

Swift, K. J. (1995). An outrage to common decency: Historical perspectives on child neglect. *Child Welfare, 74*(1), 71-91.

Empirically Supported Practice or Evidence-Based Interventions?
A Review of the Last Fifty Years

Leslie J. Temme, LCSW

Adelphi University

Abstract: The movement to utilize evidence-based practices within the social work profession began in the late 1950's. Initially known as the empirical practice movement, today it is called evidence based or research based practice. Improved understandings of foundations of social work practice as well as advances in research methods and technology have contributed to the flourishing of this movement. However, critics argue that this movement incorporates deterministic and often rigid practices. Are these efforts genuinely aimed at improving empirically based practices or is social work simply continuing its mission to justify itself as a profession? Who decides what is evidence based practice and who are the stakeholders? Where do practitioners and their rich history of practice wisdom fit in the scheme of things? This article explores the history and rationale of this movement, discusses pressures to utilize evidence-based practice, and examines whom actually benefits. While there is suggestion of forces beyond best practices that are contributing to this movement, it appears that the social work profession

remains mired in its quest to prove itself a profession, perhaps at the expense of the values that have been the foundation of the profession since its inception.

Social work is a unique profession with its own values, ethics, goals and areas of expertise. "Distinguished from anthropology, psychology, sociology, and other disciplines by its focus on induced change" (Fraser, 2004, p.210). The essence of social work research is the study of intervention and the development of systematic change strategies (Kirk & Reid, 2003; Fraser, 2004; Thyer, 2007). How to quantify induced change while maintaining a system open to varying strategies remains an obstacle in the implementation of evidence based practice. As early as 1917 Mary Richmond's *Social Diagnosis* described practice as a scientific process that was to begin with the gathering of facts, followed by hypothesis, which was verified by evidence to determine diagnosis and course of action. The emergence of the empirical practice movement occurred during the 1950's, as social workers searched for identity within the professional community.

The 1950's: By the late 1950's social workers had integrated psychoanalytic theory into social work practice and begun to rely on a medical model of treatment and DSM driven diagnoses. The focus of practice became problem centered, not action or solution focused. In 1958, Eaton identified the pressure stakeholders brought to the profession. Researchers, academics, and practitioners began to question the place of art, intuition, and practice wisdom within scientific paradigms. In an effort to capture practice wisdom and client/worker interactions, the profession continued to question epistemological frameworks, scientific methods, and means of measurement and meanings of constructs. Identifying the impending problems intrinsic to the empirical practice movement, Greenwood (1955) reminded researchers "casework practice theory was not developed through planned experiment but instead constructed out of practitioners rich insights derived from experience" (p.28). Here begins the dichotomy between practice wisdom and science that continues today.

The 1960's: The 1960's saw a shift within the profession from individual work towards addressing social factors as evidenced by significant increases in large social programs. Researchers recognition of methodological issues, poor measurement tools and unreliable data lead to the conclusion that the basis of scientific inquiry within social work was flawed and therefore outcomes could not be considered valid (Fisher, 1973; Goldstein, 2007). Perlman (1964) challenged the profession to be conscious of translating intervention constructs into practice that met the needs of the client versus the needs of research methods. She writes of mistrust from practitioners who increasingly experienced researchers attempts to dictate practice, versus practitioners influencing research. Perhaps in an effort at mediation, Perlman (1964) reminded us that "art is based on science and there is no evidence that science is death to art" (p.54).

The 1970's: According to Briar & Miller (1971) there was a veritable explosion of new concepts and theories within the field of casework in the 1970's. Schools of social work introduced curricula focusing on empirical practice and program evaluation. Both single case design and program analysis contributed to the integration of teaching social work students to evaluate practice. However, the profession struggled to distinguish foundation theory from practice theory and had difficulty in describing and explaining the complexities of personality. Moreover, there was the inability to successfully operationalize social work process and define outcomes (Siporin 1975; Turner, 1974). Post Modernism emerged to contribute to our understanding of knowledge and science was viewed as limited in time and context.

During this time, evidence was building regarding the efficacy of cognitive models of treatment with improved measurement of outcomes. Reid's task-centered approach, rejecting of

the medical/disease metaphor, was grounded in a person-in-situation approach, and was process-oriented, focusing on solving specific problems as identified by the client. "A strength of this approach is that research monitoring is an integral part of the design and serves as a basis for progressive modifications of the model" (Reid & Epstein, 1972, p.217). Most important to note is the allowance for progressive modification. This was not a static process that resulted in specific interventions but a process that allowed for modification. Task-centered practice was a major contributor to the development of intervention research.

Further influencing the movement towards empirical practice and evidence-based interventions, a number of social programs from the 60's were evaluated and found to have poor outcomes. Funding sources began to look for means of accountability within programs. As problems appeared to become more complex for clients, practitioners faced increased government regulation and accountability, cost effectiveness evaluations, and third party reimbursement requirements. A conservative sociopolitical environment that questioned practice had a stake in seeing specific evidence-based interventions flourish as a means of standardizing program outcomes and controlling spending.

The 1980's: Published in 1981 the conclusions of the NASW meeting in Chicago included further definition and conceptualization of a framework for practice. New paradigms that were process oriented and client situation centered, including social constructionism and the heuristic approach, emerged (Witkin, 1991; Heinemann-Pieper, 1989). The heuristic process of trial and error with the discovery of alternatives, embraced the values of social workers commitment to addressing the needs of individual clients as the person in environment. Further, social constructionism - based on the concept that reality is constructed through language and human discourse, in relation to a particular culture or time in history - shed doubt as to whether evidence-based interventions developed by the constructs created today, under current social conditions, would be relevant tomorrow. These paradigms illustrate the importance of the person in environment, which is ever changing, and underscores how the values and meanings connected to the constructs developed today must be open to interpretation and modification.

The 1990's: In the 1990's the increase in the number of practice methods that were the subject of research studies added fuel to the debate centering on the development of criteria to define empirically supported methods. Thyer & Meyers (1998) maintained that evidence-based practice was the right of the client to receive the most effective treatment available. However, the differences between empirically supported practice with progressive modification and prescribed evidence-based interventions had not been clearly communicated to the practice community. Evidence-based interventions became manualized and distributed as empirically sound practice efforts. Practitioners were demoralized by the appearance of practice manuals and lack of consideration for practice wisdom. They questioned whether "accepted" evidence-based interventions included self-determination of clients and asked who ultimately determines what interventions qualify as evidence-based? They recognized that if the current trend continued, it would be people who do the least clinical work that make these decisions (Raw, 1998; Wachtel, 1987). Raw criticized efforts at creating specific provisions for the utilization of evidence-based practices viewing these proposals as "a major disservice to practicing social workers and to the profession that would attempt to solve the very controversial problem of the relationship between clinical research and clinical practice by administrative and political edict" (p. 81).

The 2000's: Politics and money are the main driving forces in a capitalistic society. Financial benefits are seen in the pockets of those who hold publication rights of manuals and funding agents who may applaud and reward one type of practice but exclude and withdraw

funds from another. Howard, McMillen, & Pollio (2007) have acknowledged that "evidence-based practice (EBP) is responsive to many of the external pressures to which social work practitioners are increasingly subjected" (p.235). The social work profession must be cognizant of political climate, question the motives behind the push for "evidence-based", and be educated about differences in empirically supported practice versus evidence-based interventions.

Thyer (2007) maintained that the adoption of evidence based process learning within schools of social work would bring clinical social work "into the mainstream of the helping professions as opposed to continuing to occupy a position that has been described as marginalized" (p.31). Is the purpose of teaching in schools of social work to legitimize the profession or to encourage critical thinking, exposing students to the full and rich knowledge base available to the social work professional? Goldstein (2007) is cautious about how the academic community can provide education that will encompass and embrace an evidence based paradigm concluding that there is a danger in becoming narrow and limited in what we teach students should schools make such a commitment.

Social work researchers coming from academic settings lead the movement in empirical based practice. Critics object that understanding of the therapeutic relationship; the social worker as change agent and the intricacies of the person in situation can only be discovered in clinical settings. Schools of social work have faculty that have not been in the field in over a decade. Rosen (2003) states that "factors inherent in the practice situation render much of EBP incompatible with its routine application in practice and researchers have tended to place the burden of utilization on practitioners, thus contributing to further and unnecessary alienation between researchers and practitioners" (p.197). While fieldwork could possibly provide a link between academics and practitioners, it is unrealistic to expect that agency clinicians will be able tackle this task.

Jensen (2005) stated, "We are in the midst of a revolution of sorts, best characterized by the growing attention paid to principles of evidence-based practice" (p.3). History shows that social work has responded to the practical needs of people relative to their situation, known as the person in environment. This is a moment-to-moment, problem-solving process. The definition of need varies in terms of the perceptions of the people and of society, as evidenced by social movements and public concerns. Have we forgotten the basic premises of social work practice that is committed to the client's best interests, that encompasses value-guided practice, directed by individualized goals? In a complex and heterogeneous society values cannot be assumed by any one body of knowledge to be complete or absolute and "the premise that social work practice is goal directed proscribes any a priori adherence by practitioners to a particular course of action or method of intervention" (Rosen, 2003, p.198).

Conclusion: As early as 1958, Eaton illuminated the contrast between the art of social work practice and the science of academics. The split between those who call for inclusion of practice wisdom and process oriented studies versus those who support deterministic and prescribed treatment formulas continue. Committed to the developmental process of practice interventions, the central force of Shulman's mediating model (1968), Schwartz's (1977) interactionist approach as well as Germain and Gitterman's (1980) Life Model all highlight the interactions between the social worker, the client, and the environment. It is this interaction, this relationship, in situation, that has remained elusive in researchers efforts to develop evidence-based interventions.

Should we succeed in capturing the intricacies of social work practice how can this be translated to the clinical arena? There is tremendous misunderstanding within the practice

community about the differences between empirically supported practice and evidence-based interventions. Perhaps it is time that schools of social work step out of the box and into the treatment arena to better understand the demands of our clients and society today, making the effort to bridge the gap between academics and practitioners.

Lastly, why do authors such as Howard, McMillen, & Pollio (2007) still feel that " a greater role for scientific evidence in practice decision making would undoubtedly increase the effectiveness and enhance the credibility of the profession" (p.235)? Is the social work profession, after 50 years, still concerned about credibility within the professional community? Is the profession not recognized for its strength as an agent of change and valuable contributions to the well being of individuals, groups, families and society? Is "evidence-based" practice the answer to this quest for legitimacy? If we are true to our mission then "such a mission allows no room for swearing allegiance to a particular helping method or theory until it can be proven better than any other, in any situation" (Weissman, 1983, p.1), and our quest for evidence based practice as proof of legitimacy is futile.

References

Briar, S. & Miller, H. (1971). *Problems and Issues in Social Casework.* New York: Columbia university press.

Eaton, J. W. (1958). Science, 'art' and uncertainty in social work. *Social Work, 3,* 3-10.

Fisher, J. (1973). Is casework effective? A review. *Social Work, Jan.* 5-20.

Fraser, M. W. (2004). Intervention research in social work: Recent advances and continuing challenges. *Research on Social Work Practice, 14,* 210-222.

Germain, C. B., & Gitterman, A. (1980). *The life model of social work practice.* New York: Columbia university press.

Goldstein, E. G. (2007). Social work education and clinical learning: Yesterday, today, and tomorrow. *Clinical Social Work Journal, 35,* 15-23.

Greenwood, E. (1955). Social science and social work: A theory of their relationship. *Social Service Review, 29,* 25-32.

Heineman-Pieper, M. (1989). The heuristic paradigm: A unifying and comprehensive approach to social work research. *Smith College Studies,* 60, 8-34.

Howard, M. O., McMillen, C. J., and Pollio, D. E. (2007). Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice, 13,* 234-259.

Jenson, J. M. (2005). Research for knowledge and practice: Carrying on the tradition. *Social Work Research, 29,* 3-5.

Kirk, S. A. & Reid, W. J. (2003). *Science and social work.* New York: Columbia University Press.

Perlman, H. H. (1964). The charge to the casework sequence. *Social Work, July,* 47-55.

Raw, S. D. (1998). Who is to determine effective treatment for social work clients? *Social Work, 43,* 81-86.

Reid, W. J. & Epstein, L. (1972). *Task-centered casework.* New York: Columbia University Press.

Rosen, A. (2003). Evidence-based social work practice: Challenges and promises. *Social Work Research, 27,* 197-208.

Schwartz, W. (1977). Social group work: The interactionist approach. In Turner. (Ed.) *Encyclopedia of social work.* New York: National Association of Social Workers.

Shulman, L. (1968). *A casebook of social work with groups: The mediating model.* New York: Council on social work education.

Siporin, M. (1975). *Introduction to social work practice.* New York: Macmillan.

Turner, F. J. (1974). *Social work treatment.* New York: Free Press.

Thyer, B. A. (2007). Social work education and clinical learning: Towards evidence-based practice? *Clinical Social Work Journal, 35,* 25-32.

Thyer, B. A., & Myers, L. L. (1998). Supporting the client's right to effective treatment: Touching a raw nerve? *Social Work, 43,* 87-91.

Weissman, H. H. (1983) Knowledge base of clinical social work. p. 1-3. In Rosenblatt & Waldfogel, (Eds.) *Handbook of Clinical Social Work.* Washington: Jossey-Bass Pub.

Witkin, S. L. (1991). The implications of social constructionist perspective. *Journal of Teaching in Social Work,* 4, 37-48.

Risk Factors and Service Needs for Homeless Older Adults
Gina Rosich, MSW
Fordham University

Homeless older adults comprise a growing yet understudied segment of the population. While the majority of studies describing the characteristics of homeless people and their pathways to homelessness tend to focus on families and so-called 'working age' adults, some researchers have begun to consider the consequences of an aging society on policies and services for this population. Social workers can benefit from understanding the risk factors and service needs of older adults experiencing or at risk of homelessness in order to prevent homelessness and/or provide necessary services to assist older clients in gaining and retaining permanent housing.

Literature Review

Many factors put adults at risk of homelessness, and these factors may be exacerbated by age. Older adults are a particularly vulnerable population of homeless due to the co-occurrence of diseases associated with aging and the sometime severe conditions that characterize living on the streets or in other unsafe conditions (Hecht & Coyle, 2001; Burt, Aron & Lee, 2001). Incarceration is common among the homeless (Burt et al., 2001). Incarceration has a cyclical effect on homeless individuals, and history of incarceration puts individuals at high risk of long-term homelessness (Kushel et al, 2005). Incarceration may not be an aging issue specifically, but the cyclical nature of incarceration and homelessness suggests the potential for individuals to age into older adulthood without ever exiting such a cycle, which then combines to exacerbate their difficulties exiting homelessness. Economic vulnerability as a result of job loss due to illness and physical decline is a familiar story to those working with homeless older adults. Older adults relying predominantly or exclusively on Social Security benefits are more likely to live with others as income declines, making them vulnerable to household instability (Engelhardt, Gruber & Perry, 2005). It is no surprise that older adults report eviction as one of the leading pathways to homelessness (Crane et al., 2005; Crane & Warnes, 2000; Burt Aron & Lee, 2001; Stergiopoulos & Herrmann, 2003; Hecht & Coyle, 2001). Cohen et al. (1997) found perceived support and access to community facilities to be the strongest predictors to leaving homelessness for older women. Herman et al. (1997) found adverse childhood experiences such as parental neglect and physical abuse increased the likelihood of homelessness in adulthood. Zlotnick, Tam and Robertson (2003) present a conceptual model of homelessness based on (a) lack of economic resources; (b) lack of human capital such as education and job stability; (c) disaffiliation due to lack of actual and perceived support, (d) cultural identification as a homeless person which derives from living in a shelter or remaining homeless over a long period of time; and (e) impairment/dysfunction due to mental illness or substance abuse.

Study Aims

The goal of this study is to examine factors related to homelessness as they might apply to older adults. The specific aims are to: 1) Describe the percentage of homeless adults who are older adults and the duration of homelessness by age; 2) determine whether the two factors of length of time homeless and the biggest barriers to rehousing are associated with age and chronic illness; 3) determine whether length of time homeless is associated with incarceration; and 4) determine whether these factors are modified by income.

Study Hypotheses

1. The length of current homeless spell is associated with:
   a) Age; b) Number of chronic illnesses; and c) Amount of time incarcerated immediately preceding current homeless spell.
2. The factor biggest barriers to rehousing is associated with:
   a) Age; b) Number of chronic illness
3. Income modifies the relationship between length of current homeless spell and: a) age; b) number of chronic illnesses; and c) amount of time incarcerated.
4. Income modifies the relationship between biggest barriers to rehousing and: a) age; and b) number of chronic illnesses.

Methods

This is a secondary data analysis using the client portion of the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC), a cross-sectional study of service providers and homeless clients (Burt, Aron & Lee, 2001). It was approved by the Fordham University Institutional Review Board for the protection of human subjects. A hierarchical ordinal logistic regression was performed to determine the contributions of the independent variables age, number of chronic illnesses and incarceration to the dependent variable duration of current homeless spell. More than one year was used as the reference category for duration of current homeless spell. A multinomial logistic regression was performed to determine the contribution of the independent variables age and number of chronic illnesses to biggest barriers to rehousing. Lack of income/adequate housing was the reference category for biggest barriers to rehousing.

Results

The sample consisted of 4207 adults, of which 63% were male and 20% were age sixty and older. The mean age for the sample was 40 and the mean number of chronic illnesses was one. Sixty-one percent of respondents were homeless for less than one year. Figure 1 shows that 53.8% of older adults (age 60+) were homeless more than one year. Differences in amount of time homeless were statistically significant by age group χ^2 (4, N= 2586) = 102.35, p $\leq$ .001. Table 1 shows significant differences were also found for each category of duration of homeless spell by age, chronic illness and incarceration. Mean age increased from 35.5 years to 40.9 years (p $\leq$ .001). Number of chronic illnesses increased from .8 to 1.0 (p < .05). Those with the highest number of chronic illnesses were most likely to remain homeless longer, although the mean difference was small. Of those respondents who were previously incarcerated, 96.6% of those incarcerated over a year were homeless over one year, and 62.8% of respondents with less than a year of incarceration were homeless over one year (p $\leq$ .001). As shown in Table 2, insufficient income was the most frequently reported barrier to rehousing. There were significant differences in reported barriers to rehousing based on age. Mean age was highest for those reporting a physical condition or disability (M = 42.0) and lowest for those reporting family or domestic instability (M = 30.6). Mean differences existed between those reporting family or domestic instability and all others except those citing insufficient education or skills. Not surprisingly, mean number of chronic illnesses was highest for those reporting physical condition or disability as the main barrier to rehousing (M = 1.91). As such, the impact of chronic illness was felt to be a barrier for both older adults and those with chronic illnesses.

Table 3 presents the final trimmed model for the ordinal logistic regression that examined the relationship between age, chronic illnesses and incarceration with amount of time homeless (in current homeless spell). Chronic illness did not remain significant in this model, and so was

not associated with length of homeless spell. There were no interactive effects of age and income on length of time homeless. There was an interaction between income and incarceration, where those with greater income and no incarceration or incarceration of less than one year were 29% less likely to remain homeless over one year. Females were 21% less likely than males to remain homeless over one year. Education was positively associated with length of homeless spell, such that those with less than a high school diploma were 30% more likely to remain homeless over one year, and those with a high school diploma were 27% more likely to remain homeless over one year than those with education beyond the high school level.

Also per table 3, a multinomial logistic regression was conducted to examine the relationship between age and chronic illness with biggest barriers to rehousing. The structural barriers "insufficient income or housing" was used as the basis for comparison. For every chronic illness reported, respondents were 16% more likely to report an addiction or disability as a barrier to rehousing, 15% less likely to report vocational barriers and 10% less likely to report the need for additional social services. Females were more likely than males to report insufficient income than any other barrier. Education was associated with addiction/disability and need for additional services such that those with greater education were less likely to report them as barriers to rehousing than insufficient income. Institutionalization other than foster care or group home was the only disaffiliation variable significant in the model, and those institutionalized as youth were 42% less likely to report addiction/disability as a barrier to rehousing compared with insufficient income. The interaction between age and income was significant, such that as age and income increased, respondents were equally likely to report the need for additional income and the need for additional social services. An interactive effect of age and income revealed equal need for income and social services ([OR] = 1.00, [CI] = 1.00, 1.00).

Discussion

Hypothesis one was supported at the bivariate level. Increased age, chronic illness and incarceration were all significantly related to increased length of current homeless spell. There were also differences in barriers to rehousing based on age and chronic illness. Hypotheses two and three were only partially supported. Chronic illness, commonly associated with aging, was a perceived barrier to rehousing for homeless adults. It is possible that living with chronic illness may impact other areas of functioning in ways that cannot be overcome by increased income. Older adults with chronic illness may find life on the streets or in shelters too physically demanding and illness may keep them from performing necessary tasks to exit homelessness such as obtaining documents or entitlement income. This was supported in the model examining barriers to rehousing, as income did not moderate the impact of chronic illness. Respondents were still more likely to cite their illness than income as their biggest barrier. This suggests that clients are not receiving adequate supports to mitigate the impact of illness in their lives in relation to housing status. Income was the most frequently reported barrier to rehousing. Yet it only moderated the effect of incarceration on duration of homelessness. This suggests that homeless individuals who were formerly incarcerated may face considerable structural barriers to rehousing such as being barred from Section 8 or public housing for drug crimes and may also face difficulties finding employment. Many respondents were poor, as the mean income of the sample ($389 per month) was below the poverty line. The similar outcome for those experiencing institutionalization as youth suggests the possibility of lifelong incarceration spells. A regression analysis examining the relationship between incarceration and barriers to rehousing could address this research question.

As income and age increased, respondents reported the equal need for additional social

25

services and additional income. This suggests that services which might mitigate the effect of aging are lacking in shelter systems. Older adults need both structural solutions and social services. These might include traditional aging network services provided to older adults in the home such as assistance with IADLs and ADLs, transportation, medication monitoring, and adjustments to the environment which aid mobility, reduce injury and allow for rest and constructive social interaction. Income cannot replace such assistance.

Some aspects of Zlotnick, Tam and Robertson's (2003) theory were more important for the aging population than others. Disaffiliation did not appear to play a major role for respondents in this study. Impairment, lack of actual or perceived support and lack of economic resources remained important. Lack of human capital was less important for those with chronic illness and not at all important with increased age, possibly because of exits from employment due to disability, job discrimination, chosen or forced retirement. Lack of economic resources was felt most acutely by those with history of incarceration. The theoretical model does not account for chronic illness or physical disability as a measure of impairment or dysfunction. This is an important variable which should be accounted for in explaining the difficulties exiting homelessness, and should be included in the theory.

The main limitation of this study was the use of secondary data. The original researchers set out to gain a broad understanding of the homeless population from a nationally representative sample. Aging issues and homelessness were not their main focus. As such, the data collected were not tailored to questions for an analysis of aging. Since all data were self-reported by clients, there is a question of reliability of the data. No response rate was provided, opening the possibility of response bias. These data cannot be used to test for structural problems such as impact of the housing market. Cross-sectional data present problems when seeking to establish causality. We can only infer through the use of statistics that significant relationships exist, but cannot control for threats to validity. This study was conducted knowing these limitations. It was felt that an exploration of the data might yield patterns useful for further research. Homeless adults experience multiple problems in complex relationships, and regression analysis is a useful tool for measuring the weight of various factors at once.

By utilizing the construct of aging, we may begin to consider policy and practice implications for homeless services to an aging population or aging network services to the homeless population. Implications for social workers include the need to provide and tailor supportive social services to this small but growing population. Shelter and street life can be physically demanding and aging exacerbates those difficulties in ways that cannot be overcome by income alone.

In conclusion, by viewing homelessness through the lens of aging, researchers can consider homelessness as an extreme result of both structural and personal deficits. Inadequacies within economic and housing policies coincide with gaps in the aging network of services that form pathways to homelessness and extend length of homelessness for experiencing poverty, incarceration and co morbidities associated with aging. The question of senescence in relation to poverty, illness, incarceration and the strains of homelessness is ripe for further research.

References

Burt, M., Aron, L, A., & Lee, E. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington D.C.: Urban Institute Press.

Cohen, C., Ramirez, M., Teresi, J., Gallagher, M., & Sokolovsky, J. (1997). Predictors of becoming redomiciled among older homeless women. *Gerontologist*, *37*, 67–74.

Crane, M. & Warnes, A. (2000). Evictions and prolonged homelessness. *Housing Studies, 15*, 757–773.

Crane, M., Byrne, K., Fu, R., Lipmann, B., Mirabelli, F., Rota-Bartelink, A., et al., (2005). The causes of homelessness in later life: Findings from a 3-nation study. *Journals of Gerontology: Social Sciences, 60B*, S152–S159.

Engelhardt, G., Gruber, J. & Perry, C. (2005). Social Security and elderly living arrangements: Evidence from the Social Security notch. *The Journal of Human Resources*, *40*, 354–372.

Hecht, L. & Coyle, B. (2001). Elderly homeless: A comparison of older and younger adult emergency shelter seekers in Bakersfield, California. *American Behavioral Scientist, 45*, 66–79.

Herman, D. B., Susser, E. S., Struening, E. L., & Link., B. L. (1997). Adverse childhood experiences: Are they risk factors for adult homelessness? *American Journal of Public Health, 87*, 249–255.

Kushel, M. B., Hahn, J. A., Evans, J. L., Bangsberg, D. R., & Moss, A. R. (2005). Revolving doors: Imprisonment among the homeless and marginally housed population. *American Journal of Public Health, 95*, 1747–1752.

Stergiopoulos, V. & Herrmann, N. (2003). Old and homeless: A review and survey of older adults who use shelters in an urban setting. *Canadian Journal of Psychiatry*, *48*, 374 – 380.

Zlotnick, C., Tam, T. & Robertson, M. (2003). Disaffiliation, substance use, and exiting homelessness. *Substance Use and Misuse, 38*, 577 – 599.

Table 1 Age and Incarceration by Duration of Current Homeless Spell. National Survey of Homeless Assistance Providers and Clients (NSHAPC)

Client Characteristics	Duration of Current Homeless Spell									ANOVA	Multiple Comparisons
	>6 months (A)			6 – 12 months (B)			> 1 Year (C)				
	N	Mean	SD	N	Mean	SD	N	Mean	SD	P	
Age	742	35.5	10.4	834	37.9	11.0	1010	40.9	10.4	≤.001	A, B & C are all significantly different at (p<.05)
# of chronic illnesses	775	0.8	1.1	874	0.9	1.2	1063	1.0	1.2	<.01	A > C (P<.05)
Duration of incarceration	Percent			Percent			Percent			P on ANOVA	
Not incarcerated	33.4			34.5			32.1			≤.001	
< 1 Year	7.3			29.9			62.8				
> 1 Year	0.0			3.4			96.6				

Table 2 Age and Number of Illnesses by Barriers to Rehousing. National Survey of Homeless Assistance Providers and Clients (NSHAPC)

|		Age				# of Chronic Illnesses		
	N	Mean	SD	P on ANOVA	N	Mean	SD	P on ANOVA
	2655	38.0	10.9	$\leq$.001	278	.87	1.2	$\leq$.001
				Tukey's HSD				Tukey's HSD Multiple
Barriers to Rehousing	N	Mean	SD	Multiple Comparison	N	Mean	SD	Comparison
1. Insufficient income	807	37.8	11.4	6*, 8***	857	.96	1.3	3***, 6***
2. Lack of suitable housing	268	37.9	11.1	8***	278	.97	1.2	3*, 6***
3. Lack of job or employment	650	38.6	10.3	8***	672	.70	.95	1***, 2*, 6***
4. Insufficient education or skills	70	34.8	10.1	6***	72	.71	1.1	6***
5. Addiction to drugs or alcohol	254	37.5	8.5	6**, 8**	270	.77	1.0	6***
6. Physical condition or disability	78	42.0	10.9	1*, 4**, 5*, 8***, 10*	81	1.91	1.4	1***, 2***, 3***, 4***, 5***, 7***, 8***, 10***
7. Mental health condition	91	39.0	9.4	8***	95	.99	1.1	6***
8. Family or Domestic Instability	45	30.6	10.6	1***, 2***, 3***, 5**, 6***, 7***, 9**, 10**	46	.61	1.0	6***
9. Insufficient services or lack of information	39	40.2	13.0	8**	42	1.24	1.5	---
10. Other	353	37.6	12.0	6*, 8**	371	.75	1.1	6***

* p=.05 ** p=.01 ***p $\leq$.001

Table 3. Final Trimmed Regression Models for Length of Current Homeless Spell and Biggest Barriers to Rehousing

| Variables | Length of Current Homeless Spell | | | Biggest Barriers to Rehousing (Insufficient income or housing reference group) | | | | | | | | |
| | | | | Vocational Barriers | | | Addiction/Disability | | | Requires Additional Social Services | | |
	OR	P value	CI	OR	P value	CI	OR	P value	CI	OR	P value	CI
# of chronic illnesses		n/s		.85	.02	.75, .97	1.16	.04	1.01, 1.33	.90	.21	.77, 1.06
Age	1.03	<.001	1.02, 1.04	1.01	.33	.99, 1.02	.99	.31	.97, 1.01	.98	.04	.97, 1.00
Incarceration (> 1 year reference)												
No incarceration	.20	.11	.03, 1.45			(Not included in this model)						
<1 Year Incarceration	.53	.54	.07, 3.98									
Income	1.42	<.001	1.42, 1.42	1.00	.47	1.00, 1.00	1.00	.75	1.00, 1.00	.99	.06	1.00, 1.00
Female gender	.79	<.001	.71, .89	.54	<.001	.43, .68	.34	<.001	.26, .45	.77	.04	.60, .99
Education (> HSD reference)												
Less than High School Diploma	1.30	<.001	1.14, 1.48		n/s		.54	<.001	.40, .73	.62	<.001	.47, .83
High School Diploma	1.27	<.001	1.11, 1.44		n/s		.68	.01	.51, .91			
Other Institution (in youth)		n/s			n/s		.58	.001	.41, .80		n/s	
Chronic illness * income		n/s			n/s			n/s			n/s	
Age * income					n/s			n/s		1.00	.05	1.00, 1.00
Incarceration * income												
No incarceration * income	.71	<.001	.71, .71			Not entered in this model						
<1 Year Incarceration * income	.71	<.001	.71, .71									
N	2232						2589					
Nagelkerke R²	.124					.10						
P values												
Model Fitting Information		<.001						<.001				
(Goodness-of-fit) Pearson		.56						.40				
(Goodness-of-fit) Deviance		.01						1.00				
Test of Parallel Lines		.05						Not applicable				

Figure 1 Distribution of clients by length of current homeless spell and age group

29

Length of Current Homeless Spell
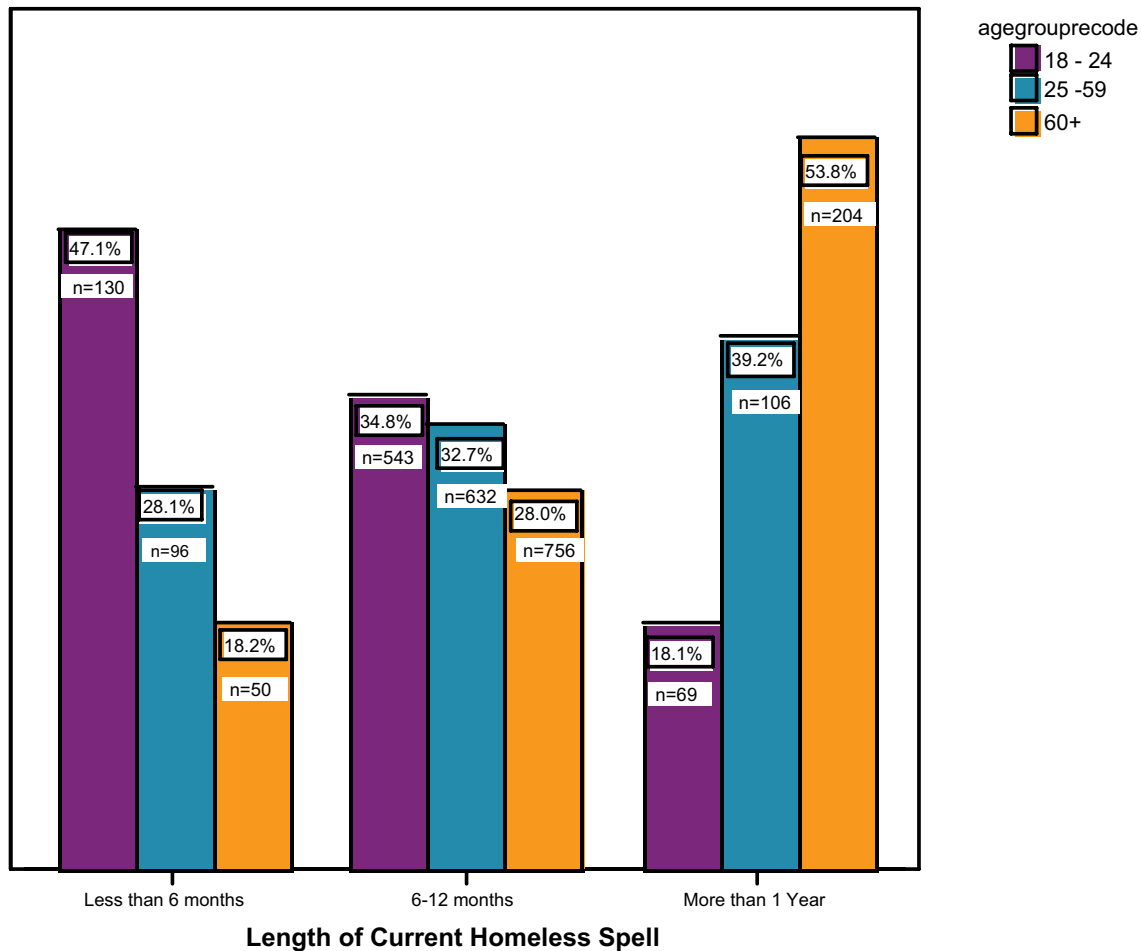
χ^2 (4, N = 2586) = 102.345, p $\leq$ .001

The Influence of Patriarchy on Elder Female Substance Abuse

Stephanie Elias Sarabia

New York University

In order to understand the problem of substance abuse in older women, it is necessary to explore the political, social, and cultural factors that contribute to this social problem. Feminist theory points us to the pervasive impact of women living their lives in a patriarchal society, and illuminates how "sexism and female oppression seem intimately tied to women's substance abuse" (Nichols, 1985).

Feminist theory grew out of a number of movements that fought for the equality of women. Often divided into three waves, the feminist movement began with a focus on women's suffrage, the first wave. "The personal is political" (Hanisch, 1969, p.1) embodied the second wave, which fought for the social and legal parity of women. This wave campaigned against oppression based on one's gender and used the lived experience of women to point out gender inequality in our society. One criticism of these initial movements is how they narrowly represented women reflecting only the perspective of white-middle class women. Conversely,

the third wave of feminism has strived for a more inclusive representation of ethnically and economically diverse women, including postcolonial and third-world feminism. The essence of this movement, and subsequently feminist theory, is gender equality, and vital to both are to "document the seriousness of women's oppression and develop theories to account for it" (Nicholson, 1997, p. 7).

The most obvious and overarching concept of feminist theory that relates to the experience of substance abuse among women of all ages is patriarchy. Often referred to as an essential point of feminism, patriarchy has been defined as "a system of thought and social relations that privileges and empowers men and creates relationships between the genders that disfranchise, disempower and devalue women's experience" (Payne, 2005, p. 251). Evidence of a patriarchal way of thinking and relating can be seen in the social pressure experienced by the cohort of older women that compelled them to become homemakers. Although this pressure was not detrimental to all women, it denied women a free choice regarding their future. The stigma of abusing a substance also was perceived differently based on one's gender further supporting the argument of the relevancy of patriarchy on women who abuse substances. In the coming paragraphs the relationship between these aspects of patriarchy and their influence on elder women and substance abuse will be explored.

The patriarchal approach to social relationships has particular relevancy to the experience of this cohort of older women and the risk factors for their developing a substance use disorder. The current cohort of older women came of age during a time when the acceptable role for a young woman, regardless of her education or desires, was that of a wife and mother. As a result, innumerable women adhered to this gender role stereotype denying their aspirations and severing their connections to work and school. The result was social isolation as their daily lives revolved only around their home. Inevitably, some of these women began to complain or display symptoms of depression resulting from the oppression of their power to make their own choices (Van Den Bergh, 1991). Subsequently, they were often medicated for those symptoms by predominantly male physicians. Conversely, there were some women who embraced their role as a wife and a mother yet were not immune to abusing substances in their lifetime. For example, an alternate life trajectory reflects how a woman's identity can be intertwined with her role as a wife and a mother, as opposed to a man's independent identity (Gilligan, 1997). This scenario sets women up for difficulties later in life when her children are grown, or in the event of the death of her spouse, when the way she identifies herself no longer applies. Current studies have demonstrated a correlation between widowhood and alcohol abuse in older women (Gomberg, 1994). Although this trajectory can be reflective of a white-middle class experience, which erroneously was the primary focus of the second wave of feminism, it is important to recognize how the dominant experience in a culture can also influence minority women given its overall effect on cultural norms. It is the experience of the dominant culture that solidified the stereotypes and cultural norms that impacted the current cohort of older women.

Central to patriarchy is the premise that the female experience is disenfranchised. Evidence of this can be seen in the harsh, moralistic stigma applied to women who abuse substances, but not to men. Even though stigma can act as a deterrent to a woman for developing a substance use disorder, stigma can also act as a barrier to accessing treatment for a woman who is already engaged in substance abuse, which is reflected in the lower treatment utilization rates for older women as compared to older men (CASA, 2006). Providing historical reference of "addiction as stigma" for older women is the fact that many of these women were born during a time when women could not drink in public as a result of laws or cultural norms. Women who

defied these boundaries endured the attributes of a person who was morally deficient in qualities that extended beyond her sobriety, a label not applied to men. Often viewed as promiscuous or a bad mother, substance-abusing women often denied the existence of a problem, and subsequently accessing treatment, to protect their reputation, and that of their family (Carter, 1997; Van Den Bergh, 1991). One-way women of this generation were able to avoid stigma, both in their younger years and today, was through the use of prescription drugs. By abusing a substance prescribed by a physician, a woman can deny the existence of addiction claiming she is under a doctor's care and following her doctor's orders. A feminist perspective of this example yields two dynamics that put older women of this generation at risk for current substance abuse issues. First, the perceived acceptance associated with receiving one's drugs from a physician lends legitimacy to a potentially destructive substance abuse issue without the stigma associated with other illicit substances. Second, given the historical use of medications, such as "mother's little helper," to solve their problems this cohort of women is accustomed to looking outside of themselves to solve problems. Such an approach supports an external locus of control and disenfranchises a woman's ability to solve her own issues (Van Den Bergh, 1991). These points are reflected in the current literature on older women and prescription drugs. Current research purports that physicians prescribe mood-altering substances more often to older women than men or younger women (Blow & Barry, 2002; Simoni-Wastila & Yang, 2006).

The feminist concept of patriarchy also has relevance in evaluating the current approach to substance abuse treatment demonstrating efficacy for older women. Keeping in mind the gender-based stigma associated with substance abuse, it is telling that research on older women suggests brief interventions are preferable for this group (Blow, 2000; Eliason & Skinstad, 2001). The privacy of this intervention, which is delivered in the normative setting of a physician's or other professional's office, minimizes stigma as a barrier to accessing treatment. Furthermore, this treatment approach supports a woman's internal locus of control as it purports that the client chooses her recovery pathway once informed of the need to reduce her use due to negative consequences on her body or life. A feminist approach to substance abuse treatment advocates supporting a woman's internal locus of control, in contrast to a medical model that disempowers her through suggesting that an external power is better able to "fix" her (Downing, 1991). Another reason why traditional substance abuse treatment services are a poor fit for older women is their adherence to a 12-step model, prescribing group treatment as the modality of choice. Such a treatment approach requires clients to admit to the group that they are an addict, which may be overwhelming for a woman who will endure sex-based stigma.

Patriarchy's devaluation of the female experience is further evident in the historical use of research conducted on men to develop substance abuse treatment services, then offering those same services to women ad hoc. CASA (2006) makes note of the disservice done to women by the substance abuse treatment community by neglecting to research and design programs specifically for women. This, just add women and stir attempt at gender equality misses the mark according to CASA's (2006) recommendations, a position supported by tenets of feminist theory.

Although feminist doctrine seems a natural fit for understanding substance abuse in older women, its concepts, such as patriarchy, are rarely acknowledged in the substance abuse treatment community. This analysis demonstrates the relevancy of the feminist concept of patriarchy in approaching the issue of substance abuse particularly in the cohort of women over 65.

References

Blow, F. C., & Barry, K. L. (2002). Use and misuse of alcohol among older women. *Alcohol Research and Health, 26*, 308-315.

Blow, F. C. (2000). Treatment of older women with alcohol problems: Meeting the challenge for a special population. *Alcoholism: Clinical and Experimental Research, 24(8),* 1257-1266.

Carter, C. S. (1997). Ladies don't: A historical perspective on attitudes toward alcoholic women. *Affilia*, 12, 471-485.

CASA. National Center for Addiction and Substance Abuse at Columbia University. (2006). *Women under the influence*. Baltimore: The Johns Hopkins University Press.

Downing, C. (1991). Sex role setups and alcoholism. In N. Van Den Bergh (Ed.), *Feminist perspectives on addictions* (pp. 3-29). New York: Springer Publishing Company.

Eliason, M. J., & Skinstad, A. H. (2001). Drug and alcohol intervention for older women. *Journal of Gerontological Nursing, 27*(12), 18-24.

Gilligan, C. (1997). Woman's place in man's life cycle. In L. Nicholson (Ed.), *The second wave: A reader in feminist theory* (pp. 198-215). New York: Routledge.

Gomberg, E. S. (1994). Risk factors for drinking over a woman's life span. *Alcohol Health & Research World, 18*, 220-227.

Hanisch, C. (1969). *The personal is political*. Retrieved on December 7, 2008, from http://scholar.alexanderstreet.com/download/attachments/2259/Personal+Is+Pol.pdf?version=1

Nichols, M. (1985). Theoretical concerns in the clinical treatment of substance-abusing women: A feminist analysis. *Alcoholism Treatment Quarterly, 2*, 79-90.

Payne, M. (2005). *Modern social work theory (3rd ed.).* Chicago: Lyceum Books, Inc.

Simoni-Wastila, L., & Yang, H. K. (2006). Psychoactive drug abuse in older adults. *The American Journal of Geriatric Pharmacotherapy, 4(4)*, 380-394.

Van Den Bergh, N. (1991). Having bitten the apple: A feminist perspective on addictions. In N. Van Den Bergh (Ed.), *Feminist perspectives on addictions* (pp. 3-29). New York: Springer Publishing Company.

Recruitment and retention of older adults:
Lessons shared from conducting an intervention study
Donna Wang, LSW
Fordham University

Introduction

Many social work researchers are hesitant to conduct intervention studies. A colleague of mine remarked, "No way would I conduct an intervention study. It's like triple jeopardy: You need to bank on finding willing subjects, need to bank on them showing up, then you need to bank on changing them? No thanks!" In addition to these obstacles, intervention studies are also costly and time consuming.

Despite some of the challenges associated with intervention research, I chose to do an intervention study for my dissertation, "The impact of a yoga intervention on the mental well-being and physical functioning in older adults living in the community." The study was a classical experimental design that entailed designing a yoga intervention, recruiting a community sample from a low-income senior housing building, and carrying out the study using random assignment of subjects to either a yoga intervention group or a neutral socialization group that were shown movies. Measures for this study included depression, morale, hope, isolation, balance, flexibility, and lower body strength. In an effort to include as many subjects as possible, the study did not use inclusion criterion of a mental health diagnosis or cutoff score. Approval for this study was granted by Fordham University's Institutional Review Board. Informed consent was provided for each subject at the time of enrollment. The informed consent and study

procedures were carefully explained to each subject in a one-on-one setting. If the person agreed to participate in the study, she or he then signed an informed consent form. Because the residents of the senior housing building are presumed to be independent and capable of making their own decisions, it was unnecessary to involve any other parties.

Researchers have been urged to share their struggles and successes regarding recruitment with other researchers (Harris & Dyson, 2001). Thus, the purpose of this article is to share some of my experiences and insights regarding recruitment and retention in order to help doctoral students decide if an experimental study may be feasible for their dissertations. This is important for at least two reasons. First, I hope it will allow doctoral students to determine how much time will be needed to carry out an intervention study. Second, it provides specific strategies and challenges that may be applicable to other types of intervention studies and target populations.

Recruitment and retention of subjects for studies targeting older adults has been widely documented as more difficult than other populations. Arean and Gallagher-Thompson (1996) cite that between 70% and 80% of older adults approached to participate in mental-health studies agree to participate, whereas the standard in younger samples is 90–95%. Despite incorporating many strategies suggested by other researchers for increased recruitment, such as transportation to the cite, providing monetary incentives, and minimizing participant confusion by having the same interviewer administer baseline and follow-up measurements (Arean, Alvidrez, Nery, Estes, & Linkins, 2003), this study had a small sample size despite various and ongoing efforts to recruit participants. After multiple administrations of the intervention, the final sample size was 18 (N=18), with 35.3% of the eligible residents recruited into the study. Recruitment for the study began with hanging informational flyers around the building, distributing flyers under each resident's door, word of mouth by building staff, and holding informational sessions about the study. If a resident expressed interest, she or he was instructed to return on the day of enrollment to provide informed consent and to complete the pretest. With these strategies, there was a limited response, and it became apparent that the recruitment strategy would need to be tailored to the population. Thus, each resident was personally invited to participate by either me or the building social worker. I offered to visit individual apartments to explain the study one-on-one prior to enrollment. Recruiting was considered exhausted after every eligible resident had been contacted.

Recruitment

A barrier to recruiting and retaining participants is the provision of transportation to the research site (Arean & Gallagher-Thompson, 1996). I took this potential barrier into account by conducting the entire intervention at the housing building, as suggested by past researchers (McNeely & Clements, 1994). However, depending on the target population, conducting the study at the participants' housing site may not always be feasible. In addition, because all the subjects share a common living space, this sampling strategy increases the threats to validity because it increases the possibility of contamination and reactivity to selection. Thus, when considering where to recruit and where to conduct an intervention study, researchers must be made aware of these types of tradeoffs.

Recruitment into studies involving physical activity such as yoga also poses special challenges (Jancey et al., 2006). Fear of physical strain or medical conditions obviously influenced many potential subjects into declining to participate. In addition, misunderstanding the intervention was a barrier to participation. Even though it was stressed that the yoga was gentle, would be conducted while seated, can be helpful with chronic and painful conditions, and

can be modified to meet the needs of the most severely impaired person, residents still voiced concern about "not being able to get on the floor" or "doing anything with my bad back."

The researcher kept a log of all the attempts made to recruit subjects, recruitment plans, and issues that arose with the subjects regarding recruitment. Most of the reasons for not wanting to participate focused on time or physical constraints. Few people voiced an aversion to mental-health treatment as a reason for nonparticipation. This could be due to a lack of knowledge of what yoga and the intervention entailed. Also, although the study was designed as an alternative treatment for mental and physical health, it did not provide a direct and obvious intervention for mental health.

Harris and Dyson (2001) caution researchers not to underestimate the difficulty in recruiting frail older adults into research and ensuring that the data collection period is sufficient to recruit an adequate number of participants. Part of the value of this study is the lessons learned concerning what was done well and what could have been improved to increase recruitment and retention for studies targeting older populations. Tolmie, Mungall, Louden, Lindsay, and Gaw (2004) conducted a study to examine the reasons why older adults choose to participate in research studies. They found that curiosity was an important factor for preenrollment, whereas self-benefit and a desire to help researchers were important motivators in actual enrollment.

Retention

The attrition rate in this study was 5.6% (1 out of 18), which is consistent with the literature, which notes that the average dropout rate for studies targeting older adults is 10% (Arean & Gallagher-Thompson, 1996). A negligible dropout rate may suggest that the participants were satisfied with their choice to participate and content to support the study for its duration (Harris & Dyson, 2001). However, retention of the participants became increasingly difficult as the study progressed. By the third wave of the intervention, attendance adherence decreased. The first wave required little recruitment effort: For the most part, the subjects in the first wave pretty much "came to the researcher," whereas by the third wave, the "researcher went to the participants," and personal invitations and continued follow up were necessary for enrollment and retention. This could be an indicator of the motivation level of the groups or the overall health between the three waves, with the first wave being more relatively healthy and active, whereas the third wave was perhaps less healthy and more inactive. This trend could have implications for other researchers conducting intervention studies; special efforts could be made for the harder-to-target subjects and planning for statistical analyses.

Successful strategies in recruitment and retention

The percentage of eligible residents recruited into this study and low level of attrition could be partially attributed to my relationship with personnel at the site. I had a relationship with the social worker and the building management prior to the implementation of the study. These relationships were based on mutual respect for each others' work ethics and skills. Because of this, I was given considerable trust and support in the implementation of the study. For example, the building manager allowed me into the building at any time and allowed me to randomly knock on doors. The building manager and social worker accompanied the researcher when recruiting whenever possible. The building management informed and invited me to all community events where a number of residents would be congregating, and gave me priority in the use of the community room. The social worker allowed me to use her name in recruiting subjects. It is possible that the open and trusting relationship between the building staff and me caused the residents to feel a sense of "safeness" and trust for me and the study. Visiting older adults in their homes, considering the practical needs of the participants, attending community

events, and inquiring about factors that affect recruitment and retention have been regarded as trust-building strategies (Moreno-John et al., 2004). In addition, after the implementation of the first wave, other residents saw what the study entailed, and that I had kept all my "promises" (e.g., payment, the sessions, and luncheon). However, with the lack of anonymity in the study, the participants could have also felt pressure to participate in and/or complete the study.

Implications for Research and Practice

Difficulty in the recruitment and retention of older adults into research studies is commonly cited by scholars; however, once recruited into studies, the dropout rate is lower for older adults than for younger samples. Two areas of research for the retention and recruiting of subjects into intervention research could provide valuable information when designing studies that provide optimal recruitment and retention efforts. First, for recruitment and retention, it would be useful to study whether the role of the researcher's efforts affects the recruitment and retention rate. This could potentially provide future research with specific recruitment strategies. In this study, I made special efforts to engage the management and residents and continually followed up with residents with reminder calls and support to continue in the intervention. Examining how much follow up and trust-building is needed to successfully recruit and retain participants would be beneficial for future intervention research.

A second area for retention research is why the dropout rate is lower for older adults than other populations. A common misconception of nongerontological researchers is that older adults have an abundance of leisurely time, when in fact frailer older adults often use their time and energy to simply accomplish daily living (McNeely & Clements, 1994). Given this notion, the fact that there is a lower dropout rate for older adult participants suggests that older adults are selective in choosing their activities, and that their choices are made judiciously and wisely. The lower dropout rate could also be an indication that individuals are satisfied with their choice to participate in studies.

The reasons for a lack of attrition can be applied to practice. One possibility is that the time and care taken to explain the study and to make sure that the informed consent was genuine may indicate that the choice to participate was freely given (Harris & Dyson, 2001). On the other hand, researchers should consider the lack of anonymity in treatments and the pressure to participate in treatment. Although the lack of attrition in this study is considered a strength, it is important to determine if this was based on satisfaction with the participants' choice to enroll or was due to pressure. Coercion, even subtle, in research is considered unethical practice.

Conclusion

I hope that this article provides some insight into the implementation of an intervention study for older adults. Lessons learned in this dissertation study, from recruitment and retention to the implementation of the intervention, will, I hope, be useful to other researchers. Given the challenges of intervention research, along with the necessity to produce empirically validated practices, it is hoped that this article will illuminate intervention researchers' needs when garnering support for such studies. Intervention researchers need to be forthright about the issues and unpredictable experiences that can compromise the integrity of a study. Only when this is done can we continue to refine our intervention study skills and practices, and offer our clients the best possible services and treatment.

References

Arean, P., Alvidrez, J., Nery, R., Estes, C., & Linkins, K. (2003). Recruitment and retention of older monitories in mental health services research. *Gerontologist, 43* (1), 36–44.

Arean, P., & Gallagher-Thompson, D. (1996). Issues and recommendations for the recruitment and retention of older ethnic minorities into clinical research. *Journal of Consulting & Clinical Psychology, 64 (*5), 875–880.

Jancey, J., Howat, P., Lee, A., Clarke, A., Shilton, T., Fisher J. et al. (2006). Effective recruitment and retention of older adults in physical activity research: PALS study. *American Journal of Health Behavior, 30* (6), 626–635.

Harris, R., & Dyson, E. (2001). Recruitment of frail older people to research: Lessons learned through experience. *Journal of Advanced Nursing, 36* (5), 643–651.

McNeely, E., & Clements, S. (1994). Recruitment and retention of the older adult into research studies. *Journal of Neuroscience Nursing, 26* (1), 57–61.

Moreno-John, G., Gachie, A., Fleming, C., Napoles-Springer, A., Mutran, E., Manson, A. et al. (2004). Ethnic minority older adults participating in clinical research: Developing trust. *Journal of Aging & Health, 16* (5), 93S–123S.

Tolmie, E., Mungall, M., Louden, G., Lindsay, G., & Gaw, A. (2004). Understanding why older people participate in clinical trials: The experience of the Scottish PROSPER participants. *Age & Ageing, 33* (4), 374–378.

Bookworm's Corner

Book Review

Arnold S. Relman, M. D. **New York: Public Affairs, 2007**. 205 pp. $24.00 hardback, ISBN-10: 1586484818, ISBN-13: 978-1586484811.

A Second Opinion: Rescuing America's Healthcare
Reviewed by Nada Elias-Lambert, LMSW
University of Texas- Arlington

With healthcare reform at the forefront of political debate, Dr. Relman's book comes at a timely point in American history. With the prevailing rhetoric and healthcare reform proposals being touted by recent presidential candidates, the general public may be having a hard time separating myths and self-serving claims from reality. In *A Second Opinion*, Dr. Relman provides a 'second opinion' about the state of our healthcare system and the major reforms it requires. He outlines a thoughtful and measured approach on how to effectively rescue America's healthcare system. *A Second Opinion* does an excellent job of dispelling the confusion about healthcare reform and helps readers understand key facts and issues that demand new policies. Dr. Relman's background as a practicing physician, author, professor and medical journal editor, in addition to his clear compassion for people, provide him with a solid background to write this book.

This book is divided into four sections. In the first sub-section, Relman provides a brief history of the American healthcare system and the problems associated with its commercialization. He discusses how healthcare has transformed from a professional service for the sick to one of the country's largest industries. He addresses the fact that today's healthcare system is more about making profit than it is about wellness or helping the sick and injured. Relman states that this transformation of healthcare is primarily responsible for today's healthcare problems.

The second sub-section discusses ways in which government and private insurers have tried to contain the rising costs of healthcare and why these efforts have been unsuccessful. Here, Relman discusses the different types of reform attempts, such as HMOs, Medicare, Medicaid, and the new concept of Consumer-Driven Healthcare. Recently, attempts at reform are more focused on trying to create competition in the healthcare industry in order to lower costs for consumers. But, as Relman contends, healthcare should not be an industry where its focus is on creating competition, as in other types of industries. The goal of the healthcare industry should

be to create a system of providing quality healthcare to all members of the community at an affordable price.

In the next sub-section, Relman proposes a plan for reform of the U.S. healthcare system and considers practical problems of achieving this proposed reform. His proposal includes: a) changes in the insurance and delivery systems of American healthcare that could potentially control the rising costs, b) provide universal coverage, and c) improve the quality of care provided. His recommended solution is for single-payer insurance that is funded primarily through federal taxes and administered by a centralized federal government entity. Relman's proposal would mandate a major overhaul of our current healthcare system, but the potential gains from this overhaul are perceived as invaluable. There are two parts of his proposal that he maintains will make it work. He states that single-payer insurance is necessary, but that is not sufficient by itself. He also believes major reform to the way physicians are organized in practice and how they are paid is also necessary for an overall healthcare reform.

In the final sub-section, Relman compares the healthcare systems in the U.S. and Canada and attempts to appeal to the moral conscience of physicians. He analyzes and discusses the features of the Canadian healthcare system and characterizes it as a good model, in most ways, for America. In his final chapter, he pleads with physicians to seriously address the cause of major reform. He reminds physicians why they became physicians in the first place: to help those who are sick and/or injured. He urges physicians not only to support the development of single-payer insurance, but to also help devise the delivery system since they are the 'major players' in delivery of healthcare.

This book is essential for anyone interested in learning more about America's healthcare system and how it got to where it is now. This book is useful for social workers because it addresses how to reform one of the major United States systems that provides various obstacles to many social workers' clients. Social workers often advocate on behalf of their clients rights to healthcare, regardless of ability to pay or situational circumstances, and this book provides a potential way to reform our current healthcare system to better assist our clients.

Relman's book provides an excellent summary and analysis of the current healthcare system in the United States and recommends specific, fundamental changes to how the system is financed and how care is delivered. Relman discusses how social policy needs to be changed in order to reform the U.S. healthcare system. He analyzes succinctly and clearly the various aspects of the healthcare industry, then recommends changes to the current system. The US spends much more on healthcare than other industrialized countries for no better overall results. In most of the developed world, universal healthcare coverage is standard. To develop a healthcare system that covers everyone and provides good quality care at a cost we can afford to live with, we need to change not only our system of insuring and paying for healthcare, but also the way we organize and deliver that care.

Relman correctly identifies and criticizes the universally negative role of the commercialization of healthcare in its various manifestations: for-profit hospitals, for-profit health insurers, and procedure-based reimbursement for physicians. His recommended solution of a single payment and single insurance system that is funded primarily through federal taxes and administered by a centralized federal government entity has good potential of success since it is based on already existing systems like the Securities and Exchange Commission. The key to the new delivery system will be development of prepaid multispecialty groups where physicians are paid largely by salary (thus having much less incentive to over- or underuse resources). This system could achieve universal coverage without adding costs; combined savings could easily

amount to at least 30% of present expenses—more than enough to pay for those now uninsured. Relman's overall reform proposal has the potential to succeed because under the proposed universal system, money now spent on health insurance would be pooled, redirected to an efficient central insurer, and distributed to a largely not-for-profit system for medical care.

Overall, Relman's book provides timely and important insights into the current healthcare system's problems and a solid, practical proposal for reform. Anyone interested in healthcare and policy reform should consider this text as a 'must-read' in order to be better appraised of an issue looming on the horizon of America's future.

Book Review

O'Connor, A. (2001). *Poverty knowledge: Social science, social policy, and the poor in twentieth-century U. S. history.* **Princeton: Princeton University Press**.
Reviewed by Peter Kindle, Doctoral Candidate, LMSW
University of Houston

In less than 300 pages of text, Alice O'Connor, currently associate professor of history at the University of California at Santa Barbara, unveils how knowledge is constructed and how, once constructed, knowledge can become fodder for ideology and political manipulation. Thus used (or abused), knowledge shapes both the institutions (i.e., policies, procedures, eligibility standards) and the broader cultural meanings associated with the concept of poverty.

Her central premise, written self-consciously in the frustrating (to liberals) period following the *end of welfare* promised in the 1994 Clinton welfare reform, is that future solutions to the problem of poverty are contingent upon "a redirection in contemporary social scientific poverty knowledge" (p. 4). Yet this volume does not contain a detailed blueprint for a future research agenda. In fact, she claims that "reconstructing poverty knowledge is more than simply a matter of generating new research questions for social scientists to pursue" (p. 8). What O'Connor is attempting to do is to awaken in her readers a deeper understanding of how knowledge is socially constructed. Her history of *poverty knowledge* becomes, then, a kind of case study or primer on how social scientists who desire to make a contemporary impact on social policy need to reflectively process the institutional, societal, and cultural import of their work.

The first section, from the Progressive Era in chapter one to the antecedents of Kennedy/Johnson's War on Poverty in chapter five, anchors 20th century poverty knowledge in reactions to the natural law defense of Social Darwinism and the moralism of relief agencies. This poverty knowledge was intentionally quantitative and focused on collecting objective social facts, not individual moral failings. The dominant paradigm for poverty knowledge became Chicago's social ecology that understood poverty to be the natural consequence of the cultural disorganization accompanying immigration with an anticipated terminus in future assimilation; however, cultural disorganization was understood to be a treatable symptom rather than a causal contributor to poverty. Poverty knowledge was purposive, directed at structural, economic, and labor reform to produce more egalitarian distributions of wealth and power.

The collapse of the economy in the 1930s resulted in a subtle change in the focus of poverty knowledge (chapter two). In this phase, immigrant deviant cultural patterns in the north and cultural (i.e., racial) pathologies in the south were perceived to be determinative of working class poverty. Further, as African Americans migrated north during the 1940s, the racial barriers

to black assimilation became more apparent (chapter three). Gunnar Myrdal's *An American Dilemma* (1944) set the framework for the racialization of poverty with black Americans relegated to a lower caste-like status reinforced by white racism. The economic prosperity of the post-war years, Cold War competition for influence in poor third world nations, the behavioral science explosion, and idealization of the (new) nuclear family created the context for development of the idea of a *culture of poverty* (chapter four). Poverty knowledge was now relegated to a list of behavioral and psychological traits rooted in dysfunctional family patterns sustaining pockets of poverty. The "isolated, maladjusted, and politically passive" poor "needed the galvanizing force of outside intervention to break what had become an internalized 'vicious circle'" (p. 123).

Chapter five is a short parenthetical insert laying the background of experimental community action programs – a pattern that took on a temporary but highly important role in Kennedy/Johnson's War on Poverty.

In the second section, the War on Poverty made a significant impact on poverty knowledge (chapter six through eight). Chapter six deals with the broad political issues related to poverty knowledge; chapter seven in more detail with the Office of Economic Opportunity (OEO); and chapter eight with the academic consideration of the Culture Wars. It was during the decade of the 1960s that poverty became identified, for the first time, as a distinct social problem that required specific government action. Targeted first through an economic growth initiative, then through consideration of economic restructuring and income distribution, and finally settling on community action programs, the War on Poverty in O'Connor's hands becomes a case study of how political considerations and scientific research interact to produce conflicting and ineffective policy decisions. By the end of the 1960s, poverty had been objectified as inadequate income, the culture of poverty had morphed into discussions of human capital deficits, and poverty issues were no longer coupled in policy and political discourse with issues of race or economic structural inequities. Poverty knowledge, under OEO auspices became specialized, individualized, and statistical. Academic researchers did not completely forsake racial and structural considerations; however, academic research was largely severed from reform initiatives, and the techniques of quantitative poverty research focused on individual human capital deficits had much in common with the earlier culture of poverty. In conservative hands, the research and techniques developed to understand and prevent poverty were redirected, in the third section of the book, against welfare rather than against poverty.

Chapter nine, the beginning of the last section of the book, chronicles the poverty research industry spawned by the War on Poverty. Poverty research from 1965 to 1980 grew from $3 million to $200 million annually. Poverty knowledge was again changed as a result of federal funding. The questions raised by federal funding agencies were narrow, not expansive, and focused on the identification of the human capital deficits of the poor and on measurement of the effectiveness and efficiency of government income support programs. Even high unemployment and chronic inflation in the 1970s did not result in challenges to the dominant market-centered worldview or existing structural inequities. In the 1980s, the problem of poverty was reinterpreted as a problem of dependency. Liberal analysts advocating structural changes to enhance opportunity and erode dependency provided the data and frameworks later used by conservative analysts to attack welfare itself. The problem was no longer poverty; the problem had become welfare dependency. Chapter eleven traces the *end of welfare* and presents an outline of what poverty knowledge must become to address alleviation of poverty rather than reduction of the number on welfare rolls. This brief four page section basically calls for

redefinition of poverty knowledge as analysis of the political economy and the related structural impediments to economic opportunity.

This ending is clearly the greatest weakness of *Poverty Knowledge*. If political decisions are only rarely a product of rational analysis, as O'Connor has so compelling shown, then the challenge for liberal/progressive researchers is to understand the contemporary political Zeitgeist in which poverty knowledge is embedded. The recent inauguration of the Obama administration signaled a distinct repudiation of the conservative perspective that has dominated poverty knowledge since the 1970s. This perspective, rooted in understanding poverty as a specialized domain in which individual characteristics are the most significant factors, has impeded consideration of institutional and structural obstacles to poverty alleviation. Progressive and liberal researchers and policy analysts may be facing a time when executive attention can be refocused away from individual deficits to modification of social, structural, and institutional factors that create bridges of opportunity through which the poor might crossover to middle class stability.

What is needed is an understanding of how progressive poverty research can best impact the existing political discourse. It is unfortunate that O'Connor provides so little of this guidance considering the wealth of historical background of which she displays so much mastery. However, one need not be a historian to notice that political and policy discourse has become dominated by the constructs and vocabulary of economics. Social workers in practice and academe who hope to impact poverty knowledge may well consider the investment of time and energy to master the art of expressing the systems analyses to which we are accustomed in the thought forms and categories of the economist. Even Obama's opportunity-directed approach is most likely to be persuaded by innovative system analyses that identify structural barriers and propose new openings to economic advance. There seems little reason why the social work community should not take an active lead in generating a new systems understanding of poverty knowledge.

Guidelines for Submission

In order to be considered for publication in *Perspectives on Social Work*, all submissions must meet the following criteria:
- The author must be a currently enrolled doctoral social work student.
- Only original work will be considered. It is acceptable to submit a piece that has been published elsewhere or is currently under consideration as long as it is that student's original work.
- Only electronic submissions are accepted. Submissions should be e-mailed as a Microsoft Word attachment to the following e-mail address: journal@sw.uh.edu
- Submissions for the featured articles should be 5 – 7 pages in length with not less than one-inch margins and 12-point font. Submissions for book reviews may be 2-4 double-spaced pages. Submissions must be double-spaced.
- Submissions must meet APA guidelines (5th Edition) for text, tables, and references.

Feedback Guidelines

The editorial staff encourages thoughtful responses from readers focusing on scholarly debate and dialogue. Please send feedback to Journal@sw.uh.edu