Perspectives on Social Work

Table of Contents

This *Perspectives* issue comes at a time and place when our country is experiencing a momentous period in history. Sixteen men and one woman are fighting for the highest office in the land, and each has promised to provide a new beginning, and to change the course of events if elected. This leaves me to wonder: How engaged are we social workers in the political process? We cannot observe the political dialogue from afar, hanging back on the fringes of the committed while completely uninvolved in elevating the political discourse. Political writers of antiquity and their disciples have wrestled with the question of what is the best form of government. Naturally of course, the immediate question is: Best for whom?

Our profession prides itself on core values that provide a foundation on which social justice and social change rests. Of the seventeen aspirants, whose administration will be the best? Guiding us must be rational and sound choices, based on the very principles that we and our forbearers have held sacrosanct. It must be a regime that respects the basic rights of all; irrespective of color or creed, gender or sexual orientation, class or background, and one that recognizes the value of unity within diversity. That regime must be willing to bring its constituents, the vulnerable, the oppressed and those afflicted with the pain of poverty to the table of political glory. Our social work ethics remind us that it is wrong to have 47 million Americans without insurance, and ignore millions of our youth failing to graduate from high school, and worse still, watch as millions go to bed hungry while living in the richest country in the modern world. As social workers, we cannot afford to sit on a pity pot and observe events passing us by; we must act, silence is not an option, and the time is now.

Volunteering for campaigns, watching debates/reading and at the very least voting and encouraging clients to vote and be informed voters should be a center piece of our work among others.

Finally, to all the doctoral students who submitted papers for this issue, the editorial staff commends you for placing your trust in our ability to choose the best submissions for our journal. We had so many submissions this time that we had to reject more than we could accept, which is a nice problem to have but makes it so hard to choose from a talented group of doctoral students. I hope you enjoy this issue of the journal and that you take some new knowledge with you when you come to the end of it.

The editors are pleased to present the abstracts of the presentations given at the 3rd annual Doctoral Student Symposium at the University Of Houston Graduate College Of Social Work. The purpose of the annual symposium is to give the doctoral students an opportunity to present their research interests to their peers, their professors, and to the community.

Does a High State Minimum Wage Cause High Unemployment?
Elena Delavega, BS

One of the classic arguments against instituting a state minimum wage that is higher than the federally mandated minimum wage is that it creates unemployment. However, in a state- by-state analysis there does not appear to be a correlation between high unemployment and a high state minimum wage. When high welfare benefits were included for analysis, the correlation increased slightly. This suggests that there may be other factors that influence unemployment, and this study suggests the direction of further research.

Ethical Principles in the World
Darla Beaty, LCSW & P. T. Ada Cheung, MSW

Ethical issues are the essential elements in the social work field. Therapists are following the ethical principles to counsel and work with their clients. Researchers are conducting experiments or studies related to humans with ethical concerns. In this global world, different countries are using different standards of ethical principles. This presentation is going to compare the ethical principles between western and eastern countries and how the ethical concerns will guide us to balance the purpose of researchers and participants' benefits.

Social Justice Issues for Newcomers
P.T., Ada Cheung, MSW & S. F. Venus Tsui, MSW

There are few studies on newcomers facing social injustice in the US. Indeed social justice occurs everyday and in many different aspects. It is particularly hard for newcomers like new residents, international students, new foreign workers to seek help when they come across unjust issues when they first come to the United Status, where the socio-economic system is different from their country of origin. In this presentation, the experience of some Asian people facing unjust issues will be shared, and their struggles as well as their values during the process of fighting for justice will be examined

Courtroom Decision Making in a Multicultural Society
Jack Griffin-Garcia, LMSW

What is the process by which a jury or a judge goes through in order to make a decision regarding a person who has committed an offense? Are personal or societal biases factors that influence the sentencing decision? In this presentation, the author outlines a conceptual framework of how personal and societal biases can influence the sentencing process. Also

covered is the role that professions like social work can play by providing education and empirical research that demonstrate the impact of discrimination in contemporary society.

Lesbians Surviving Culture: Relational-Cultural Theory Applied to Lesbian Connection
Amy Russell, LMSW

Relational-Cultural Theory (RCT) tenets of understanding women and the importance of relationship can explore how lesbians build connection in a sociopolitical culture of disconnection. Disconnection isolates different others and necessitates buffering self or community from detrimental societal actions. An overview and evaluation of RCT is applied to lesbian connection and disconnection. Lesbian strategies of disconnection reveal healing through relational, political, and spiritual strategies. Conclusions show RCT as a useful theoretical framework to understanding lesbian growth and development, but practitioners are cautioned when assuming all disconnection is harmful.

Panel Discussion on Self-care among PhD Students
Darla Beaty, LCSW, P. T. Ada Cheung, MSW, Agnes Dulin, LMSW,
Joy Malbrough, MSW, Amy Russell, LMSW, & S. F. Venus Tsui, MSW

Involvement in the rigors of studying in a PhD program is historically a stressful process. Self-care becomes the most important element in balancing PhD students' mental health and daily functioning. This panel discussion invites PhD students from different cohorts to come and share their secrets to success in caring for themselves while they are experiencing adjustments, not only to class and dissertation requirements, but in other areas of their lives. Discussion will revolve around how to cope with changes in such facets of life such as family relationships and friendships, pregnancy, a new residence, financial hardships, and university expectations.

Predictors of drug use patterns among Hurricane Katrina evacuees living in Houston
Larry Hill, LMSW

Hurricane Katrina evacuees (n = 200) with a history of illicit drug use were identified through intensive community outreach strategies in Northwest and Southwest Houston. A cross-sectional multi-methods approach was implemented within 8 – 14 months after the day of the disaster using a collection of standardized instruments frequently used in disaster research. These assessed mental health, illicit drug use, psychological and personal trauma, health status, and sexual and HIV-related risk behaviors. Preliminary results indicated a higher prevalence of tobacco, alcohol and marijuana use after the disaster than before as well as a decrease in crack, cocaine, ecstasy, and sedative/tranquilizer/barbiturate type drugs. Analysis of drug use patterns indicated that the majority of crack, cocaine, ecstasy, and sedative/tranquilizer/barbiturate users decreased their consumption compared to before the disaster. As drug-using evacuees resettle into their new communities they may also re-establish old drug use patterns. Therefore, social workers and other mental health professionals may benefit from seeking opportunities to assist these communities in sustaining this overall decreasing pattern of drug use.

Attachment and Resilient Theory to Explain Condom Use
Eusebius Small, MSW

This presentation highlights a fundamental problem of adolescents' engaging in risk sexual behavior with nearly half of all high school students in the United States reporting a history of sexual intercourse. Sexual risk factors are outlined. The paper advances a contextual thinking of

how two theories, attachment and resilient theory can be used as core ideas in explaining whether an adolescent may use or may not use condom during a sexual engagement. The paper therefore discusses the application of both theories to the critical analysis of sexually transmitted illnesses.

Reflections on Countertransference and the Holding Environment in Psychodynamic Social Work Practice
Kara A. Cavel, LICSW

Introduction

The British object relations theorist D.W. Winnicott contributed to psychoanalytic theory and practice through his extensive work in pediatric care. Winnicott emphasized a child's interaction with the environment, and postulated that "…human infants could not start to *be* except under certain conditions" (as cited in Buckley, 1986, p. 239). One of these necessary conditions for growth and development is achieved through the activity of holding. Winnicott believed the caretaker's ability to adapt to the infant and the infant's physical and psychological needs defined the concept of the "good-enough" parent. The "good-enough" parent is an essential component of the holding environment (St. Clair, 2004, p. 70). The concept of the holding environment also extends to other people and social structures of the child's life such as the family, the school, and other social systems all contributing to a child's ability to achieve healthy development (Applegate & Bonovitz, 1995). When the child's holding environment allows her to express creative gestures without unnecessary impingements, the self naturally evolves (Fonagy & Target, 2003). When this occurs, the child eventually develops a true self, Winnicott's term for health (Winnicott, 1960). Thus, the conditions of the child's holding environment highly contribute to the development of her true self. In the following paper, I will use Winnicott's concepts of the holding environment, countertransference, and true self/false self to explore my psychodynamic social work practice.

Countertransference and the Holding Environment

Countertransference, or the clinician's ability to use the feelings stirred up in her to better understand the client's internal world, is as a crucial, reflective part of my social work practice (Frosh, 2003). In the following presentation of case material, the use of my countertransferential experience helped me to recognize that the original conditions of my holding environment were not good enough to foster my development as a novice psychodynamic social worker. As I developed a relationship with my young client, my psychodynamic conceptualization of the treatment process was initially devalued by others within the treatment setting. Consequently, I began to question whether my clinical efforts were helping my client, exacerbating my feelings of incompetence. Hence, in the absence of a good enough holding environment, I nearly abandoned the value of my psychodynamic practice, briefly embracing the belief that I was unable to provide good-enough treatment for my client. As a novice clinician, my insecurities, in combination with a not-good enough holding environment, contributed to my sense of failure and defeat when treating my young client. Upon further examination of this experience, I began to understand that the feelings and responses evoked within me from this experience were deeply connected to and reflective of my client's internal dynamics.

6

Theoretical Conceptualization of the Client and Treatment Implications

Given the abusive and neglectful conditions of my client's early childhood years, it is likely that her primary caretaker frequently failed to adapt to her needs. Because an infant depends on her caretaker for survival, it is in her best interests to seek out a way to maintain proximity to the caretaker. In order for my client to maintain proximity and closeness with her caretaker, she likely abandoned her needs, and moved into a state of compliance and accommodation to her caretaker's needs (Stark, 2000). This state of compliance fails to facilitate an authentic experience with the caregiver and disrupts the emergence of the true self (Safran & Muran, 2000). Instead, the false self develops as a defense or form of protection from the impinging and threatening conditions of the not-good enough holding environment (Target and Fonagy, 2003).

When I considered treatment, I decided that the modality of play would be a natural fit with my client's expressions. Because the client was naturally comfortable with the language of play, I entered her world through play and adapted to her mode of communication. Rather than implementing a modality of treatment that utilized a familiar form of communication for me such as verbal expression, I used play to create a holding environment in which I adapted to my client's needs, rather than she adapting to mine. More importantly, I choose not to use an alternate treatment modality, such as one that emphasized behavioral change, because it may have inadvertently facilitated an environment that directly equated my client's capacity to adapt to others needs to her sense of worth within a relationship.

In a Winnicottian theoretical framework, the goal of play therapy is to create a holding environment that enhances the child's expression of her true self without risk of threat, punishment, or compliance when expressing needs or desires. Through our dynamic interactions, I attempted to communicate to my client that she is a valuable person, encouraging her to understand that she has her own set of unique needs which are separate from others and that deserve attention and responsiveness. In addition to this therapeutic goal, I also attempted to create a holding environment that facilitated brief regressions to earlier developmental states. During this time, through my therapeutic actions and attunements, I made an effort to create a reparative environment to address the deficits partially facilitated by her original, impinging holding environment.

The Rupture

Despite my therapeutic intentions, the members of the child's holding environment did not recognize the value of this type of psychodynamic practice because concrete behavioral changes could not be directly and immediately attributed to the treatment process. Instead, the notion that individual therapy over time would significantly impact the child's ability to relate to others as a whole person with less distress and insecurity was dismissed because the child's problematic behaviors persisted within her home setting. The driving forces within the child's holding environment continued to express frustration regarding the lack of immediate behavioral change that failed to result from my clinical interventions. Those within the child's holding environment who doubted the effectiveness of my clinical practice stirred up feelings within me of frustration and uncertainty about my competence as a social worker.

The powerful effect of these feelings disrupted my original treatment intentions, and led me to embrace the same notion that others had regarding my client's treatment needs. For a brief moment, I wondered if my treatment strategies should be designed to produce relatively immediate behavioral changes within the child. I doubted my ability to implement this kind of

7

treatment within the context of play therapy, believing that another clinician would be better suited for the task. Consequently, I decided to thoughtfully terminate our therapeutic relationship believing that this would allow the child to participate fully with a different therapist, whom I had convinced myself was a more effective therapist. By complying with the demands of the holding environment, not only did I subscribe to the notion that behavior modifying treatment would be best suited for my client and her caretakers, but I also briefly believed that I was an ineffective therapist for the child.

The Use of Self and Healing the Rupture

As I reflected on my decision to terminate treatment, I realized that my belief that I was not the "right" social worker for the child was deeply connected to the child's belief about herself. I identified with the child's core emotional state of feeling inadequate and at risk of rejection from others. If I refused to comply with the demands of the holding environment, I would be expected to demonstrate the value of psychodynamic treatment. However, understanding that this treatment produced interpersonal change over time, I feared that without concrete evidence in the form of behavioral change to prove effective treatment, my practice would be rejected. This rejection would confirm my sense of inadequacy and incompetence. To avoid the risk of rejection, I conformed to the demands of others rather than remaining true to psychodynamic theory and practice.

My experience coincided with the child's reluctance to willingly reveal her true self to those within her holding environment. Her painful expressions of doubt and shame about never living up to the expectations of others resonated with me. Because my young client's holding environment valued her potential ability to respond to treatment with behavioral change, her belief that she is loveable only when she changes for others was magnified. This fostered the child's continued use of her false self as a defense against the rejection of others, and impeded her ability to trust that her true self would be accepted and fostered. Just as I feared that my psychodynamic practice would be unaccepted, the child feared that her true self, if revealed, would be devalued and rejected. Consequently, this fear led both of us to comply with the demands of our holding environments by changing and adapting to their needs.

A parallel process occurred between my client and me. Similar feelings of inadequacy were evoked based on our experiences within our respective holding environments. This deeper understanding of my countertransferential feelings and their relationship to the child's internal dynamics changed my role within the child's life. I decided to resist the expectations to produce immediate change within my therapeutic practice. As her clinical social worker and play therapist, I advocated on behalf of the child, providing an explanation to those within both of our holding environments that my practice would not necessarily produce immediate results. Instead, I explained the importance of producing a set of circumstances within the therapeutic holding environment that would enhance the child's development of her true self. I embraced my psychodynamic practice, declaring that a lack of immediate change within the child should not be grounds for termination of psychodynamic treatment. Furthermore, it should be recognized that the child's true self can only emerge in a holding environment that does not enhance her feelings of inadequacy by insisting that she must change. By defending my clinical practice, I essentially fostered conditions that would allow for a more confident and competent self to emerge.

By advocating for a continued therapeutic relationship with my client, I hoped to convey that she was valuable, our relationship was valuable, and her expressions during our play are

worth recognition and exploration. If our relationship had terminated because she was not demonstrating change with her home setting, the child would have experienced yet another rejection from an adult in her life, further deepening her belief that she was not valuable or good enough. Furthermore, by stating that immediate change does not always signify growth within the therapeutic process, I embraced the belief that my role as a social work practitioner was valuable to this child's development regardless of the child's ability to demonstrate immediate change. In fact, in the case of this client, encouraging immediate change would not be ideal, because changing to satisfy others would continue to promote the existence of a false self.

My efforts were successful in maintaining a therapeutic relationship with this child. She continued to utilize the process of therapy as an opportunity to practice the expression of her true self. This gradual emerging of the true self supported within the therapeutic setting enabled the child to express parts of herself that she kept out of real engagement for so long in order to protect herself from rejection by those she needs.   As her social worker, I gained a sense of clarity and satisfaction regarding my role and had the privilege to be a part of the child's growth and change over a period of time.

References

Applegate, J. & Bonovitz, J. (1995). *The facilitating partnership: A Winnicottian approach for social workers and other helping professionals.* Northvale, NJ:Jason Aronson Inc.

Fonagy, P. & Target, M. (2003). *Psychoanalytic theories: perspectives from developmental psychopathology.* N.Y.: Brunner Routledge.

Safran, J.D. & Muran, J.C. (2000). *Negotiating the therapeutic alliance: A relational treatment guild.* New York: The Guilford Press.

Stark M. (1999). *Modes of therapeutic action: Enhancement of knowledge, provision of experience, and engagement in relationship.* Northvale, NJ: Jason Aronson, Inc.

St. Clair, M & Wigren, J. (2004). *Object relations and self psychology: An introduction, Fourth edition.* Belmont, CA: Brooks Cole.

Winnicott, D.W. (1960). Ego distortion in terms of true and false self. In D. W. Winnicott (1965). *The maturational process and the facilitating environment.* Madison, CT: International Universities Press (pp. 140-152).

Winnicott, D.W. (1986). The theory of the parent-infant interaction. In P. Buckely (Ed.),*Essential papers on object relations* (pp. 233-253). New York: New York University Press.

An Analytical Framework for Policy Practice: A Value Perspective
Jane Hayes, Doctoral Candidate

Introduction

Today, the social work profession is challenged to reflect on its commitment to policy practice in the context of a conservative political ideology (Dubois & Krogsrud-Miley, 2005; Karger & Stoesz, 2006) that has and continues to dominate the national dialogue. This conservative political ideology shaped the devolution policies of the 1980s and the more recent fiscal and social welfare policies of both Republican and Democratic administrations. These policy trends contributed to an erosion of public funding for public and private social services (Gronbjerg & Salamon, 2002), eliminated cash entitlements for families with dependent children (Schneider, 2002), and opened up a debate on the viability and future of the Social Security Act of 1935. As a result of such trends, social work must consider policy practice as integral to social work in its assessment of the impact of these conservative policies on the most vulnerable of populations with whom the profession works.

Historically, the social work profession has been committed to the humanistic value of individual freedom and the democratic ideals of civic and social responsibility (Agnew, 2004). Individual freedom emphasizes the individualistic perspective of self-determination, choice, and personal responsibility; while, the democratic ideals of civic and social responsibility emphasize service and social justice (Agnew; Specht & Courtney, 1994). As the profession enters the 21st century, Ife (1997) states:

> *At the core of social work is a vision of humanity. This is expressed in various ways: the social work commitment to the worth of the individual; the continual reference to some idea of social justice; [and] the code of ethics that enshrines the values of humanism ... (p. 99).*

According to Ife, it can no longer be assumed that society has a commitment to these historical values.

It is this belief in the dignity of each human being and pursuit of justice for marginalized populations that is proposed as the foundation of any policy practice framework. Humanism places value and dignity on the individual to grow and develop within a society organized to provide resources and opportunities. Social work is intended by its mission to work with the individual for personal change and to work with society for social and political change to provide these resources and opportunities.

Therefore, policy practice is driven by the humanistic values of freedom, the dignity and worth of the individual, and the responsibility of society to ensure equal access to economic, social, and political resources to fulfill basic human needs and sustain human development (NASW, 1999). Also, policy practice is shaped by a liberal ideology that acknowledges the role of government to protect the freedom of the individual and provide equal access to resources in order to ensure the individual pursuit of interests. This liberal political ideology incorporates the values of freedom, equality, and democracy (George & Wilding, 1993). Any policy practice framework must enable social workers to view social and political activism as a continuum of practice rooted in a humanistic/social justice perspective and a liberal ideology.

Statement of Purpose

It is the intent of this paper to examine the frameworks available to social workers for policy practice. Analyzing policy requires a social worker to integrate a variety of frameworks to produce one that is applicable to the policy/political arena. It also requires that a distinction be made between policy analysis to inform decision making and policy analysis for political action. Policy analysis to inform decisions requires a social worker to maintain an objective and value neutral perspective to generate policy recommendations. Policy analysis for political action also informs the decision makers, but requires the social work policy practitioner to analyze the policy in relation to social work values as well as to take action to implement the policy. Within this policy/political arena, a framework must address substantive, value, and environmental issues. No one framework can address all these issues, thus the necessity of integrating basic concepts of a number of frameworks. The frameworks to be examined for their contribution to this discussion include the analytical descriptive ((Dobelstein, 2003), value critical (Chambers & Wedel, 2005), value committed (Chambers & Wedel), and policy advocacy (Jansson, 2003).

10

Policy Practice Frameworks

Analytical Descriptive Framework

Dobelstein's (2003) behavioral model exemplifies an analytical descriptive approach to policy analysis. This model is firmly rooted within a social science research foundation. It is a logical model requiring the policy analyst to objectively define the social problem and evaluate all policy solutions to ensure that the preferred alternative can solve the problem. For the social work policy analyst, the behavioral framework with its emphasis on scientific data and research methods provides the knowledge required to understand the specifics of the policy as well as the ability to assess the efficiency and effects of the policy solution.

Dobelstein's model gives consideration to the social values that shape the normative definition of the social problem. However, it emphasizes the significance of value neutrality in policy development.

Value Critical Framework

The value critical framework, as discussed by Chambers and Wedel (2005), emphasizes the importance of value perspectives in policy analysis. This approach allows for and encourages value laden judgments as an integral part of policy analysis in contrast to the value neutrality of the behavioral model. According to Chambers and Wedel, the analyst expects that value conflicts will exist between those operating from different frames of reference as well as conflict within the policy analyst's own frame of reference. This framework acknowledges the significance of these differing value perspectives and allows the social worker to approach the policy process prepared to analyze policy using value based criteria.

Value Committed Framework

The value committed framework (Chambers & Wedel, 2005) goes beyond the acknowledgement of the role of values in policy practice and calls for social work activism on firmly held values such as social justice. This model implies the importance of political action to advance policy that rectifies social and structural problems through a distribution of resources and opportunities. Chambers and Wedel state:

> *There are moments when they [social workers] can be plausibly called by their professional commitments to all three [analytical descriptive, value critical, value committed] of these approaches. A calling to activism is recognizable in the roots of the social work profession-a calling to actively pursue particular strongly held positions based on fundamental professional values about how things ought to be as against a very different real world (p. 67).*

The challenge then is to introduce a framework that acknowledges the significance of values and the responsibility of the social work policy practitioner to politically act to establish policy that alters conditions of social injustice.

Policy Advocacy Framework

Jansson (2003) advances a policy practice framework for political advocates. Jansson (2003) defines policy practice "as efforts to change policies in legislative, agency, and community settings whether by establishing new policies, improving existing ones, or defeating the policy initiatives of other people" (p. 13). Haynes and Mickelson (2006) advance political social work as a macro practice intervention that targets systems and structures of power for the purpose of changing policy on a local, state, or national level.

Jansson (1994) broadens the understanding of macro practice to include the significance of how political action and policy change may impact organizational and community change. The Jansson model details the tasks, skills, and competencies of policy practice, considers the context of policy development and the influence of values and ideologies, and views political action as an integral component of the model.

Discussion

Framework Linkages

All of the frameworks are consistent in their use of data to identify and describe the social problem as well as to inform policy choices. Each systematically incorporates a sequence in policy making that includes problem definition and the development of policy solutions, while acknowledging the context of values and ideologies that influence and shape the social problem and alternative policies. The frameworks also order an analysis of the efficiency and effects of the policy solution. They are consistent in determining justification for the distribution of scarce resources as well as the effects of the policy solution as to how the solution is a good and appropriate fit to solve the social problem.

Framework Distinctions

The frameworks differ in their understanding of the influence of values on policy choices, the role of the social work policy analyst in policy making, and the goal of policy practice. The behavioral framework roots its analytical process in social science data and research methods that prescribe a value neutral approach to policy choices. In contrast, the value critical, value committed, and policy advocacy frameworks acknowledge the role and significance of values and ideology in defining the problem and identifying the solutions while also utilizing the data. These frameworks integrate value criteria as a component of analysis unlike the behavioral model.

The frameworks also differ on the role of the social work analyst. According to the behavioral model, the policy analyst is to remain objective and value neutral in the process to make evident the best solution to the problem. The value critical and value committed frameworks both acknowledge the role of social work as not only analysts but policy actors who take action to change policy or impose a vision of how a society is to be through structural change. The policy advocacy framework incorporates and broadens the role beyond analyst and activist to a policy initiator (Jansson, 2003). According to this model, the policy practitioner/initiator is one who establishes a discourse with those stakeholders usually marginalized or outside of the policy making process and engages them in a process to shape and implement policy choices.

Finally, the frameworks differ as to the goal of policy practice. The behavioral model proposes that the goal of policy analysis is to address social problems through data analysis and to present the best solution. The value critical framework suggests that policy decisions are value laden and the goal of policy practice is not only to address social problems but to address political realities through analysis and change. The value committed framework adheres to the advancement of values that are considered the reality and truth, i.e., social justice. The goal of policy practice for the value committed framework is to impose such values on society through social and structural change. The policy advocacy framework proposes that the goal of policy practice is to initiate and shape policy solutions through a discourse inclusive of all stakeholders.

Conclusions

Jansson's (2003) policy advocacy framework provides a model for social work policy practice that integrates policy analysis for decision making and political action while advancing social work values. The model incorporates the concepts of the other frameworks through problem analysis, assessment of the impact of values and ideologies on problem definition and solutions as well as an analysis of the efficiency and effect of the policy choice. It distinguishes itself from the other frameworks in its proposal that policy practice incorporates practitioners as policy initiators, who act on social work values to propose policy developed in dialogue with other stakeholders and who politically advocate for the passage of the policy. According to the Jansson model, and in contrast to the other frameworks discussed in this paper, the model integrates political action for the enacting of policy as a legitimate task of the policy making process rather than an add on discussion regarding the importance of political action.

The Jansson's (2003) framework is a comprehensive approach that acknowledges policy analysis as a social science discipline, integrates values into the policy process, and places a unique emphasis on political action as a task of the policy making process. It bridges the gap between individual and policy/political practice, and incorporates concepts from the analytical descriptive, value critical, and value committed frameworks. It is applicable to legislative, organizational, and community policy and identifies the tasks, skills, and competencies to be practiced by social workers. Jansson's policy practice framework for political advocacy has great promise for social work in the 21st century.

References

Agnew, E. H. (2004). From charity to social work: Mary E. Richmond and the creation of an American profession. Chicago: University of Chicago Press.

Chambers, D. E. & Wedel, K. (2005). Social policy and social programs: A method for the practical public policy analyst. Boston: Allyn and Bacon.

Dobelstein, A. W. (2003). Social welfare: Policy and analysis (3rd ed.). Scarborough, ON, CA: Thomson, Brooks and Cole.

DuBois, B. & Krogsrud-Miley, K. (2005). Social work: An empowering profession (5th ed.). Boston: Allyn and Bacon.

George, V. & Wilding, P. (1993). Ideology and social policy. Great Britain: Guernsey Press.

Gronbjerg, K. & Salamon, L.M. (2002). Devolution, marketization, and the changing shape of government-nonprofit relations. In L. M. Salamon (Ed.), The state of the nonprofit sector (pp. 447-470). Boulder, CO: Westview Press.

Haynes, K. S. & Mickelson, J. S. (2006). Affecting change: social workers in the political arena (6th ed.). Boston: Allyn and Bacon.

Ife, J. (1997). Rethinking social work: Towards critical practice. South Melbourne, Australia: Addison Wesley Longman.

Jansson, B. J. (1994). Social policy: From theory to practice. Pacific Grove, CA: Brooks/Cole.

Jansson, B. J. (2003). Becoming an effective policy advocate: From policy practice to social justice (4 ed.). Pacific Grove, CA: Brooks and Cole.

Karger, H.S. & Stoesz, D. (2006). American social welfare: A pluralistic approach (5th ed.). Boston: Allyn and Bacon.

National Association of Social Workers (1999). Code of ethics. Washington, DC: NASW.

Schneider, R. (2002). Influencing state policy: Social work arena for the 21st century. The social policy journal, 1(1), 113-116.

Specht H, & Courtney, M. (1994). Unfaithful angels: How social work has abandoned its mission. New York: Free Press.

Passive Abuse: A Conceptual Framework for Attachment Theory and Adolescents
Stephen N. Baldridge, LMSW

The link between attachment, parental involvement and childhood behavioral outcomes has been studied at length, specifically as it relates to adjustment and success later in life. Due to the implications that early childhood behavioral difficulties and development have on later adulthood success (Fronstin, Greenberg, & Robins, 2005), it is important that attention is given to the issues surrounding familial attachment and caregiver interactions. In order to develop appropriate theories and treatment specific to this subject, research must continue to focus around the caregiver/child relationship, the variables that affect the level of attachment, and the variables that influence that attachment.

Review of Literature

There are several key concepts that a majority of the literature identifies as having direct relationships to early childhood behavioral outcomes, specifically antisocial behaviors, aggression, and more in particular, Severe Emotional Disturbance (SED). These four characteristics are single parent families, mental functioning of maternal figure, socio-economic status, and race (Kobak, Little, Race, & Acosta, 2001). A closer examination of each of these common concepts will yield a more clear understanding for future research, specifically in regards to the theory of attachment.

Single-parent families

A significant amount of research has been conducted on families without a continuous father figure and serious behavioral and emotional issues with children in those families. Studies indicate that a child in a mother-only family, or in a family that does not have one father figure throughout the key developmental years of that child are more likely to suffer from behavioral difficulties (Carlson, 2006; Carlson & Corcoran, 2001). Further research indicates that the lack of a continuous "traditional" family (one consisting of two parenting figures), or multiple disruptions within a family structure may also be an indicator of antisocial, aggressive, and other problematic behavioral outcomes (Carlson & Corcoran, 2001; Kobak et al., 2001; McLeod, Kruttschnitt, & Dornfield, 1994; Teachman, Paasch, Carver, & Call, 1998).

Data gathered in a qualitative study states that even in a traditional household, the absence of a father due to work constraints or other outside influences could possibly have the same effect on a child (Sibebotham, 2001). An additional qualitative study conducted by Ruffalo, Kuhn, and Evans (2006) suggests that children suffering from SED may compound this lack of parental involvement through the severity of their behaviors, in turn, pushing parents away.

Mental functioning of maternal figure

Another area that has ties to behavioral outcomes in children is the intellectual and emotional status of the maternal figure in a family. Children whose mothers display a high risk of depression or have generally low psychological functioning are more likely to display behavioral difficulties (Carlson & Corcoran, 2001).

In addition, mothers with higher scores on standardized IQ tests, as well as mothers with higher educational attainment, tend to have children with higher developmental levels (Crockett, Eggebeen, & Hawkins, 1993; Korenman, Miller, & Sjaastad, 1995).

Socio-economic status (SES)

Studies indicate children from chronically poor families exhibit greater behavioral difficulties and problems than those who are not (Carlson & Corcoran, 2001; Korenman, et al., 1995; McLeod et al., 1994). In additional to this, low SES can lead to other stressors that are correlated with attachment disorders, such as neighborhood violence, family instability (Kobak et al., 2001) and poor nutrition (Korenman et al., 1995).

Race

There is little to no association documented between African-Americans and Whites in regards to children's behavioral outcomes (Korenman et al., 1995; McLeod et al., 1994). The reason race plays a role in this framework, however, is there is a regular overrepresentation of the minority population in a great number of studies relating to this phenomenon (Carlson, 2006; Carlson & Corcoran, 2001; Kobak et al., 2001; Korenman et al., 1995; Teachman et al., 1998). African-American children are not more likely to be labeled with behavioral disorders, but rather they are disproportionately represented in families with lower SES and/or with single parents (Crockett et al., 1993; McLeod et al., 1994).

<div align="center">Conceptual Framework</div>

Single-parent families, mental well-being of maternal figure, SES, and race (as it relates to SES) all can be linked to interaction and attachment with a primary caregiver. Literature associates this lack of attachment with a primary caregiver to aggressive, antisocial, and problematic behaviors later on in childhood and adolescence (Shaw, Owens, Vondra, Keenan, & Winslow, 1996). Furthermore, a study conducted by Kobak et al. (2001) compared SED children to children identified as high-risk of SED (but not identified as SED) using both quantitative methods and in-depth interviewing of families. Associations were made between prolonged and unplanned separation from primary caregiver and SED children. Similar instances were not identified in the non-SED group (Kobak et al., 2001).

The significance of the four key concepts of this conceptual framework is not that they are mutually exclusive or exhaustive, but that they are very closely related. Causal links can be made among the four in outlining the theory of attachment with a focus on primary caregiver interaction relative to behavioral outcomes. As mentioned, African-Americans are more likely to live in poverty and with a single parent, followed by Hispanics, then Whites (Crockett et al., 1993; McLeod et al., 1994). Poverty, in turn, is then linked to low parental involvement. This could be due to a number of factors, such as parents working more than one job, working longer hours, working erratic schedules etc. As a result, a high proportion of single parental households with high risk of poverty are more likely to have low levels of parental involvement (Carlson & Corcoran, 2001; Crockett et al., 1993).

Mental and intellectual functioning of the maternal figure also can be linked to low parental involvement. Findings support the hypothesis that in a single-parent family, a maternal figure's psychological functioning is more likely to be lower (Carlson & Corcoran, 2001). When examining reasons why maternal mental functioning is significant, a qualitative study concluded that mothers who suffer from mental disorders are more prone to be hospitalized due to these issues, which takes them out of the family structure and away from their role as primary caregiver. Also, these mothers are typically less able to access appropriate parental supports to assist with issues faced by their children (Caneja & Johnson, 2004).

These four key concepts identified in the literature may be linked and can be traced back to the issue of parental involvement. (Appendix A). The review of the literature leads to further examination of the concept of caregiver involvement, family structure, and other aspects centering on the theory of attachment. The theory of attachment proposed here is based upon the strong assumption that a person's development is a direct result of the emotional bonds and relationships they form early in life, especially with a primary caregiver (Forte, 2007). Of Bowlby's (1988) three major theoretical assumptions, the third asserts that humans can follow a number of developmental pathways, some positive, some negative (leading to problematic behavior). Factors surrounding an individual's development, particularly interaction with a primary caregiver, have a direct impact on which path that individual will follow. This assumption is strongly supported by research on attachment and caregiver involvement with children.

Discussion

Further research needs to be conducted based on this conceptual framework. While much research has focused on the theory of attachment as it relates to physical and emotional abuse, there are definite gaps that need to be filled when examining attachment in families where overt, noticeable abuse is not so easily identified. If the phenomena discussed in this article are truly causing behavioral and emotional issues in children, it is possible that parents causing these deficits in attachment are actually harming and abusing their children passively/unwillingly. By focusing on the key concepts identified throughout this framework, researchers could possibly begin to distinguish patterns in parenting that could play a part in proper/improper attachment between children and caregivers. This identification could help in developing proper and effective interventions that could ultimately decrease the development of problematic behaviors in children.

References

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Carlson, M.J. (2006). Family structure, father involvement, and adolescent behavioral outcomes. *Journal of Marriage and the Family,* 68, 137-154.

Carlson, M.J. and Corcoran, M.E. (2001). Family structure and children's behavioral and cognitive outcomes. *Journal of Marriage and the Family,* 63, 779-792.

Crockett, L.J., Eggebeen, D.J., and Hawkins, A.J. (1993). Father's presence and young children's behavioral and cognitive adjustment. *Journal of Family Issues,* 14, 355-377.

Diaz-Coneja, A. and Johnson, S. (2004). The views and experiences of severely mentally ill mothers: A qualitative study. *Social Psychiatry and Psychiatry Epidemiology,* 39, 472-482.

Forte, J.A. (2007).*Human behavior in the social environment: Models, metaphors, and maps for applying theoretical perspectives for practice.* Belmont, CA: Thomson Brooks/Cole.

Fronstin, P., Greenberg, D.H, and Robins, P.K. (2005). The labor market consequences of childhood maladjustment. *Social Science Quarterly,* 86, 1170-1195.

Kobak, R., Little, M., Race, E., and Acosta, M.C. (2001). Attachment disruptions in seriously emotionally disturbed children: Implications for treatment. *Attachment and Human Development,* 3, 243-258.

Korenmanm S., Miller, J.E., and Sjaastad, J.E. (1995). Long-term poverty and child development in the United States: Results from the NLSY. *Children and Youth Services Review,* 17, 127-155.

McLeod, J.D., Kruttschnitt, C., and Dornfeld, M. (1994). Does parenting explain the effects of structural conditions on children's antisocial behavior? A comparison of blacks and whites. *Social Forces,* 73, 575-604.

Ruffalo, M.C., Kuhn, M.T., and Evans, M.E. (2006). Developing a parent-professional team leadership model in group work: Work with families with children experiencing behavioral and emotional problems. *Social Work,* 51, 39-47.

Shaw, D.S., Owens, E.B., Vondra, J.I., Keenan, K., and Winslow, E.B. (1996). Early risk factors and pathways in the development of early disruptive behavior problems. *Development and Psychopathology,* 8, 679-699.

Sidebotham, P. (2001). Culture, stress and the parent-child relationship: A qualitative study of parents' perceptions of parenting. *Child: Care, Health and Development,* 27, 469-485.

Teachman, J., Paasch R.D., Paasch, K., Carver, K., and Call, V. (1998). Sibling resemblance in behavioral and cognitive outcomes: The role of father presence. *Journal of Marriage and the Family,* 60, 835-848.

Conformists, Innovators, and Rebels: Adapting to the Devaluation of Social Work in Home Health Care

William D. Cabin, JD, MSW

Introduction

This article emerged from a pre-dissertation, interview-based pilot study of a convenience sample of 14 home care social workers. The interviews occurred between August-December 2006 in the New York City metropolitan area. The study goal was to explore factors influencing the decision-making process of home care social workers regarding Alzheimer's disease patients, paralleling an earlier study of home care nurses (Cabin, 2007). Both studies were prompted by a literature review indicating a dissonance between the need for psychosocial care by Alzheimer's disease home care patients, statistically-significant evidence of effective psychosocial interventions to improve patient and caregiver outcomes, and government home care policy which does not cover such interventions (Cabin, 2006a, 2006b).

The literature review also revealed there has been some research on the frustrations of home care social workers and unmet patient needs (Egan & Kadushin, 1999, 2001, 2004, 2005). However, there is no research on social worker coping strategies and no studies of the home care nurse and social worker decision-making process given this practice setting (Cabin, 2005, 2006a, 2006b). The study employed the phenomenological tradition of constructivist research (Patton, 2002). This methodological tradition aims for a rich description of the lived experience of the home care workers, allowing for themes they identify as most salient to emerge through interviews.

The pilot study a significant theme from the interviews, which is the subject of this article: The coping strategies of home care social workers working with Medicare and Medicaid home health benefits which devalue social work services for patients.

The Context: Medicare and Medicaid Home Health

Home care social workers' coping strategies cannot be understood without understanding the context of care. The context is the Medicare and Medicaid home health benefits which are the primary payers for nearly 2 million Medicaid and 3million Medicare home health recipients annually (National Association of Home Care and Hospice, 2006; National Center for Health Statistics, 2006). Medicare currently spends $13 billion or more annually and Medicaid spends $5 billion or more annually for home health care services (Health, United States, 2006; Medicare Payment Advisory Commission, 2005).

Medicare and Medicaid home health are based on an acute care medical model, requiring that eligible patients be homebound; in need of skilled, part-time or intermittent skilled nursing care or physical therapy; and have a condition with a finite and definite end point, all as prescribed by a physician-certified plan of care (Health Care Financing Administration, 1999). If the requirements are met, the patient may receive additional skilled nursing, physical therapy, speech therapy, occupational therapy, home health aides, or social work services. Physical

therapy and skilled nursing represent an estimated 72% of national home health visits (Medicare Payment Advisory Commission, 2003, 2004a).

Medicare regulations do not permit social workers to initially assess clients or develop the plan of care. Nurses, or in some instances physical therapists, must initially assess and develop the client's plan of care for physician certification. Covered social work services are limited to assessing the client, only upon a nurse or physical therapist referral; assisting the client to obtain community resources, though social workers may not assist the client or family in completing Medicaid or other applications; and making two to three counseling visits to the client's family member or caregiver, only if designed to remove a clear and direct impediment to client treatment or rate of recovery (Centers for Medicare & Medicaid Services [CMS], 2006). As a result, social work historically represents only 1-2% of all national Medicare home health visits (Medicare Payment Advisory Commission, 2003, 2004a, 2004b). There is even less use of social work services in Medicaid home health because social work is not a required service under federal Medicaid basic benefit legislation, with estimates at less than 1% of all Medicaid home health visits (National Association for Home Care & Hospice, 2006).

Further evidence of the limited coverage and value granted social work is the small number of social workers employed in Medicare-certified home health agencies. In 2003, social workers were second only to occupational therapists with fewest full-time equivalent (FTE) employees in all Medicare-certified home health agencies. There were 4,598 social worker FTEs compared to 132,691 nurse FTEs, 53, 332 home health aide FTEs, and 16,693 physical therapist FTEs (National Association for Home Care & Hospice, 2006).

Merton's Typology of Individual Adaptation

In reviewing interview transcripts for common themes, it became apparent that Merton's five mode typology of individual adaptation to cultural goals and institutional means might provide a useful analytic framework (Merton, 1957). While Merton's typology was aimed at broader cultural norms, social structure, and political and social action, it conceptually appeared applicable to individual coping strategies and organizational goals. Merton's first type was the conformist who accepted goals and their institutionalized means of achievement. Second was the innovator who accepted the goals, but devised different means of achievement. Third was the ritualist who scaled down or modified goals to increase likelihood of achievement while accepting the institutional means of achievement. Fourth was the retreatist who retreated virtually into their own world, creating different goals and means of achievement. Fifth was the rebel who viewed the goals as either totally or partially illegitimate and used a combination of existing institutional means and new means to achieve their goals.

Three modes of adaptation to the Medicare requirements which devalue social work emerged among the 14 social workers' description of their practice experience. One was *the conformist*, who adhered almost mechanically and rigidly to the organization's policy and procedures, regardless of perceived patient need. At the other extreme was *the rebel* who modified or replaced organizational requirements with their personal and professional care standards when they believed the organizational goals frustrated fulfillment of patient need. In the middle was *the innovator* who adhered to corporate policy and procedure, but tried to create flexibility to meet more patient needs than would be met under the conformist's strict interpretation. Most of the social workers (9) were *conformists*; some (3) were *innovators*; and few (2) were *rebels*.

The Conformist

The conformist is the ultimate organization person, taking the agency's corporate care guidelines as gospel, regardless of patient need. Corporate guidelines typically focus around on the Medicare Home Health Agency Manual coverage guidelines (Health Care Financing Administration, 1999) and Medicare home health prospective payment system (PPS) which was implemented nationally October 1, 2000. PPS intensified the link between fiscal requirements, practice, and care delivery by linking reimbursement to a mandatory national home health assessment instrument. The seventy (70) item instrument is the Outcome and Assessment Information Set (OASIS), which is used for reimbursement and outcome measures (Medicare Payment Advisory Commission, 2003, 2004a). An OASIS form is used for each patient's initial admission to a sixty-day care episode, renewal for subsequent sixty-day episode, transfer, and discharge. Twenty-three (23) of the OASIS items are used to score the patient into one of over eighty (80) Home Health Resource Groups (HHRGs), which are the basis for agency reimbursement during the sixty day period.

With the advent of OASIS and PPS, home health agencies are allowed to operate on a risk basis, keeping Medicare revenues exceeding cost while absorbing losses. As a result, here has been increased focus on limiting visits per episode to ensure costs are less than the HHRG payment (Medicare Payment Advisory Commission, 2003, 2004a, 2005).

> *I just do what I'm told. It's no different than ever. Social work is*
> *not viewed as important. It's all about the wound, or the hip, the*
> *diabetes, the urinary problem. It's about medical issues. The*
> *people part is irrelevant. So, if I get a referral, I just do what*
> *little I can and block out the patient's needs. (Social Worker AC)*
>
> *I started doing home care twenty years ago. I thought it would be*
> *fullfilling. Then I realized there's no social work in home care. It's a*
> *joke. At first I complained about us not dealing with patient needs.*
> *It made no difference. I had to make a choice: leave or stay and*
> *accept the routine. I stayed. They tell me how many visits to do and*
> *that's what I do. Life is too short to be Don Quixote. (Social Worker TD)*

The Innovator

Despite the focus on acute care and PPS, there are some social workers who attempt to find flexibility in the corporate guidelines.

> *There's always room for more than meets the eye. You have to be a bit*
> *assertive with the nurses, but not too pushy. I talk to them informally*
> *and usually always they'll refer me an assessment visit. Some even let*
> *me come on their initial assessment. I find I can identify and communicate*
> *the patient needs better with the nurses. I usually get more social work*
> *visits from them, which is the whole point. If I do not get in early and*
> *politely to the nurses, then the patients get less. (Social Worker LS)*

The Rebel

Social work has a long history of advocating for social justice (Mullaly, 1997; Reisch & Andrews, 2002) and the NASW Code of Ethics presents social justice and advocacy as ethical

obligations for social Workers (NASW, 2003). There are some home care social workers who heed the call.

> *I became a social worker to help people. I never expect the system to be fair. If it was fair, there'd be no need for social workers. I go to work every day ready to fight for my client. I constantly meet and call nurses and therapists. I push them for social work referrals. Once I get them I do what is needed. I don't care if they ordered only two visits. If I feel four or five or more are necessary, then I do it and explain after. The nurses usually don't have a problem. They know there's more need for social work. They just don't want to get in trouble authorizing a lot upfront. I make it easy for them. They blame it on me, I take the flack, and the patient benefits. That's my goal, help the patient. (Social Worker CA)*

<div align="center">Research, Policy, and Practice Implications</div>

These findings are from a small non-randomized sample and, as such, are not generalizable. However, the qualitative research goal was exploratory and not intended to produce generalizable results (Patton, 1990, 2002). They provide insights as to the range of coping strategies used by social workers. These insights inform current and future practitioners on effective options for balancing regulatory compliance, professional ethics and meeting patient needs. From a research and theory-building perspective, the findings also indicate the utility of the Merton (1957) typology in sorting through a myriad of responses. The typology might be used further in a more extensive, national qualitative study or possibly a mixed method study using interviews, focus groups and a survey of home care social workers. From a policy perspective, the responses and regulatory data indicate a need for advocacy by the National Association of Social Workers (NASW) for a more robust home health social work benefit. To date, NASW has not viewed home care as a worthy topic for policy advocacy. In its 376-page (excluding index and NASW Code of Ethics) *Social Work Speaks, NASW Policy Statements: 2003-2006* (2003), there is one, fourteen line paragraph about home care and it does not advocate increasing home care social work coverage.

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

Cabin, W. D. (2005). Palliative home care for Alzheimer's disease patients and Caregivers. Unpublished paper. February 13, 2005. New York: Hunter College School of Social Welfare.

Cabin, W. D. (2006a). Medicare fiscal requirements' impact on home care nurses care decisions for Alzheimer's disease patients. Unpublished paper. May 27, 2006. New York: Hunter College School of Social Welfare.

Cabin, W. (2006b). The phantoms of home care: Home care nurses' care decisions for Medicare home health Alzheimer's disease patients. Unpublished paper. July 14,2006. New York: Hunter College School of Social Welfare.

Cabin, W. D. (2007).The phantoms of home care*:* Home care nurses' care decisions for Medicare home health Alzheimer's disease patients. *Home Health Care Management & Practice, 19* (3), 174-183.

Egan, M. & Kadushin, G. (1999). The social worker in the emerging field of home care: Professional activities and ethical concerns. *Health & Social Work, 24,* 43-55.

Egan, M. & Kadushin, G. (2001). Ethical dilemmas in home health care: A social work perspective. *Health and Social Work, 26*(3), 136-149.

Egan, M. & Kadushin, G. (2004). An exploratory study of social work practice under the Medicare prospective payment system in home health care. *Journal of Social Work In Long Term Care, 3*(1), 43-60.

Egan, M. & Kadushin, G. (2005). Managed care in home health: Social work practice and unmet client needs. *Social Work in Health Care, 41* (2), 1-18.

Health Care Financing Administration (1999). *Medicare home health agency manual* (HCFA Publication No. 11). Washington, DC: U.S.Government Printing Office.

Centers for Medicare and Medicaid Services (2006). Retrieved July 15, 2006 from: *Coverage guidelines for Home Health Agencies, Medicare Reference Guide, September 2005, 190.* Retrieved July 15, 2006 from http://www.cahabagba.com

Medicare Payment Advisory Commission (2003). *Report to the Congress: Medicare payment policy.* Washington, DC: Medicare Payment Advisory Commission

Medicare Payment Advisory Commission (2004a). *Report to the Congress: Medicare   payment policy.* Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission (2004b). *Home health services payment system.* July 13, 2004. Washington, DC: Medicare Payment Advisory Commission.

Medicare Payment Advisory Commission (2005). *The home health payment system:Presentation to Senate Committee on Finance staff.* March 28, 2003 by Sharon Bee Cheng. Retrieved December 5, 2005 from: http://www.medpac.gov

Merton, R. A. (1957). *Social theory and social structure.* Revised edition. Glencoe, IL: The Free Press.

Mullaly, B. (1997). *Structural social work: Ideology, theory, and practice* (2d Ed.).Don Mills, Ontario: Oxford University Press.

National Association for Home Care & Hospice (2006). *Basic statistics for home care.* Washington, DC: National Association for Home Care & Hospice.

National Association of Social Workers (2003). *Social work speaks: National Association of social workers policy statements, 2003-2006.* Sixth edition. Washington, DC: NASW Press.

National Center for Health Statistics (2006). *Health, United States, 2006.* Hyattsville, MD: U. S. Government Printing Office.

Patton, M. Q. (1990) (2d Ed.). *Qualitative evaluation and research methods.* Thousand Oaks, CA: Sage.

Patton, M. Q. (3rd Ed.) (2002). *Qualitative research and evaluation methods.* Thousand Oaks, CA: Sage Publications, Inc.

Reisch, M. & Andrews, J. (2002). *The road not taken: A history of radical social work in the United States.* New York: Brunner-Routledge.

Conceptualizing Gender Equity in Indian Health Care System
Ankita Deka, Doctoral Candidate

Ensuring gender equity in access to basic services has remained an enduring challenge in the political economy of social policy development in most nation states. In India, an analysis of the problem of lack of access to basic services like health care assumes significant complexity, as poverty interplays with structural inequities arising out of caste, class and gender. Gender based differences are not unique to India as they have been the fundamental characteristic of most human societies and they impact all aspects of an individual's political, socio-cultural , economic and intra-psychic life (Chafetz,1990). However, gender based discrimination has existed in the fabric of the Indian social system for a very long time and has adversely affected women's development. Gender inequity in access to basic services, stems from the way the gender roles ascribed by society impact the way resources and rights are distributed amongst men and women. Therefore, inequity in health care access is also characterized by the way resources are allocated, distributed and utilized by men and women in India (Thukral, 2002).

Since independence India has made some strides regarding its health status. Much of this development has been spearheaded by knowledge and technological development. The paradox of the development of technology and knowledge to combat degenerative diseases is that it has also led to greater polarization in access to sophisticated treatments. Women in India continue to die from child-birth related complications, pregnancy, malnutrition and common infections. In a report published by the World Bank in 1991, there were indications that in spite of persistent health risks amongst women in India, studies of health care usage show that women continue to use less health care services.

In India women's health status is not an issue of mere bio-medical analysis but it also calls for deep research and interventions on the intrinsic relationship between physical health and social status. This paper examines the socio-political, cultural and economics of women's health in India.

Context of Inequity

Equity is a broad and elastic term that has connotations to ideas of social justice. Inequity is distinctly different from inequality as it refers to those inequalities which are unjust and artificially created. Equity in health can refer to minimizing disparities in prevention, diagnosis and cure of physical and mental health amongst groups with varying degrees of social status and privilege. Discrimination against the female child starts from childhood in the family when she gets less nutrition, health care, education and other goods as compared to the male child (Thukral, 2002). Research indicates that women are considered to be both economic and social burdens for families though women contribute in many ways to the family economics. The invisibility of women's work which is mostly relegated to the household and is 'unpaid' is termed as 'unproductive'. Besides, women are primarily viewed as caregivers and nurturers even when they have sufficient presence outside their homes. The social neglect of women results in their low levels of education and access to resources and it exerts a negative impact on their health status.

In a discussion of lack of access to basic healthcare there is an imperative to introspect on the relationship between gendered poverty and how it impacts women's access to services. In India women are overrepresented amongst the poor. India holds the dubious record for the highest number of poor living in a single country (Thukral, 2002). About 26% of its rural population and 12% of its urban population live under conditions of abject poverty (Deaton & Dreze, 2002). However, given women's low status in society same social phenomenon like poverty affects women more adversely than men. Poverty is a multi-dimensional phenomenon that goes beyond hunger and malnutrition. It is characterized by incidences of high morbidity rates, higher mortality, lack of access to basic services like health and housing; it also signifies exposure to unhealthy and unsafe living environments (Ghosh, 1998). Women have less personal and institutional means of support to overcome poverty, as their assets, skills, options and education are limited by their social status.

A Framework to Analyze Gender Inequity

In analyzing the issue of gender inequity in India it is important to engage in a historical and contemporary analysis of gender relations. The colonization, decolonization and national development process in India influenced the framing of gender relations. The colonial project was a handiwork of nineteenth century sexual, racial and class based institutions (Mohanty, 1991). The colonialism process blended very well with the already existing gender discriminatory ideologies present in the fabric of the Indian social system. The post-colonial nation state was unprepared to deal with the conflict between national agendas and inegalitarian development trends. This conflict created further handicaps for women as they struggled between their traditional roles and the promise of modern freedoms (Rajan, 1993). The problem of access to health care is rooted in the ambiguities of the nation state which have perpetuated the construction and institutionalization of hypothetical gender relations in the first place. In relation to India the problem of gender inequity and access to basic services like health care takes a new dimension given the spate of socio-economic and political changes the country has

22

encountered in the last decade. Economic reforms were initiated in India in 1991, following a severe balance of payment crisis (Prabhu, 2001). The reforms have brought about significant changes in the government expenditure patterns in the social services. Economic transformation alters the process of redistribution of economic and social goods. Given women's low entitlements, lack of access to credit, land, lack of information about the markets and low skills, women, particularly the poor have been virtually excluded from the gains of globalization (Murthy, 2001). In fact, in times of such economic transition women bear the extra burden as their work load increases but their consumption of even basic goods decreases.

Amongst other goods the Indian government was committed to delivering universal comprehensive health care, while the budgetary constraints resulted in this promise remaining unfulfilled. However, the issue remains that in the absence of public health services, women and other vulnerable groups with low entitlements will be left without access to critical health services. Relying on private health care alone will not be sufficient in providing equitable health care, as access to private care is associated with high costs which in turn affect health care utilization by vulnerable groups.

The shrinking role of the public sector health delivery system owing to the market reforms has exacerbated the problem of access for women. While there is a strong need for private sector health care the state cannot withdraw itself from providing basic services to groups and individuals who cannot access private goods. Ironically, however, even in states that have ensured public spending of health care services the vulnerable groups have very little access to the system and it is mostly the rich who avail the services .The development of the private sector health-care has resulted in super-specialty hospitals and diagnosis centers, however, there access is patronized only by the very affluent class.

<center>Effects of Gender Inequity in Health-Care</center>

Maternal mortality rates are very high in India about 453 deaths per 100,000 births (Velkoff & Adalakha, 1998). Maternal mortality rates are preventable in the presence of access to adequate health services during the pregnancy period; however, most women lack access to prenatal and other referral services (International Institute for Population Sciences, 1995). The absence of government health care facilities and rising costs of private health care can be attributed as the persistent causes for low health care utilization by women. Besides, waiting time at clinics, distance to health care facilities are also other factors associated with health care access and utilization (Borah, 2006). Indian women face considerable health risks from high levels of fertility and their childbearing age exposes them to a host of physical and mental health problems. Because of strong son-preference women undergo multiple pregnancies in most parts of India in association with closely spaced births. Given women's low status and education levels women are mostly unaware of the ill-effects of sexually transmitted diseases including HIV/AIDS. Even when they have some information given their status it is highly unlikely that they will have any say in taking precautionary steps to limit their exposure to the risks. The prevalence of female feticide and infanticide has also been cited as extreme cases of gender bias in India (Thukral, 2002).

Women in India particularly in rural agricultural areas work arduously both in the household, on family lands or other jobs to supplement their family's income. However, their poor nutritional status as compared to males puts a lot of strain on their health. Women are also exposed to hazardous working conditions like smoke from the kitchen fire which has adverse health effects. Besides, a large number of poor low-skilled Indian women work in the informal

sector economy which characterizes poor working conditions and health hazards. It is also significant that the faulty socialization process, neglect and discrimination both within and outside the family leave women very vulnerable to both physical and mental health issues. However, there is a big gap in literature on the associations between women's social status and their mental health. The second National Family Health Survey by International Institute of Population Sciences in 1998-1999 reports that only 52% of Indian women are ever consulted on issues pertaining to their health. In many cases women simply lack the freedom to access basic health care. Factors like unavailability of female health care providers, and distance to the clinic also create cultural constraints for women seeking health-care.

Discussion

The poor state of health of women in India is clearly linked to their social status. Historical and contemporary forces have reinforced the gender disadvantage pertaining to the problem of access. In order to improve women's health status and create opportunities for access to health services, institutional changes have to be incorporated. Policy makers should take into account that institutions both public and private have to be transformed to ensure gender equity. Merely instituting policies can never address a problem that has taken such deep roots. The role of the state vis-à-vis the market has to be analyzed from the gender perspective. Health is intrinsically linked to other indicators like education, income, social mobility etc and therefore any intervention to improve women's health status calls for a holistic intervention amongst various stakeholders namely the family, state and civil society. As India emerges from the shadows of a reticent developing economy into a global leader it needs to address the issues of gender inequity. The socio-political and economic development of India is still a mere rhetoric in the face of such persistent inequity. The challenge of the development dialogues is to address this inconsistency.

References

Borah, B. J. (2006). A mixed logit model of health care provider choice: Analysis of NSS data for rural India. *Health Economics*, 15, 915-932.

Chafetz, J. S. (1990). *Gender equity: An integrated theory of stability and change*. California: Sage.

Deaton, A., & Dreze, J. (2002). Poverty and inequality in India: A re-examination. *Economic and Political Weekly,* 3729-3748.

Ghosh, J. (1998). Assessing poverty alleviation strategies for their impact on poor women. Geneva: United Nations Research Institute for Development. Retrieved July 25, 2007 from http://www.unrisd.org/unrisd/website/document.nsf/0/B07EE8CF48E690CC80256B67005B7038?OpenDocument.

International Institute of Population Sciences (1998). *Second national family health survey*. Mumbai, India: International Institute for Populations Sciences.

International Institute for Population Sciences (1995). *India national health survey 1993-94*. Mumbai, India: International Institute for Populations Sciences.

Mohanty, C. T. (1991). Cartographies of struggle: Third world women and the politics of feminism. In Mohanty, C. T., Russo, A., and Torres, L. (Ed.), *Third world women and politics of feminism*. Bloomington, USA: Indiana University Press.

Murthy, R. K. (2001). Introduction. In Murthy, R. K. (Ed.)*, Building women's capacities: Interventions in gender and transformation.* New Delhi: Sage.

Prabhu, K. S. (2001). *Economic reforms and social sector development: A study of two Indian states*. New Delhi: Sage.

Rajan, R. S. (1993). *Real and imagined women: Gender, culture and post-colonialism.* London: Routledge.

Thukral, E. G. (2002). Poverty and gender in India: Issues for concern. In Edmonds, C. and Medina, S., (Ed.), *Defining an agenda for poverty reduction*. Manila, Philippines: Asian Development Bank.

Velkoff, V., & Adalakha, A. (1998). Women's health in India. Washington, D.C.: United States Department of
        Commerce. Retrieved August 1, 2007 from http://www.census.gov/ipc/prod/wid-9803.pdf.
World Bank (1991). *Gender and poverty in India*. Washington, D.C.: World Bank.

_____

Still Forcing Back the Color Line: Implications for Social Work Research and Practice
Julia M. Wesley, MSW

Introduction

        In 1903, William Edward Burghardt DuBois reported that the problem of the 20th century
was the problem of the color line. The color line symbolized relations between the darker and
lighter races throughout Asia, Africa, America and the islands (DuBois, 1903). Shortly after
Emancipation, the color line facilitated the disenfranchisement of freed Blacks in the United
States (U.S.). Slavery had been abolished but the color line continued to hold back justice for
freed Blacks newly cast as wards of the state, requiring financial and social governance and
protection. DuBois (1903) indicated that "despite compromise, war, and struggle, the Negro
[was] not free" (p. 28). Instead, the social, economic, and political existence of freed black men
was volleyed between the political positions of the divided North and South. Three years later,
DuBois (1906) reported that Blacks had begun to force back the color line. A small number of
Blacks formed independent groups, became land owners, and participated in unions. Numerous
Blacks sacrificed immediate gratification and often risked their lives for social, economic, and
political rights. However, these achievements and sacrifices were associated with negative social
and economic costs. Aware of this quandary, DuBois (1906) stated "Negroes have forced back
the color line, but undoubtedly increased the color-prejudice of workingmen by so doing" (p.
239).

        More than a century later, it appears that the color line and the quandary remain. There
are indeed implications for 21st century social work research and practice, but the problem of the
color line is scarcely tended to in recent social work literature. Thus, the problem of the color
line, the forcing back of the color line, and 21st century relevance are discussed in the following
sections. Based on DuBois' writings, the first section provides a historical overview of how
Blacks struggled to force back the color line in the 20th century. The second section extends the
color line discussion to the 21st century. It provides a critical review of a 2007 national
conference on race and its salience for current social and economic issues. The final section
discusses implications for social work research and practice.

Forcing Back the Color Line

        DuBois (1906) projected that the economic future of Blacks hinged on the unhindered
uplift of the independent group, comprised of educated and talented Black professionals. These
Black professionals were former house servants who had become teachers, barbers, physicians
and businessmen and whose clientele had been built from within the Black community (DuBois,
1906). DuBois proudly implicated the independent group as being equivalent to middle class
White Americans. The independent group networked and established various self-help
organizations with the expressed aim of building economic capacity within Black communities.
Unfortunately, only having Black clientele limited the professional development and economic
growth of the independent group (DuBois, 1906).

        Unionizing was a very important impetus for economic betterment among working class
Blacks. Black worker demands for higher, more equitable wages were met following protests

and strikes. However, economic battles were often won at the expense of social benefit, such that child labor and length of workday increased. This became a negative consequence for both Black and White workers. The Southern Black farmer was perceived to be well off because of his White and Black clientele and his status as a share cropper or land owner. DuBois (1906), however, revealed that if black farmers appeared to make too much money, White clientele took their business elsewhere. With regard to land ownership, the land was worth so little that from an economic standpoint, the farmers were still quite poor. Given these challenges, DuBois reported that racial uplift and union battles were not enough. Despite obvious advancement and hope, the negatives would soon outweigh the positives. It would seem that collaboration across difference, instead of independence was paramount to building the economic capacity of Blacks. In fact, DuBois (1906) asked:

> How long will it be before the White working men discover that the interests that bind him to his black brother…are greater than those that artificially separate them? …[T]hat discovery will not be made until the present wave of extraordinary prosperity and exploitation pass and the ordinary every day level of economic struggle begins. (pp. 239-240)

Forcing Back the Color Line in the 21st Century

Over 100 years later, scholars report that the problem of the color line persists. Squires and Kubrin (2007) report that urban metropolitan areas are characterized by sprawl, concentrated poverty, and segregation by race. These conditions are compounded over time and result in perpetual social and economic isolation. As a racial group, Blacks (12.6%) had the highest percentage of individuals below 50 percent of their 2004 poverty levels. According to Fronczek (2005), "[f]or those below 50 percent of their poverty level, being in poverty may be a chronic situation and they may have the hardest time moving out of poverty" (p. 18). How can social work researchers and practitioners help address this problem without fueling race prejudice?

In March 2007, the Applied Research Center (ARC) sponsored *Facing Race*, a national conference on racial justice held in New York, which began on Thursday, March 22, 2007 and ended on Saturday, March 24, 2007. The purpose of this conference was to go beyond pondering the concept of racial justice by facilitating strategy and successful model dissemination. ARC, which is headquartered in Oakland, California, is a public policy institute that focuses on racial justice research, advocacy, and journalism. Angela Glover Blackwell (PolicyLink Founder and Executive Director), Winona LaDuke (White Earth Reservation, 1996/ 2000 Vice Presidential candidate), and Juan Gonzales (co-host of *Democracy Now*) were notable panelists at the conference. Each panelist fielded impromptu questions from the audience instead of reading prepared speeches. To start, plenary panelists answered tough questions about race and in particular, if the problem of the "color line" persists in the 21st century. In addition, the audience asked panelists which issues "defined" racial justice, how to approach White House transition, and strategies for bringing structural racism into the policy arena.

Redefining the Color Line

Each of the panelists indicated that the color line is still the problem of the 21st century, but that the U.S. color line issue has been globalized and "digested". Today, natural disaster relief, immigrant rights, criminal justice, community planning, child welfare, education, and healthcare inequities appear to be facilitated by a multi-dimensional color line. It's no longer just about relations between Asia, Africa, America and the islands. The new color line represents

relations within and between the darker races as well between the lighter and darker races throughout the world and America. LaDuke (personal communication, March 23, 2007) commented that people of color have digested the dominant culture's Eurocentric worldview and are now "facing [the] need for decolonization". This point tied well with Blackwell's (personal communication, March 23, 2007) point that structural racism is "baked-in" to zoning, housing, transportation, healthcare, and policing strategies and related institutions. Gonzales (personal communication, March 23, 2007) indicated that each new generation of immigrants buys into unjust oppression toward other minorities.

Strategies for Racial Justice

Blackwell (personal communication, March 23, 2007) argued that it is extremely problematic that "where you live is a proxy for opportunity" and that the way citizens think of government needs to change. She posited that the Department of Housing and Urban Development (HUD) be disposed of altogether. Although a bit idealistic considering the current bipartisan "affinity" to HUD, this comment was intriguing. Blackwell's position is very similar to the civic outrage that prompted civil rights amendments to the housing and community development block grant program during the 1970s. While these amendments codified civic participation, bureaucrats refused to put enforceable language in the law and certainly not in the regulations. Over 30 years later, not surprisingly, the every day citizen still has little voice. Gonzales (personal communication, March 23, 2007) displayed maps that showed how urban areas are being "re-designed" and then stated that it is time to "take back the cities for those who live in them". LaDuke summed up the discussion with her position on sustainability, "The U.S. Government is about conquest…we encourage refugees…a house based on conquest is not sustainable" (personal communication, March 23, 2007).

Fortunately, at least one strategy for forcing back the color line while building sustainability has proven itself to be fairly successful in both the 20th and 21st centuries. That strategy is indigenous participation and leadership. Efforts to force back the color line during the 20th century might have been impossible without indigenous participation, organization, and leadership. Current social work literature shows that indigenous engagement and leadership development is essential for sustainability. Facing Race provided two workshops on community organizing, which were facilitated by The Center for Third World Organizing (CTWO), based in Oakland, CA. These invaluable workshops fused 21st century self-help strategies with the political strategies used to resolve 20th century union conflicts. The first was entitled *Stirring the Pot: Introduction to Community Organizing* and the second was *How to Win: Developing Great Campaign Strategies*. These comprehensive "mini" trainings included a clear understanding of the distinct roles and limitations of service providers, how to mobilize existing and external human, financial and political resources, and finally, how to develop issue campaigns. Neither workshop romanticized the conditions of those with limited power. Instead, both helped workshop participants tease out variables critical to empowerment and consciousness-raising organizing tactics.

Implications for Social Work Research and Practice

The strategies presented in this paper are not only consistent with social work's history, but are in keeping with the National Association of Social Worker's (NASW) mission to enhance the well-being of people, while helping vulnerable populations become empowered to meet their basic human needs (NASW, nd). Today, unlike any other time in history, this mission is a

framework for social work research and practice worldwide. Nonetheless, it is likely that other worldviews may help inform Western world research and practice. Gonzales recommends that we look to other countries for models of social change, since of late; the U.S. has not been the leader. For instance, a little more than 2 years after the 2004 Asian Tsunami, an NPR (2006) reported that a resident said, "I arrived two days after the tsunami…I'm constantly amazed to see the extent to which reconstruction occurred". Although reconstruction in Indonesia is moving much slower than projected, initial relief efforts were reportedly "extraordinary". There is evidence that a considerable amount of progress was related to the grassroots and collaborative spirit of the relief effort. Thus, a rigorous evaluation of Indonesian relief and rebuilding programming following the Tsunami may yield helpful social work strategies, particularly for rebuilding post Hurricane Katrina.

Conclusion

Despite social and economic growth among people of color, there is considerable evidence that the problem of the color line persists in the 21st century. Because this problem does appear to be "baked-in" into the systems that govern daily life, racial prejudice is less obvious. However, statistics show that the effects are too profound to ignore. Forcing back the color line is certainly about social work leading the way in addressing broader socioeconomic inequities head on. It is about social workers being uninhibited in addressing root causes. Finally, social workers can help give meaning to the overused term "empowerment". This means going beyond facilitation and forging solidarity with people of color toward social, economic and racial justice. Without radical attention here, the forcing back of the color line will continue to be slow, resulting in greater harm than good for everyone.

References

DuBois, W. E. B. (1903). *The souls of black folk*. Virginia: University of Virginia Library Electronic Text Center. Retrieved May 17, 2007, from http://etext.virginia.edu/toc/modeng/public/DubSoul.html

DuBois, W. E. B. (1906). The economic future of the Negro. *Publications of the American Economic Association, 3rd Series, 7*(1), 219-242.

Fronczek, P. (2005). Income, earnings, and poverty from the 2004 American community survey. *American Community Survey Reports* [Electronic file: ACS-01 August 2005 US Census Bureau, Department of Commerce]. Retrieved April 7, 2007, from http://www.census.gov/prod/2005pubs/acs-01.pdf

NASW (nd). *Code of ethics of the National Association of Social Workers: Preamble*. Retrieved March 30, 2007, from http://www.socialworkers.org/pubs/code/code.asp

Squires, G. D., & Kubrin, C. E. (2007, March/April). Privileged places: Race, opportunity, and uneven development in urban America. *Focus Magazine, 35*(2), 6-7.

Sullivan, M. (2006, December 26). Two years on: Tsunami relief is lagging. *NPR*. Retrieved May 2, 2007, from URL: http://www.npr.org/templates/story/story.php?storyId=668241

Bookworm's Corner

Book Review
Morris, A. D. (1984). *The origins of the civil rights movement: Black communities organizing for change.* **New York: The Free Press. Reviewed by Melinda Pilkinton, MSW, LCSW, ACSW**

Although Mr. Morris' work is more than two decades old, it remains a definitive chronicle of the history of the African American Civil Rights Movement in the United States. Mr. Morris researched archival records and conducted personal interviews with forty-nine significant personalities of this movement to document the story. The depth of his research is admirable. In this book, the story of civil rights is told for posterity. The rich details augment the telling of the history and, in part, serve to correct some of the previously held erroneous beliefs about the movement. Within and beyond the details lie incredible stories of courage, persistence, sacrifice, honor, pride, and evidence of such moral responsibility that one is inspired by the actors.

Additionally, the author critiqued the movement based on three theories: classical collective behavior theory, the theory of charismatic movements, and the resource mobilization theory. The theories provided a framework for both positive and negative comparisons.

While Mr. Morris did not entirely agree with the precepts of the aforementioned theories, he did express some agreement with segments of the theories. Primarily, he agreed that collective behavior theory involves the goal of social change, which was applicable to this movement. He differs with the concept regarding the absence of planning and organization. In collective action theory, the presence of planning and organizational activities is absent and the use of existing organizations is not typically found; thus, the events of the Civil Rights Movement do not mesh with this aspect of the theory, according to Mr. Morris.

Charismatic theory posits that individuals possess specialized skills or talents that contribute to their attractiveness and ability to perform needed functions in movements. Mr. Morris agreed that charismatic theory applied to the Civil Rights Movement in that Dr. King was highly visible, a gifted orator, and extremely motivational to the followers of the movement. According to charismatic theory, indigenous leaders arise during stress and chaos, do not adhere to formalized rules, and, moreover, if charismatic leaders are to remain leaders, they must become more rational and routine leaders. Morris departs from the theory in his analysis regarding Dr. King's influence. Dr. King remained a significant motivational force throughout his involvement in the movement and following his assassination. Additionally, the existence of charisma within the movement (possessed by Dr. King as well as many other leaders) was evident in the leaders' communities before the escalation of the Civil Rights Movement. In this case, charisma was not borne of spirited crowds and circumstances, it already existed.

Resource mobilization theory addresses the availability of resources needed to carry out the movement's work. Mr. Morris agreed with the application of resource mobilization theory with some reservations. Primarily, in accordance with the theory, Mr. Morris contended that the resources necessary for the movement existed within the Black community in the form of churches, the generosity of individuals, and communication networks. He disagreed that a significant portion of the resources were provided by liberal Whites. Although he acknowledged that contributions from Whites existed, he denied that the bulk of donations that funded the Civil

Rights Movement were from Whites and emphatically asserted that Black communities contributed heavily, particularly through their churches.

The strength of this book is that it provided an overview of a grassroots movement that served to change many existing laws, mores, and traditions of the times. In the field of social work, practitioners are called on to mobilize individuals, advocate for increased resources, and to facilitate the empowerment of others in order to obtain necessary changes to benefit clients. Mr. Morris provided numerous examples of the work of the civil rights leaders and the courage of ordinary citizens who were weary of their 'second-class' status. These inspiring histories are motivational for those who desire to help others. This book has relevance in the regard that basic human needs are universal and that the social work profession is charged with helping to alleviate the needs of vulnerable populations by the most effective means possible. In spite of the age of this work, social workers should find it to be meaningful for social justice and advocacy issues.

Mr. Morris' story is replete with examples of the phenomenon of a few individuals who wanted societal change who were able to build a ground swell of enthusiasm for the effort. Communication, networking, and brainstorming were significant factors in the planning process. In this manner, the smallest group often grew to large numbers of individuals who were willing participants in the action. Additionally, the primary actors of the Civil Rights Movement had a profound sense of social capital and influence which were heavily used throughout the entire movement. The leaders recognized the strengths and weaknesses of individuals, the pertinent skills these individuals had to offer, and whether or not the person could withstand public exposure or scrutiny. All of these skills are essential daily tools in macro practice as well as in other areas of social work.

_____
Book Review
Simmonds, J. (2006). Children in change: A group curriculum for kids ages 8-14 who are experiencing family change. Minneapolis, MN: Family & Children's Service, 77 pp. (paperback). Reviewed by Camille R. Quinn, AM

The home lives of children have changed considerably over the past few decades. There has been an increase in the numbers of children born to single and/or divorced parents and children spending a portion of their childhood in single-parent households (Mare & Winship, 1991). Children whose parents live separately are often disadvantaged as compared to children whose parents live together (Amato, 1994) and given that the current rate of divorce for first-time American marriages is 50 percent it is more likely that children will face challenges. In addition, the number of children born into cohabiting families is increasing. As a consequence, about two-fifths of all children spend some time in a cohabiting family, and the greater instability of families begun by cohabitation means that children are also more likely to experience family disruption (Bumpass & Lu, 2000). For all of these children, mastery is an ongoing task that requires special tools and preparation. Therefore, the prevalence of family change and the potential effects on children requires our attention and effective methods must be emphasized to assist children in becoming successful. Social workers would be remiss if they use one-dimensional clinical approaches when treating children with these experiences. Also, comprehensive interventions and guidelines that address the full spectrum of children's needs should be utilized. The book covered in this review has attempted to provide a curriculum including several techniques specially designed for children experiencing changes in their home lives.

Overview of the book

"Children in change: A group curriculum for kids ages 8-14 who are experiencing family change" is a straightforward and fairly concise tool to educate and guide children who are experiencing life changes. The book's overall goal is to normalize the experiences of children whose family lives are changing, and to provide coping strategies. It is based on a support group model with exercises for younger and older children and includes a Background Section as well as instructions for the facilitator and 12 weekly lesson plans: Welcome Week, Family Forms, People I Live With, A Look Back in Time, Introduction to Feelings, My Change, My Feelings, How Our Families Express Their Anger, The Worry Burden, Hopes and Dreams, Working Through Grief, Reaching Out and Final Celebration. This review will focus primarily on the background section and five of the weekly lesson plans but activities from the other lesson plans will be touched upon.

Included in the Background Section are the history, program objectives, lesson plan design and key points about family change, curriculum goals, and information regarding how to facilitate effective groups. This section provides a solid overview and enough information to begin the weekly group sessions. Each lesson plan outlines the objective, supplies needed, preparation required prior to the session, notes or information for the facilitator, learning activities, closing activities and some helpful hints. There is slight variation depending on the chapter but it is fairly consistent throughout. It is stressed that participants attend all sessions to ensure confidentiality, but this was not discussed in detail in the Background section; it may have been helpful if it were included there as well.

Welcome Week is the first session and includes strategies for creating group rules by the participants and facilitator. The activities are distinguished by the age of the participants and the primary goal is to develop group cohesion and lay the groundwork for the upcoming sessions.

A Look Back in Time is designed to better understand each participant's life journey. This is accomplished through creating a "Family Timeline". Each participant uses symbols to identify different life experiences for each year of their lives. This project allows the facilitator and the other participants to share in each other's life journey. The exercise has the potential to provide for each group member an understanding of the role that history plays in their present and future lives.

How our Families Express their Anger is an extension of the previous session on feelings. It should provide an opportunity to validate each participant's angry feelings and help them identify positive ways to manage and control their anger. The most compelling aspect of this session is a marshmallow play activity where the participants create marshmallow people reflective of themselves and someone else in their family with whom they are angry, then perform a role play. The activity allows the participants the opportunity to deal with their anger toward that person even if they cannot express it to them directly.

Working through Grief provides information about grief, loss and depression. Reaching Out prepares the participants for termination. It focuses on the participants and their ability to identify supportive people and resources they can use once the group ends. There are some powerful activities in this session, such as the Helping Hand and Who Can I Trust which require participants to think about whom they can trust and who will be their support once the group sessions end.

Lastly, there's a Trust Affirmation activity where the participants read an affirmation aloud as a group while each looks in a mirror. By far, these are some thoughtful exercises to end the session.

Conclusion

This book is a solid curriculum for facilitators and it provides a comprehensive outline of lesson plans for children experiencing changes in their families. It includes useful information and activities to aid individuals that facilitate groups with children. All of which will be useful guides to address the increase in the numbers of children needing additional support due to their family changes. Simmonds clearly demonstrates the need for objective and thoughtful and therapeutic interventions. She also highlights why group sessions must be open and inclusive when working with children. It is plausible that Simmonds will update and revise this book. An update should incorporate activities that embrace issues related to diversity, such as the race and class of the children. Also, the inclusion of sample drawings for some session exercises like Welcome Week may better illustrate what the participants should strive to accomplish during the session. This book can serve as an effective guide for social workers that provide group services for children. Moreover, social workers could use this book as a foundation for their comprehensive work with children.

References

Amato, P. (1994). Life-span adjustment of children to their parents' divorce. *The future of children, 4*(1), 143-164.

Bumpas, L. and Lu, H. (2000). Trends in cohabitation and implications for children's family contexts in the United States. *Population Studies, 54*, 29-41.

Gastil, J. (2004). Adult civic education through the national issues forums: Developing Democratic habits and dispositions through public deliberation. *Adult Education Quarterly, 54*(4), 308-328.

Mare, Robert D., and Winship, C. (1991). Socioeconomic change and the decline of marriage for Blacks and Whites. C. Jencks & P. E. Peterson (Eds.) *The urban underclass* (pp. 175-202). Washington, DC: Brookings Institution.

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.

Submissions for the Spring 2008 issue of *Perspectives on Social Work* are due no later than December 15, 2007.

Feedback Guidelines

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