Perspectives on Social Work

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From The Editors

As we began work on this issue our excitement mounted regarding the 2008 presidential election. The diversity in this presidential race is truly historic, for the first time either a woman or an African-American will get a presidential nomination. We remain hopeful that we are on the cusp of a real change- a buzzword for this election.

This issue was marked by many changes to our process in an aim to further professionalize the process and product. We are in the works of moving to a peer-review process and have invited reviewers to help in this end. Currently, all invited reviewers were among our colleagues here at the University of Houston Graduate College of Social Work. However, as we move toward the future we hope to be inclusive of reviewers from diverse social work PhD programs nationwide. Additionally, we have formed an editorial board to assist in the decision-making process.

As an integral part of this process, we would like to welcome the newest members to the editorial board, Elena Delavega and Eili Kaganoff. Many thanks to both of you for your eagerness to learn and participate!

Special thanks are also extended to those who accepted the review invitation for this issue. We are grateful for your hard work. We understand that the winter break is a rare opportunity for a little relaxation to catch your breath, however each of you accepted the task with no reservation. The invited reviewers for this issue include: Ada Cheung, Byron Parker, Darla Beaty, Jennifer Herring, Josephine Tittsworth, Karen Mokoro, Larry Hill, Peter Kindle, Sheree Ahart, Shetal Vohra-Gupta, Thang Luu, and Tziona Regev.

We look forward to the remainder of 2008 hoping to further *Perspectives on Social Work*, as well as possibly watching history unfold in the upcoming election.

Best regards,
Editorial Board

The CV Builder
University of Houston, Graduate College of Social Work
Perspectives on Social Work congratulates the following doctoral students on their accomplishments for fall 2007

Venus Tsui and **Ada Cheung** presented a juried paper at the Council on Social Work Education 53rd Annual Program Meeting (2007, October) in San Francisco, California on "Chinese male victims of partner abuse: Prevalence rates between 2001-2007" with Monit Cheung and Patrick Leung.

Darla Beaty, **Ada Cheung**, **Joy Marlbrough**, and **Venus Tsui** presented a "Doctoral self care panel" at the Council on Social Work Education 53rd Annual Program Meeting (2007, October) in San Francisco, California.

Venus Tsui presented a paper at the 15th International Consortium for Social Development Symposium (2007, July) in Hong Kong on "Male domestic violence victims: Prevalence and service characteristics" with Monit Cheung and Patrick Leung.

Ada Cheung and **Darla Beaty** presented at the 15th International Consortium for Social Development (2007, July) in Hong Kong on "Ethical principles around the social work world" and "Internalized oppression then and now".

Peter A. Kindle presented "Linking Financial Literacy and Social Justice" at the 22nd National Meeting and Conference of the Social Welfare Action Alliance (2007, June) in New Orleans, Louisiana, and "Does Graduate Social Work Education have an Open Enrollment Policy" at the 53rd Annual Program Meeting of the Council of Social Work Education (2007, October) in San Francisco, California. His publications included a review of *Black Males Left Behind* in *Research on Social Work Practice* (2008), *Getting Your MSW: How to Survive and Thrive in a Social Work Program* in the *Journal of Teaching in Social Work* (2007), and, with Monit Cheung, *Modern Social Work Theory* in *Research on Social Work Practice* (2007). He edited the second edition of *Themes of the Times for Social Welfare Policy* (2008) and contributed the *Policy Update* to the Research Navigator edition of Karger and Stoesz' *American Social Welfare Policy: A Pluralist Approach* (2008). Collaborative projects include "School Selection Preferences of Public and Private University MSW Students: A Retrospective Study" with Ira Colby that has been accepted for publication by the *Journal of Social Work Education* (in press), and the chapter "Social Welfare and Economics: Redefining the Welfare State in a Global Economy" with Howard Karger that has been accepted for publication in the *Comprehensive Handbook of Social Work and Social Welfare, Volume Four: Social Policy and Policy Practice* (in press).

--Call for Submissions--

The 4rd Annual University of Houston Graduate College of Social Work
Doctoral Social Work Student Research Symposium
March 27, 2008 in Houston, Texas

The Planning Committee invites social work doctoral students and doctoral candidates to submit abstracts describing their research for the Fourth Doctoral Social Work Research Symposium.

Dissertation research-in-progress, independent study projects, concept papers, theoretical models, and other student research are eligible for consideration. Submissions are also being accepted for individual or panel discussion on issues related to social work research and education. Authors will be notified of accepted abstracts by Wednesday, March 5, 2008.

The authors of selected abstracts will be invited to present their research at the Symposium as a presentation of 15 to 20 minutes in duration. Accepted abstracts will be published in *Perspectives in Social Work*, the doctoral student journal, in September 2008.

The abstract (150 words) should include a statement on the nature of the research issue or problem, methodology or conceptual framework, and implications for social work practice, research, or policy.

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Social Work and Sustainable Development: A Postmodern Community Development Framework

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In 2002, at the World Summit on Sustainable Development in Johannesburg, world leaders faced strong skepticism and a cry from the world for more progress and results towards a more humane world. It is no secret that progress in implementing sustainable development has been extremely disappointing since the 1992 Earth Summit, with poverty deepening and environmental degradation worsening (United Nations, 2002). Under heavy pressure, world leaders pledged their commitment to sustainable development, while recognizing that poverty remained a major issue, "the deep fault line that divides human society between the rich and the poor and the ever-increasing gap between the developed and developing worlds pose a major threat to global prosperity, security and stability" (Johannesburg Declaration, 2003, p.2).

However, progress continues to be slow, over thirty years have passed since the first Earth Summit was held in Stockholm in 1972; millions of dollars have been spent in sustainable development programs; several agreements and declarations have been signed; yet poverty continues to hold families and children around the world hostage as environmental degradation continues to get worse (Commission on Sustainable Development, 2007). New approaches to poverty eradication and environmental preservation are being called for, and the social work profession must engage in this discussion and provide alternatives to a more humane world. Social Work as a profession has been concerned with poverty and the environment since its inception. According to the social work code of ethics (1999), the primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people. It further states that "fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living" (NASW, 1999 what is the page number).

In this article, the author uses the postmodern view to examine possible causes of poverty, and propose alternatives to current sustainable development projects. The scope of this article does not allow for an in-depth discussion of postmodernism. As such, the author has intentionally elected to provide a brief discussion of postmodernism and will focus on two key aspects, knowledge production and the displacement of the subject, while examining the postmodern view of poverty to provide the context for the proposed framework. The author develops an argument for a new approach to sustainable development based on (a) decentering the poverty expert, (b) incorporating substantive knowledge from local community members, and (c) understanding current societal structural changes, combined with social work's approach to community development and focusing on the development of human capabilities. A brief discussion regarding postmodernism and poverty follows next.

What is postmodernism?

Postmodernism can be understood in two distinct ways: as object, ontology, and as attitude, epistemology (Harvey, 1989; Lyotard, 1984; Yapa, 1996). Yapa (1996) described the object as the way people see the world and how it has changed over the last 25 years. As object postmodernism is concerned with the history and structural developments, which have taken place since the late 1950's with the completion of Europe's reconstruction (Brown, 1992, Harvey, 1989, Jameson, 1991; Lyotard, 1984). As attitude postmodernism is concerned with the theoretical and representational mood of society, it is the how we know what we know, in other words, it is the attainment and production of knowledge (Lyotard, 1984; Yapa, 1996).

Jameson (1991) described postmodernism as a cultural expression of the late capitalism, which he contends is the third stage of capitalism. This stage started in the late 1950's with the completion of Europe's reconstruction from the Second World War and the end of the United States' global domination (Brown, 1992, Harvey, 1989, Jameson, 1991; Lyotard, 1984), which coupled with new technologies and the ever growing capital mobility have given rise to this new stage that authors have called late capitalism (Jameson, 1991), post-industrial (Lyotard, 1984), post-fordist (Brown, 1992) and postmodernism (Harvey, 1989, Jameson, 1991; Lyotard, 1984). Jameson (1991) contends that postmodernism involves the cultural expressions – architecture, arts, media and so on – of this third stage of capitalism. These expressions not only represent a break and rupture from the modern society, but they symbolize a new period in history, which many call postmodernism (Harvey, 1989; Jameson, 1991; Lyotard, 1984). The postmodern view of poverty is examined next.

Postmodernism and Poverty

To fully comprehend the postmodern view of poverty, it is important to understand both structural and epistemological changes impacting societies (Harvey, 1989, Jameson, 1991; Lyotard, 1984). Yapa (1996), contended that "postmodern attitudes raise important questions about the nature of signs, representation, language, power, and policy" (p. 708), choosing to focus on epistemological aspects giving rise to poverty. Brown (1992), on the other hand, elected to consider "structural changes" which he called the "postmodern drift of capitalism". Brown (1992) contended that the high technology revolution has contributed to the constitution of a new economic order based on the free market global economy, which produces "both greater insecurity and greater means for self-expression" (p. 383) leading to greater income disparities around the world.

Postmodernism contends that "the material deprivation experienced by the poor is a form of socially constructed scarcity" (Yapa, 1996, p.707). In modern economics, scarcity has been defined as the distribution of scarce resources among unlimited wants (Yapa, 1996). While scarcity is seen to be socially specific, unlimited wants are seen to be socially constructed (Yapa, 1996). Yapa (1996) proposed the "nexus of production relations" to provide a better understanding of the causes of poverty. In this nexus, production is seen to be constructed within the discursive and non-discursive relations among six key elements – academic, ecological, technical, political, social and cultural (Yapa, 1996). These "relations act and react upon each other constantly to maintain a dynamic system of mutually constituted elements" (Yapa, 1996, p.709). The socially constructed scarcity that affects the poor in developing countries is, thus, seen as a direct result of economic development (Yapa, 1996).

Furthermore, current development strategies contribute to the creation of scarcity further disempowering the poor by ignoring the fact that outside forces also contribute to poverty, and

that poverty is not created and maintained within impoverished communities only (Yapa, 1996). Therefore, the answers to poverty require substantive action at multiple sites within the nexus of production at a variety of levels (Yapa, 1996). "By decentering the poverty expert as subject of the discourse, we mobilize the resources of a large number of other agents of change who have substantive knowledge of how scarcity is constructed in their fields of experience" (Yapa, 1996, p. 722). This mobilization contributes to the design of more effective development strategies.

Conversely, Brown (1992) has argued that the high technology revolution has fostered an "increasingly integrated, self-regulating, competitive, and highly globalized world market system" (p. 384). With this increasingly globalized market system, American businesses watched their previously held dominance disappear (Brown, 1992; Jameson, 1991). To increase its competitiveness, many American businesses have relocated to countries that offer better business opportunities with lower-wages, abundance in natural resources, and less government oversight (Brown, 1992). While this trend has led to higher levels of unemployment in the United States, it has also had disastrous consequences to local communities and natural resources (Brown, 1992). National and local governments no longer have control over their own land, which has led to growing depletion of local resources and exacerbation of income inequalities where the poor continue to grow poorer (Brown, 1992). The proposed sustainable development framework which considers both structural and epistemological factors of postmodernism is presented next.

Sustainable Development: A Postmodern Community Development Framework

The social work approach to community development presents an alternative approach to current poverty eradication efforts, which have had mediocre results at best. However, for community members to fully engage and benefit from community development activities, human capabilities such as well nourishment, ability to read and write, and ability to escape avoidable mortality and disease, must be further developed (Anand & Sen, 2000). Human capabilities are often seen within the larger concept of human development. Human development, in turn is frequently defended as a goal in of itself as it directly "enhances the capacity of people to lead worthwhile lives" (Anand & Sen, 2000, p. 2038). By focusing on the development of human capabilities social workers can increase people's abilities to do things (Sen, 1999), and thus, expand the means for people to engage in, and benefit from sustainable development activities. For instance, in some Asian countries social workers have mobilized communities to create day care centers which not only educate children but improve their nutritional standards leading to a healthier more educated community that, in turn, is able to benefit from development strategies (Midgley, 1996).

Community development offers an approach to poverty eradication, which is also conducive with the postmodern view of decentering the practitioner as the poverty expert and involving substantive knowledge from local community members and or indigenous people. According to John Friedman (cited in Spruill, Kenney & Kaplan, 2001), the community development approach "places the emphasis on autonomy in the decision making of territorially organized communities, local self-reliance (but not autarchy), direct (participatory) democracy, and experiential social learning" (p. 105). Hall (1996) highlighted how social workers assisted, identified and harnessed substantive knowledge from local community members to help the Mamiraua community in the Brazilian Amazon develop and implement a plan to reconcile the conservation of Mamiraua's rich biodiversity with the livelihood needs of its local population. This project is now considered a success example of sustainable development projects that

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promote economic development, environmental conservation, and protects the rights and needs of local indigenous groups (Röper, 2000).

Spruill, Kenney, and Kaplan (2001) further argued that a systems approach, which takes into account other communities or systems within which the community is embedded or it is interdependent, provides a more realistic method to further the process of social learning and community interaction. A systems approach can foster the dissemination of information, and thus promote the sharing of knowledge among and within systems and or communities, which then leads to a decrease in knowledge gaps that have hindered development for years (Spruill, Kenney, & Kaplan, 2001). The Mamiraua project, for example, integrated knowledge from communities throughout the Brazilian Amazon, which participated in the project in conjunction with Non-Governmental Organizations (NGOs), and State and National government officials allowing for a greater sharing of knowledge among local Amazon communities leading to a more effective management plan (Hall, 1996; Röper, 2000). As such, strategies that involve the local community and focus on developing their capabilities, which in turn may lead to the production and dissemination of new knowledge as well as to the empowerment of local communities to become active agents of change themselves, may be an alternative to current programs that continue to focus on remedial and market- driven strategies (Midgley, 1996).

Conclusion and Recommendations

Sustainable development aims to promote development, which meets the needs of the present generation while guaranteeing that the needs of the future generations will also be met (United Nations, 2003). Today, the needs of the present generation are not being met, and this is evident by the growing number of people suffering from poverty all around the world (Commission on Sustainable Development, 2007). Social workers play a vital role in engaging communities in activities that promote human capital, mobilizing community members to create and enhance social capital, and fostering opportunities for low-income and special needs groups to engage in productive employment and self-employment activities (Midgley, 1996).
These projects place emphasis on the autonomy in the decision making of communities, local self-reliance, participatory democracy, and experiential social learning (Hall, 1996; Röper, 2000; Spruill, Kenney & Kaplan, 2001). Therefore, sustainable development programs should engage in economic and human development activities focusing on the development of human capabilities while promoting environmental preservation, within the framework of decentering the practitioner/scientist as the poverty expert and involving substantive knowledge from local community members. Furthermore, by developing human capabilities and involving substantive knowledge from local community members, sustainable development programs will empower local communities to make decisions as to the best use of local natural resources to promote economic development and ensure environmental preservation. Finally, if we do not address poverty issues now our generation will be sustaining a world of poverty and environmental degradation for generations to come.

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The Role of Distant Intercessory Prayer in Social Work

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Many social work professionals and academics are dubious when discussing the role of prayer within the context of practice intervention (Gubi, 2004). As a result, the field has witnessed little research regarding the efficacy of prayer in the clinical treatment of mental health. Despite research inadequacies, many social workers utilize prayer on behalf of their clients (Gubi, 2001). Given the push for evidence-based practice, the field of social work must begin to aggressively evaluate clinical treatment that involves prayer.

In an effort to ease skeptics from the onset, it should be noted that the concepts of prayer and science are not mutually exclusive. The purpose of prayer research is not to assert the presence of a higher power, but rather to determine the role prayer should play in clinical social work (Halperin, 2001). While it is theoretically possible that a transcendent being exists, it is also possible that prayer produces effects without intervention from a non-physical entity (Kennedy, 2002; O'Laoire, 1997; Roberts et al. 2006). Prayer research does not need to center on the realm of the metaphysical. Leder (2005) presents theoretical possibilities derived from the discipline of physics. Further research may reveal that prayer influences change supernaturally, naturally, or not at all (Hodge, 2007).

There are many different forms of prayer. The American Heritage Dictionary (1997) defines prayer as, "a reverent petition made to God or another object of worship" (p. 1074). Within the therapeutic context, prayer can be overt or covert. Overt prayer refers to prayers done with the client, while covert prayer, a type of intercessory prayer, refers to prayers offered privately by the therapist on behalf of his or her client (Gubi, 2001). Intercessory prayer is a type of prayer offered by one person on behalf of someone else. Intercessory prayer that is not conducted in the physical presence of the beneficiary is referred to as distant intercessory prayer. Distant intercessory prayer (DIP) is also known as distant healing and bioenergetic healing (Hodge, 2007). While intercessory prayer in proximity may theoretically be explained

physically and or psychologically, Masters and Spielmans (2007) argue that DIP currently has no theoretical biomedical explanation and is therefore considered a form of alternative medicine.

Despite scientific uncertainty, prayer remains an integral part of people groups around the world. Christianity, Judaism, and Islam all have established practices of prayer for health and healing. Given the historical prevalence of prayer practices, it seems unlikely that prayer will cease to play a role in the health habits of individuals. A survey of hospitalized patients revealed that 50% of patients wanted their physicians to pray for them (Halperin, 2001). Recognizing the value of prayer within the context of patient care, many medical schools have developed curriculum specifically addressing prayer and practice.

Across the discourse of medicine, psychology, and social work, there has been a push for the establishment of evidence-based practice. The American Psychological Association (2006) identifies the purpose of evidence-based practice as the need to improve patient outcomes through the use of clinical expertise that is supported by research while affirming patient values. Determining treatment efficacy is the first dimension of evidence-based practice (APA, 2006). Currently, research regarding intercessory prayer is inconclusive and fails to meet the standards for which evidence-based practice argues.

National surveys reveal that 57% of social workers reported offering private prayers for their clients (Canada & Furman, 1999). British national surveys revealed similar findings for mainstream British accredited counselors (Gubi, 2004). A significant number of counselors who use DIP have never discussed prayer in supervision (Gubi, 2001). If practitioners do not discuss DIP with colleagues and are not supplied with research regarding the efficacy of DIP, competency may be questioned.

The NASW Code of Ethics (1999) acknowledges that social workers may have differing opinions in respect to values, ethical principles, and ethical standards. Despite these differences, social workers are mandated to utilize interventions that ensure competent practice in light of research. Clinicians, however, must be careful not to inappropriately restrict patient choice of treatment due to lack of clear research evidence regarding a treatment (APA, 2006). The purpose of this paper is to provide a relevant review of DIP literature to inform social work practitioners of the effectiveness of DIP as a treatment intervention.

Literature Review

Theoretical Conceptualizations

One of the fundamental gaps in research on DIP is the lack of a scientific theoretical conceptualization (Masters & Spielmans, 2007). While general public intuition may link prayer effectiveness to the intervention of a deity, such a concept is considered not researchable within the discourse of modern science. Leder (2005) offers two conceptual frameworks from the field of quantum mechanics that establish a "limited compatiblism" (p. 926) and help explain DIP: energetic transmission and non-local entanglement.

Energetic transmission refers to the notion that we are surrounded by moving energy, which is invisible to the naked eye across time and space (Leder, 2005). Consider the world of cyberspace. We never see the information or energy surrounding us, and yet somehow it can travel from point A to point B almost instantaneously. In a similar sense, healing energy can be transmitted across space from one person to another through prayer. The concept of energetic transmission would logically deduce that proximity plays a role in DIP given that signals are generally stronger when they are closer.

Non-local entanglement refers to the concept that particles primed in connection can be entangled so that one may affect the other without any communication between the two (Leder, 2005). Oman and Thoresen (2002) also refer to this concept as distant intentionality. Reports from mothers who instantly sense that their children are in trouble are a common example of non-local entanglement. Through exercises of compassion, connection, and prayer, those individuals praying for another at a distance may create a non-local phenomenon (Leder, 2005). Non-local entanglement negates the importance of distance.

Energetic transmission and non-local entanglement as applied to consciousness are not fully established within the field of physics. They do, however, represent a growing segment that presents viable options for theoretical exploration into the underlying dynamics of DIP.

Research Supportive of Distant Intercessory Prayer

Currently, there is a growing body of research that indicates the significance of DIP (Edward, 2001; Hodge, 2007; Masters & Spielmans, 2007). Within the field of medicine, DIP has been found to be beneficial in the treatment of AIDS patients, coronary care patients, elderly cardiac patients, and women undergoing treatment for infertility (Sicher et al., 1998; Byrd, 1988; Furlow & O'Quinn, 2002; Harris et al., 1999; Cha & Wirth, 2001). Studies have demonstrated that while intercessory prayer has not reached clinical significance for the treatment of heart surgery, the trend has favored heart surgery patients receiving prayer (Krucoff et al., 2001; Krucoff et al., 2005). Perhaps one of the most controversial findings is that of Leibovici. Leibovici (2001) conducted a study which determined that individuals who received prayer retrospectively spent significantly less time in the hospital and had briefer periods of infection-induced fevers.

Within the field of mental health, DIP has received less attention. Sandberg (2002) found that DIP had a significant effect reducing participant self-reported distress as measured on three Global Indices of the Brief Symptoms Inventory. When evaluating individuals with depression in outpatient treatment, DIP was determined to be an effective adjunct in reducing cognitive-affective symptoms of depression on the Beck Depression Inventory (Connerley, 2003).

A meta-analysis of seventeen studies revealed significant effect sizes (p=.015 using a random effects model and p=.006 using a fixed effects model) (Hodge, 2007). Included in the meta-analysis was a study conducted by Cha and Wirth (2001), which found intercessory prayer to be significant in increasing the likelihood of conception among women undergoing infertility treatment. As a result of accusations of scientific misconduct, Hodge (2007) recalculated effect sizes without the Cha and Wirth study (Ernst, 2006; Masters et al., 2006). While the significance of intercessory prayer was reduced in the fixed effects model (p=.031) and eliminated in the random effects model (p=.062), the analysis demonstrates a trend in favor of DIP.

Research Unsupportive of Distant Intercessory Prayer

Meta-analysis has also been shown to reveal no effect sizes for DIP. Masters et al. (2006) reviewed 14 studies and found no significance for overall effectiveness (p=.18) and small borderline significance for ill participants (p=.05). When the Cha and Wirth study was removed from analysis, overall effectiveness dropped (p=.87) along with ill participant effectiveness (p=.47).

Studies investigating arthritis, cardiac conditions, and kidney dialysis found no significance for DIP (Matthews et al., 2000; Aviles et al., 2001; Benson et al., 2006; Krucoff et al., 2001; Krucoff et al., 2005; Matthews et al., 2001). Mathai and Bourne (2004) conducted a pilot study examining the impact of DIP on child psychiatric disorders revealing no significant effect. DIP had no effect on anxiety, self-esteem, mood, and depression (O'Laoire, 1997).

A large clinical multi-site experimental study by Benson et al. (2006) investigated DIP and found no significant recovery benefit for cardiac patients. Further, patients certain of receiving DIP actually experienced more complications than those uncertain of receiving DIP (Benson et al., 2006). Similarly, Walker et al. (1997) found that individuals believing that they were receiving prayer took three months longer to reduce alcohol consumption than the comparison group. Knowledge of DIP cannot be assumed to have a benign effect.

Limitations of Current Research

Masters and Spielmans (2007) note the lack of methodological sophistication utilized in the design of most research on DIP. Consequently, DIP research has been plagued with threats to reliability. Of critical importance are the issues of prayer content and measurement of dosage. While the majority of DIP studies have utilized Christian prayers, some studies have employed a mix of prayers from other major religions (Krucoff et al., 2001; Seskevich, 2004). In addition to religious prayer, Sicher et al. (1998) incorporated DIP from graduates of bioenergetic and meditative healing institutions. No significant difference has been determined based on the belief system of those engaging in prayer (Seskevich et al., 2004). Generally, intercessors offer DIP for the research participant in their own personal prayer style (Connerley, 2003; Mathai & Bourne, 2004; Seskevich et al., 2004). Consequently, no information is provided as to the direct content of each particular DIP intervention.

In addition to lacking records of prayer content, studies by Aviles et al. (2001), Byrd (1998), Benson et al. (2006), Krucoff et al. (2001), Seskevich et al. (2004), Walker et al. (1997), and others have failed to record or specify the amount of daily prayer offered for each client. Others studies that did not mandate daily prayer also failed to record the amount of prayer offered over the course of the intervention (Leibovici, 2001; Mathai & Bourne, 2004). While Masters & Spielmans' (2007) meta-analysis revealed no significant influence of frequency and duration of prayer, many argue that measurement of the dose and duration of prayer is necessary to establish exposure to DIP interventions (Krucoff et al. 2005; Oman & Thoresen, 2002; Targ, 1997; Kennedy, 2002; Masters et al., 2006).

Research on DIP is often confounded by personal prayers of research participants and/or others who offer prayer on behalf of individuals with an illness. Since there is no way to eliminate outside prayer on behalf of research participants, experimental studies have sought to utilize random assignment into prayer and control groups (Masters & Spielmans, 2007). The comparison of the DIP intervention is then compared to the control group, who receives treatment as usual. Even if such a design adequately addresses the confounding variable of outside prayer, Kennedy (2002) argues that DIP may imply that certain individuals are more effective at praying than others.

Conclusion

Proper study and DIP theory development are needed to protect the efficacy of social work practitioners, the health and well-being of social work clients, and the overall reputation of the social work field. The use of DIP by the majority of nationally surveyed social workers providing direct practice, despite inconclusive evidence, suggests the need for further empirical study of DIP as a practice intervention (Canada & Furman, 1999; Hodge, 2007). A Cochrane review of intercessory prayer summed up the status of the current research. "The evidence presented so far is interesting enough to justify further study into the human aspects of the effects of prayer" (Roberts et al., 2006, online).

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Moral Hopelessness and HIV/AIDS Global Paralysis

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No disease ever in history, other than the plague of the 14th century, has caused such serious psychological and emotional distress, affecting families and communities as the AIDS pandemic. The United Nations AIDS Program (UNAIDS) and the World Health Organization (WHO) now estimate the number of people living with HIV/AIDS today is 40 million. More than 25 million people have died of AIDS since 1981. At the end of 2007, women accounted for 48% of all adults living with HIV worldwide, and for 59% of those in sub-Saharan Africa. Young people (under 25 years old) account for half of all new HIV infections worldwide and about 6,000 become infected with HIV everyday (UNAIDS/WHO, 2007). Most of the infected (22.5 million) live in Africa, a continent home to only 10% of the world's population, but shouldering over 70% of all cases and 95% of all orphans according to the UNAIDS/WHO report.

About 2.5 million adults and children became infected with the Human Immunodeficiency Virus (HIV) in 2007 alone. Furthermore, an estimated 33.2 million people worldwide are living with HIV/AIDS. The year also saw 2.1 million AIDS-related deaths despite recent improvements in access to antiretroviral treatment. The purpose of this paper is to highlight the problem of indifference in the approach to the disease by the world community and how this ambivalence has turned a controllable problem into a lethal one. It argues that the scale in numbers of the sufferers, the helplessness faced by their governments in instituting meaningful care, and the desperation of the victims, has created a state of moral hopelessness. Moral hopelessness, as defined in this paper, is a situation of total individual and collective surrender that is pervasive. The Beck Hopelessness Scale conceptualizes hopelessness as an individual's negative expectancies regarding the future (Beck, 1988). This paper provides a unique perspective that questions the conventional thinking surrounding the issue of HIV/AIDS and provides a direction that includes a new disease definition and approach.

HIV/AIDS has taken different faces since it was first identified in 1981 in the USA by the scientists at the Center for Disease Control and Prevention (CDC). Following a series of similar reports from the University of California Los Angeles Medical Center of a rare illness that had

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occurred among five homosexual men (Gottlieb, 2001; Oppong & Kalipeni, 2004), the CDC decided to act. At the time, it was thought that the disease was limited to certain high-risk groups, including gay men, hemophiliacs and injecting drug users (IDU) (Gottlieb, 2001).

In 1984, research in Central Africa revealed that the disease affected men and women equally and for epidemiologists studying the disease in 1986, it became clear that this disease had become a particular brewing danger to the developing world, especially in Central and East Africa (Oppong & Kalipeni, 2004). Later in 1986, WHO declared HIV/AIDS to be a pandemic and a serious mortal problem. It is now over twenty years in this declared "campaign" against this menace and researchers, patients and afflicted families are still asking: "Why"? Why is it that more than 40 million people are now living with the disease with millions more dead? It is apparent that knowledge of the disease was there even in the mid-1980s. This knowledge was utilized by affluent nations for the good of their citizens; for the poor however, the opposite is true. This has created a reality of moral hopelessness.

This paper argues that the egalitarian principles that have usually promoted fairness and equity might have been ignored in addressing the HIV pandemic. Soon after the WHO announcement of the HIV global epidemic, rich nations initiated drastic mechanisms and programs to alleviate the problem and this was reflected in a dramatic plummeting of the numbers of those infected. This was the case for the United States. Elsewhere however, particularly for governments of poor nations that had neither the funds nor the infrastructure required to deliver the appropriate response, many were left in a state of debased moral hopelessness.

Emile Durkheim, a 19th century French sociologist, introduced the concept of anomie in his book, *The Division of Labor in Society*, published in 1893 (Calhoun, 2007). Durkheim used anomie to describe a condition of moral recklessness that was occurring in society. There was a breakdown of rules and regulations, and people's moral responsibility and accountability to one another was lacking. Anomie, simply defined, is a state where norms (expectations on behaviors) are confused, unclear or not present. It is normlessness or moral recklessness (Lemert, 1993). Today nations operate under a universal system of rules (norms) and conventions (treaties) that guide human activities and decisions. A good example is the Universal Declaration of Human Rights. If for some reason those established rules, having been sanctioned by nations of the free world, fail to protect those under their protection (the powerless), a situation of anomie is created. This is the situation in which people with HIV virus often find themselves.

There is a collective anomie on a grand scale surrounding the issue of HIV/AIDS. Developing nations are undergoing episodic moral hopelessness, defined as the state of desperation, defeat and confusion that puts them in a "coiled up", "given up" mode. It is a situation of despair sustained by the hope that rich nations will one day have the conviction to come to their aid. It is a state of "total surrender." The parallel between anomie and moral hopelessness is that the former creates chaos, the latter, desperation. The mood today for most people in the developing world and their governments in reaction to this calamity is despair, and their response as pietism, devoted now to burying their dead and the observance of "final rites." Plainly speaking, the HIV/AIDS problem has gone beyond these countries' ability and capability, thus creating this moral hopelessness. The public health infrastructure of most of these countries has been choked to capacity through many centuries of battling endemic ailments such as kwashiorkor, malaria, typhoid, cholera, dysentery and others. The emergence of HIV/AIDS in the 1980's not only sent shockwaves through an already fatigued system, it created

a paralysis far greater than imagined. Faced with no choice at all, many nations have desperately watched their life expectancies drop to a decade's low.

<p style="text-align:center">HIV as a Human Rights Issue</p>

Fifty-nine years after the Declaration of Human Rights, the world still has not reached a practical consensus on making AIDS a binding human rights issue. Article 25 of the Universal Declaration of Human Rights underscored clearly the social and economic rights of all persons:

> Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

This paper argues that despite proclamations by the United Nations regarding what are acceptable basic rights, there is little progress in the quest for social and economic rights for all individuals. The right to health and medical care has not been given a serious consideration, particularly in the treatment of the poor. The epidemiology of HIV/AIDS in sub-Saharan Africa is fundamentally different from the rest of the world, and unfortunately corresponds with the economic deprivation of the region. Sub-Saharan Africa contains about 10% of the world's population, yet accounts for over two-thirds of the more than 40 million people living with HIV. It accounts for 70% of incidents of HIV infections, 80% of AIDS deaths and 90% of AIDS orphans (UNAIDS/WHO, 2007). One can argue that this is not an accidental phenomenon. It is a direct product of the indifference to this problem by affluent nations that has created this hopelessness. These devastating social, demographic, and economic consequences and the severity of HIV/AIDS are very unique to sub-Saharan Africa and, to some extent, the Caribbean. Consequently, they require unique responses (De Cock, Mbori-Ngacha & Marum, 2002). Even in the backyards of the industrialized world, for example in the U.S., AIDS is killing more people living in poverty from communities of color and minority populations compared to other demographic groups. By 1995 for example, over half a million people in the United States had been diagnosed with AIDS. In 1992, blacks were only 12% of the U.S. population, but 30% of AIDS cases. Latinos were 9% of the population, but 17% of AIDS cases. Blacks and Latinos together accounted for 46% of AIDS cases and 54% of deaths from AIDS (Schneider, 1998). Obviously there is no known and scientifically established genetic predisposition of the disease to minorities. The current situation is primarily a product of access or lack of access to knowledge and preventive care.

The global response to this problem has been abysmal. Since the earliest days of the problem, there has been an exclusionary, hands-off approach by the West to the problem of HIV/AIDS in Africa, a trend which Bayer (1991) defines as "HIV exceptionalism." By contrast with Africa, the AIDS incidence and mortality rates in the industrialized world have fallen, and pediatric HIV disease has completely been eliminated largely through antiretroviral (ARV) drugs (De Cock et al, 2002). Globally, however, ARV remains beyond the reach of the majority of people with HIV/AIDS. Of the 6 million people worldwide who needed ARV in 2003, fewer than 8% were receiving them (Galvao, 2005). Ironically, major international forums of the UN have identified and recognized HIV/AIDS treatment as a human rights issue. Yet, no major, legally binding mandates have been instituted or imposed to any country. Both the United States and Great Britain still bar the entry of people proclaimed to be HIV positive. At the 57th Session

of the Commission on Human Rights in April 2001, the United Nations High Commissioner approved a resolution that made access to treatment a basic human right. In 2003, UNAIDS reaffirmed the relevance of human rights to HIV/AIDS by establishing a Global Reference Group on HIV/AIDS and Human Rights (P. 1111). These covenants or treaties are of little significance when governments cannot implement them. A suffering orphan, widowed mother, or young father is left immobile without strong legal and political advocates. These highlights of the indifference are the pivot points to this paper. The hopelessness and despair borne by the victims of this disease is horrendous, yet, the world has not embraced this problem as one of the greatest threats facing mankind today.

HIV/AIDS as a Public Health Issue

The US Surgeon General under Franklin D. Roosevelt, Thomas Parran, published "Shadow on the Land" in 1937, a book outlining his plan to combat syphilis. He thought at the time that public efforts to combat the disease had been "scattered, sporadic, and inadequate." His public health program included promotion of case detection, testing (including premarital and antinatal testing), treatment, contact investigation, and public education. His intrinsic vision was to demystify syphilis, fight it with the necessary resources, and define it as a public heath rather than a moral problem (Parram, 1937). This paper argues that the HIV/AIDS issue has not been defined and addressed as an infectious disease emergency as was successfully done for syphilis. The overriding premise is that how an issue is defined strongly influences public perception. Susan Robbins (2007) has called this phenomenon a "paradigm of definition": a socially constructed phenomenon debased of its external reality and inherent essence, but by an act of mind. The public health approaches during that period which targeted testing and follow-up investigation typical of tuberculosis and sexually transmitted disease control, were deemed inappropriate for HIV/AIDS and were codified in a confidentiality lingo. Focusing primarily on informed consent and counseling, as was the case before, (although important) restricted testing for HIV. This type of "surveillance" or "caution" implicitly perpetuated the stigma and isolation associated with HIV/AIDS. Many infected people were not readily willing to participate in voluntary testing because stigma was heightened in these implicit legal controls. It is this kind of illusive lack of public health approach that might have contributed to the moral hopelessness situation we see today.

Conclusion and Implications for Social Work

The reality is that HIV/AIDS has devastated our world. Over 40 million people presently living with AIDS is a worrisome statistic. By 2010, Ethiopia, Nigeria, China, India and Russia with 40% of the world's population will add 50 to 75 million infections (UNAIDS, 2005). Social workers will have to respond in a unique and aggressive way. The worried, the ill, the dying, and the bereaved occupy social workers' caseloads and continue to touch them personally. Innocent children, young mothers and the families of intravenous drug users are becoming infected and dying (Leary, 1989; Williams, 1989). Orphaned children with AIDS languish in inner-city hospitals; gay men die; elderly parents grieve for sons, daughters, and grandsons. Governments in poverty and conflict-stricken countries have no muscle to fight the epidemic. This state of hopelessness calls for an invigorated collective will of social workers in the tradition of the pioneers in the profession who bent backwards to meet the challenges of the time. The history of social work and the profession's innovations during the Progressive Era and the New Deal under the leadership of Jane Addams, Lillian Wald, Florence Kelley, Harry Hopkins,

and Frances Perkins resulted in the creation of settlement houses, playgrounds, child labor laws, visiting nurses, maternal health clinics, social security, and labor legislation (Shernoff, 1990). HIV/AIDS is the defining issue of the day and it will require unique individuals and perspectives in dealing with it. There is an urgent need for visionary leaders in the rank of our pioneers to demand that resourceful governments respond fast and appropriately to this dreadful pandemic.

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Marriage in the Later Years: A Review of Factors That Affect Marital Satisfaction among Older Adults

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Older Americans represent the fastest growing subset of the U.S. population. Although the general population tripled over the course of the last century, the population of those over 65 years of age increased by a factor of eleven (Friedrich, 2001). Furthermore, the U.S. Census Bureau predicts that this population will soar from 33 million in 1994 to more than 80 million by the middle of the 21st century (Hobbs, 2001). Despite this ongoing demographic shift, older adults are vastly under-represented in marital research (Acitelli & Antonuuci, 1994; Goodman, 1999a; Trudel, Turgeon, & Piche, 2000) and few theoretical models exist to explain fluctuations in marital satisfaction for this population (Herman, 1994).

Nonetheless, examining factors that affect marital satisfaction among older adults is an important endeavor. Research has demonstrated that marital discord among older couples is associated with negative mental health outcomes (Sandberg & Harper, 2000; Whisman, Uebelacker, Tolejko, Chatav, & McKelvie, 2006), physical health problems (Bookwala, 2005), and even higher mortality rates (Impens, 2005). Conversely, high quality marriages in this age group mitigate the negative psychological effects of conditions such as disability (Bookwala &

Franks, 2005; Mancini & Bonanno, 2006), and are associated with better physical health (Trief et. al., 2006) and overall life satisfaction (Marshall, 2001; Shen & Wang, 2002).

Current research on elderly marital satisfaction provides mixed support for various lifespan relationship trajectories. To consolidate knowledge and identify areas for future research, this article reviews existing literature in three domains: retirement, emotional support, and intimacy. After a brief description of theoretical perspectives, the effect of each domain on marital satisfaction will be examined. Research and practice implications will also be discussed.

Marital Satisfaction Trajectories

Within the marriage literature, three developmental perspectives emerge on marital satisfaction across the lifespan (Herman, 1994). The first approach suggests a *curvilinear pattern* in which marital satisfaction starts out at high levels in the early years of marriage ("honeymoon phase"), declines during the middle years, and then rebounds in later life (Rollins & Feldman, 1970). The resultant rise in marital satisfaction among older adults does not reach the level of satisfaction during the honeymoon phase, but does represent a significant improvement after the challenges of the middle years have passed (e.g., child-rearing, financial planning, etc.).

The second approach—*steady decline perspective*—suggests that marital satisfaction decreases across the lifespan (Bradbury, Fincham, & Beach, 2000). After reaching lifetime highs in the early years, marital satisfaction starts a steady decline in the middle years. Rather than a blissful era of leisure and companionship, marital satisfaction in the later years continues a downward trajectory and reaches a lifetime low due to various issues (e.g., deteriorating health).

The third view—*no change perspective*—holds that there are no significant or consistent changes in marital satisfaction later in life (Herman, 1994). Although a proportion of older couples is more dissatisfied with their marriages than younger couples, an equal proportion of older couples are more satisfied if not more satisfied than their younger counterparts. In other words, "…the latter years of life are no more or less martially satisfying than any other phase of life" (Herman, 1994, p. 75). Support for each of these marital career trajectories will be considered within each domain.

Factors Affecting Elderly Marital Satisfaction

Retirement

Retirement from a primary career has been characterized by some researchers as being a very stressful event that has negative effects on marital satisfaction in older couples (Trudel, 2000). Because of the increased amount of time spent together during retirement, unresolved conflicts from earlier stages of the marital career can be exacerbated. Furthermore, retirement often involves a redefinition of household roles with husbands assuming a larger share of traditionally feminine tasks (Dorfman & Heckert, 1988; Kulik, 2001). While one might assume that a more egalitarian arrangement would be conducive to higher levels of marital satisfaction, women often express dissatisfaction after their husbands retire due in part to the rearrangement of household routines, a form of territorial invasion (Hill & Dorfman, 1982). For men, marital burnout has been positively correlated with equality of in-home tasks (Kulik, 2002). Thus, some retirement research supports the *steady decline perspective* for older adults.

Alternatively, another retirement study supports the *no change* perspective on marital satisfaction. Fitzpatrick and Vinick (2003) conducted a longitudinal study of 61 married couples in the greater Boston metropolitan area using the well-known and validated Dyadic Adjustment

Scale. The researchers found that in general, husbands' retirement had little effect upon wives' marital satisfaction or on wives' perceptions of marital quality. Rather than sparking a crisis, retirement was seen as a manageable process or transition.

Yet other research provides support for the *curvilinear perspective* as post-retirement changes in the division of labor at home can have positive effects as well. Kulik (2001) conducted a study of 469 Israeli couples and examined division of tasks, power relations, and quality of marriage. Kulik found that couples with two retired spouses were highly egalitarian in the division of labor and that retired couples expressed higher levels of marital satisfaction than pre-retired couples. A subsequent study by Kulik (2002) evaluated equity theory and found that perceptions of equality in family roles and power relations were associated with lower levels of marital burnout and higher levels of marital satisfaction for the wives only.

Emphasizing the importance of a life course perspective, Moen, Kim and Hofmeister (2001) examined marital satisfaction for a 534 person subsample of the multiple wave Cornell Retirement and Well-Being Study. The researchers found that the actual retirement transition is related to significant declines in marital satisfaction for both husbands and wives, and that retirement from a primary career is the strongest negative predictor of marital quality for men. However, after an adjustment period of more than two years, marital satisfaction levels rebound to pre-retired levels if not higher, and retirement actually promotes marital quality and leads to a dramatic reduction in marital conflict (Moen et al., 2001). When viewed as a process occurring over time rather than a single event, retirement appears to have a negative effect in the short term but a positive effect in the long term.

Emotional Support and Communication Patterns

Unlike retirement which is a transitional phase, emotional support and communication patterns involve interpersonal exchanges over the course of the lifetime. Carstensen, Gottman and Levenson (1995) explored the emotional climate of long-term marriages by using an experimental design involving laboratory observations of 156 couples who differed in age and marital satisfaction. Interestingly, older couples displayed more affection and less emotional negativity during conflict resolution exercises, were less likely to initiate negative sequences leading to argument escalation, and showed lower levels of anger, disgust, and belligerence than younger counterparts. After controlling for differences in marital satisfaction, the researchers concluded that "there is evidence suggesting an age-related positive affective trend within this highly intimate social relationship" (p. 146). Instead of the popular notion of emotional dampening in later years, research suggests that older couples may actually benefit from more sophisticated communication patterns than younger couples.

Both social support and emotional reciprocity appear to be key components of marital satisfaction. Based on self-reports of 80 couples ranging in age from 43 to 83, Goodman (1999b) found evidence that emotional reciprocity is associated with more positive marital evaluations. The results were strongest and most consistent for women. Conversely, imbalanced or closed communication patterns among older couples have been linked to lower levels of marital satisfaction (Hodgson, Shields, & Rousseau, 2003). Another study found that social support from spouses (i.e., giving and receiving emotional support) was strongly related to marital satisfaction and well-being among older wives (Acitelli et al., 1994). Finally, Wright and Aquilino (1998) examined levels of reciprocity and emotional exchange between older caregiving spouses and found that both variables were linked to higher levels of marital happiness and lower levels of caregiving burden. Although there is not definitive evidence that

emotional closeness and communication improve later in life, older couples that have supportive, open, and positive communication styles experience higher marital satisfaction.

Intimacy

As one form of intimacy, sexual relations between older spouses represent an important dimension of marital satisfaction. Nonetheless, these couples commonly face obstacles in this area including physiological changes (e.g., testosterone decreases, menopause), diseases (e.g., cardiopulmonary, vascular, neurological) and medications (e.g., anti-depressants, anti-Parkinson drugs) that can decrease sexual desire or functioning (Trudel, Turgeon, & Piche, 2000). These facts support the *steady decline perspective.*

Contrary to popular misconceptions, however, attitudes towards love have been shown to persist across the major stages of the lifespan (Montgomery & Sorell, 1997). Furthermore, after a comprehensive review of literature on sexuality and aging, Trudel and colleagues (2000) concluded that "sexuality is…one of the last faculties to decline" (p. 382) and that sexual satisfaction takes on expanded forms among older adults, including a heightened appreciation for physical connection and touch. These factors provide some support for the *no change perspective*.

Schiavi, Mandeli, and Schreiner-Engel (1994) conducted a study that focused specifically on the sexual satisfaction in healthy aging men and found that although the oldest age group in the study had significantly lower scores in terms of sexual experience and drive, there were no age-related changes in terms of sexual enjoyment or satisfaction. This led the authors to conclude that researchers should move beyond an exclusive focus on sexual performance, and instead explore other determinants of sexual enjoyment and satisfaction in late life.

By broadening the definition of intimacy to include dimensions beyond sex (e.g., social, emotional, or intellectual intimacy), researchers have gained additional insight into marital satisfaction among older couples. Goodman (1999a) analyzed partner intimacy, autonomy, and marital satisfaction within long-term marriages and confirmed that intimacy was positively related to marital satisfaction among all age groups. Surprisingly, however, older respondents in long-term marriages rated partners higher in intimacy than younger counterparts. Harper, Shaalje, and Sandberg (2000) addressed the relationship between daily stress, intimacy, and marital quality in mature marriages and found that intimacy actually promoted resilience by significantly mediating common stresses (e.g., deteriorating health, role redefinition, etc.). Finally, Svetlik and colleagues (2005) examined predictors of relationship loss in a study of 136 older caregivers of physically and cognitively impaired spouses. They found that "…when couples…can adapt to physiological changes and find ways to satisfy their needs for physical affection and sexual intimacy, they will evaluate their overall relationship more favorably, be less distressed, and…provide better care" (Svetlik et. al., 2005, p. 76). Thus, expanded forms of intimacy profoundly affect older couples, providing some support for the *no change* and *curvilinear perspectives.*

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

In addition to the general need for more scholarly attention to the topic (Acitelli et al., 1994; Goodman, 1999a; Trudel et al., 2000), several methodological improvements in future research will expand our understanding of martial satisfaction and aging. First, more longitudinal research is needed to accurately evaluate marital satisfaction across the lifespan. Also, rather than treating all individuals over 65 years of age as one monolithic group, more

sophisticated models of marital satisfaction need to be developed with substages (Herman, 1994). Second, future research needs to examine marital satisfaction and aging within different reference groups (e.g., racial, ethnic, socio-economic), family structures (e.g., blended families, grandparents raising grandchildren, etc.), and relationships types (i.e., remarried, cohabitating, and/or gay/lesbian couples). Although some research suggests unique patterns of marital satisfaction within specific ethnic groups (Markides et al., 1999), most studies to date have used predominately white, middle class, heterosexual participants. Third, to improve our global understanding of martial satisfaction, existing research in other countries as diverse as France (Fouquereau & Baudoin, 2002), China (Shen & Wang, 2002), and Israel (Kulik, 2002) needs to be integrated with research on American couples. Last, several emerging trends (e.g., volunteerism, second careers, in-home healthcare, assisted living facilities) were beyond the scope of this paper, but will likely impact many aspects of marital satisfaction and deserve scholarly consideration.

The literature on marital satisfaction among older adults offers several suggestions for clinical practice as well. Because many standard assessments of marital satisfaction contain items irrelevant to older persons (e.g., job ambitions, family planning) or omit items important to them (e.g., health, aging, financial difficulties) (Henry, Miller, & Giarrusso, 2005), empirically valid measurements need to be developed for this population (Clements & Swenson, 1999). Additionally, in order to effectively treat both older individuals and couples, therapists and service providers need to be knowledgeable about common marital problems and solutions unique to this age group. These practitioners often inadvertently promote inappropriate age standards and age-related stereotypes by underestimating problems such as substance abuse (Ivy, Wieling & Harris, 2000) or avoiding sensitive topics such as sexuality (Svetlik et al., 2005) with older clients. Curriculum changes in clinical training programs and professional development workshops that incorporate gerontological findings will improve service delivery to older clients. Empirical research on this population can generate knowledge with valuable clinical implications.

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**Secondary Traumatic Stress Reactions: A Review of Theoretical Terms and
Methodological Challenges**
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Introduction

The field of traumatology, particularly the study of secondary traumatic stress reactions, is a relatively new area of scientific inquiry which often presents methodological issues with the reliable measurement of this concept (Figley, 2002). The literature in this area lacks a universally-accepted definition describing a *secondary traumatic stress reaction. Secondary traumatic stress*, *vicarious traumatization* and *compassion fatigue* are currently used interchangeably in the literature when describing this phenomenon. The need to establish clarity regarding the construct validity of these terms is one of the most pressing methodological issues in this area. This paper provides a review of the concepts in the literature describing secondary traumatic stress reactions and a discussion of the differences between these concepts.

Theoretical Terms

There are three common terms used in the literature describing the negative psychological reactions mental health professionals may experience when working with traumatized clients or patients: vicarious traumatization (VT), secondary traumatic stress (STS), *and compassion fatigue (CF)* (Rothschild & Rand, 2006). The terms *secondary victimization, co-victimization, secondary survivor*, and *emotional contagion* have been used less frequently in the literature to describe these same reactions (Stamm, 1999). The similarities and differences between the three most common terms (vicarious traumatization, secondary traumatic stress, and compassion fatigue) will be described in detail below. Although these terms are used interchangeably in the literature and are similar in nature, there are subtle differences in their conceptualizations which warrant clarification.

Vicarious Traumatization

The term *vicarious traumatization* was first introduced in the literature in 1990 by McCann and Pearlman in *Vicarious Traumatization: A Framework for Understanding the Psychological Effects of Working with Victims* (McCann & Pearlman, 1990). These two authors were the first to clinically describe the effects of trauma as "vicarious" meaning mental health professionals treating trauma victims could actually experience the client's trauma (or other psychological reactions) themselves in the process of treatment. The term vicarious traumatization describes "a process of change resulting from empathic engagement with trauma survivors" (Pearlman & Saakvitne, 1999 p. 52). Pearlman describes trauma work as having the potential to impact the therapist's sense of self, world view, and spirituality, which she collectively refers to as the therapist's "frame of reference" (McCann & Pearlman, 1990; Pearlman, 1998; Pearlman & Saakvitne 1995). Changes in a therapist's *sense of self* refer to disruptions in their personal sense of identity(ies), such as identifying oneself as a helper, parent, or spouse. Disruption of *world view and spirituality* include changes in the therapist's moral principles and religious beliefs and faithfulness (McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1998; Stamm, 1999).

Other resources vulnerable to disruption by work with trauma victims include ego resources and cognitive schemata. Ego resources refer to an individual's ability to manage both

their own intrinsic psychological needs and the ability to manage the extrinsic interpersonal needs of others (Young, Klosco, & Weishaar, 2003; Pearlman, 1999). Vicarious traumatization results in a disruption in the therapist's ability to provide care for both themselves and the client, essentially, their psychological resources and abilities for care are depleted. The term *cognitive schema* refers to the therapist's personal feelings about him or herself and includes their orientation to the world around them (Young, Klosco, & Weishaar, 2003). Therapists working with victims of trauma are particularly vulnerable to disruptions in their sense of safety, trust, esteem, intimacy, and control (McCann & Pearlman, 1990; Pearlman & McCann, 1995; Pearlman & Saakvitne, 1995).

Secondary Traumatic Stress

The term *secondary traumatic stress* was first introduced into the literature by Charles Figley in his early works examining the psychiatric symptoms associated with post traumatic stress disorder (Figley, 1995). As a result of working with individuals diagnosed with post traumatic stress disorder, Figley noted that the trauma literature (including treatment models) only addressed the primary trauma victim- excluding family members, friends, and other members of the victim's support system (Figley, 1995). Figley subsequently sought to identify the psychological maladjustment that many spouses, family members, and friends experience as *secondary* victims of trauma (Figley & Barnes, 2005; Figley & Nash, 2007). This also provoked a separate area of concern for mental health professionals working with the trauma victims in clinical practice (Figley, 2002). The concern for mental health professionals led to the introduction of two very important research questions; first, does treating victims of primary trauma lead to secondary trauma, and second, how similar are the symptoms between primary and secondary trauma?

In his early work, Figley referred to this phenomenon as *catastrophic stress reaction* and *traumatization by concern* (Figley, 1995). In 1995, with the publication of *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder,* Figley introduced his conceptualization of these two terms (i.e. compassion fatigue and secondary traumatic stress) and the corresponding symptoms. Figley defines *secondary traumatic stress* as the "natural and consequential behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other (or client) and the stress resulting from helping or wanting to help a traumatized or suffering person (Figley, 1995, p.7)." A secondary traumatic stress reaction may also result from engaging in an empathic relationship with a significant other (or client) suffering from a traumatic experience and bearing witness to the intense or horrific experiences of that particular person's trauma (Figley, 1995).

Figley's definition of secondary traumatic stress is very similar to Pearlman's definition of vicarious traumatization; however, there are differences in the conceptualization of the two concepts. Pearlman's conceptualization and framework for vicarious traumatization involves both a psychodynamic and cognitive perspective and describes the phenomenon as a process resulting from empathic engagement in which the outcome is vicarious traumatization (McCann & Pearlman, 1990; Pearlman, 1998; Pearlman & Saakvitne 1995). Figley's conceptualization of secondary traumatic stress is grounded in the field of traumatology and places more emphasis on the behavioral symptoms (Figley, 1995). Figley argues that psychological and behavioral symptoms of secondary traumatic stress actually mirror symptoms of posttraumatic stress and the experience of a secondary traumatic stress reaction may include a full range of PTSD symptoms, including intrusive thoughts; traumatic memories, or nightmares associated with client trauma;

insomnia; chronic irritability or angry outbursts; fatigue; difficulty concentrating; avoidance of clients and client situations; and hypervigilant or startle reactions toward stimuli or reminders of client trauma (Figley, 1995).

Compassion Fatigue

The term compassion fatigue, also often used interchangeably in the literature with secondary traumatic stress and vicarious trauma, is best defined as a syndrome consisting of a combination of the symptoms of secondary traumatic stress and professional burnout (Figley, 1995). Although these two terms are used interchangeably in the literature, I believe they are actually two different phenomenon and warrant separate investigation. A mental health professional experiencing secondary traumatic stress typically develops this reaction as a result of working with traumatized clients and the secondary exposure to the client's trauma during the treatment process (Figley, 1995, 2002; Stamm, 1999). Compassion fatigue is a more general term describing the overall experience of emotional and psychological fatigue that mental health professionals experience due to the chronic use of empathy when treating patients who are suffering in some way (Figley, 1995, 1999). For mental health professionals who treat victims of trauma, secondary traumatic stress may contribute to the overall experience of compassion fatigue; however, mental health professionals who treat populations other than trauma victims (such as the mentally ill) may also experience compassion fatigue without experiencing secondary traumatic stress.

Countertransference

The phenomenon of countertransference has also been compared to secondary traumatic stress in the research literature; much like secondary traumatic stress there are varying approaches in the literature describing the concept of countertransference (Figley, 1995; Pearlman & Saakvitne, 1995; Rothschild & Rand, 2006). Countertransference is generally associated with the psychoanalytic school and was introduced by Freud to describe the influence of the psychoanalyst's conscious and subconscious feelings on the relationship and interaction with the patient (Rothschild & Rand, 2006). Freud felt the mind of the analyst should be like a "blank slate" allowing the patient to "transfer" his or her neurotic feelings onto the analyst for interpretation uncomplicated by the analyst's own interpersonal conflicts and neuroses (Rothschild & Rand, 2006; Appignanesi & Zarate, 1979). Freud recognized that it would be impossible to completely block all conscious and subconscious feelings from the patient and described the existence of these reactive feelings by the analyst as "countertransference" (Rothschild & Rand, 2006; Appignanesi & Zarate, 1979). There is variation in the literature regarding what constitutes a countertransference reaction between a therapist and a patient. Pearlman and Saakvitne (1995) describe the process of countertransference in two different ways, (1) as an "affective, ideational, and physical response a therapist has to his or her client, the client's clinical material, transference, and reenactments, and (2) the therapist's conscious and unconscious defenses against the effects, intrapsychic conflicts, and associations aroused by the former (Pearlman & Saakvitne, 1998 p. 23)."

Figley (1995) describes countertransference as "a distortion on the part of the therapist resulting from the therapist's life experiences and associated with his or her unconscious, neurotic reaction to the client's transference (Figley, 1995, p. 9)." Figley argues that in it's truest form, as defined by Freud, countertransference is a reaction that should only occur within the context of psychotherapy (Figley, 1995; Sexton, 1999). Essentially, in order for

countertransference to occur, there first has to be some form of transference, which is typically associated with psychoanalysis. Secondary traumatic stress may occur in any person involved in a relationship with a traumatized person (therapist, family member, friend, and co-worker) and is not limited to therapeutic interactions, which is the case with psychoanalysis. Countertransference also represents the process of displacing the analyst's conscious and subconscious neuroses onto the patient; secondary traumatic stress may occur regardless of the individual's inner neuroses and does not necessarily involve the displacement of inner neuroses onto the traumatized person (Sexton, 1999; Figley, 1995). Lastly, secondary traumatic stress occurs when working with victims of primary trauma, however, countertransference may occur in psychoanalytic process with an individual suffering from any type of mental illness and is not limited to trauma victims.

Methodological Challenges

The lack of consensus regarding the specific meaning and parameters of a *traumatic stress reaction* has hindered the methodological development of this area (Farrell & Turpin, 2003; Sexton, 1999). These terms are currently used in the research literature interchangeably as if they were one phenomenon with different names (i.e. cup and glass). Therefore, one major methodological question in this area is whether these phenomenons (or conditions) actually exist as they are currently defined, and do they exist independently of one another; or are all of these terms referring to the same experience? Because there are various theoretical terms in literature describing secondary traumatic stress reactions, there is great difficulty determining whether instruments claiming to measure this phenomenon have any psychometric value. Furthermore, the instruments in existence that do claim to measure secondary traumatic stress reactions have not been rigorously tested for psychometric validity. For example, there is still some speculation that scales such as the Compassion Fatigue Self-Test (Figley & Stamm, 1996) are actually measuring other pre-existing theoretical constructs, such as professional burnout, rather than compassion fatigue. It has been suggested that it may simply be too difficult to develop a standard measure of secondary traumatic stress due to the extensive co-morbidities that may exist between secondary traumatic stress and other anxiety and/or mood disorders (Dunkley & Whelan, 2006). Additionally, the impact of the working environment and other non-trauma related stressors on the effects of secondary traumatic are also difficult to control when attempting to obtain a true measure of this phenomenon.

Conclusion

In order to provide a clear understanding of the current theoretical concepts in this area, it was best to discuss the most commonly used concepts in the literature individually, rather than discussing the phenomenon of traumatic stress reactions as one entity combining *vicarious traumatization, secondary traumatic stress, compassion fatigue* and others. Based on a careful review of this literature, my interpretation is that although these concepts are similar, they may in fact be independently occurring phenomenon. In other words, it may be possible to suffer from compassion fatigue but not necessarily secondary traumatic stress. One might also experience a change in their cognitive self as described by vicarious traumatization, but not experience compassion fatigue or secondary traumatic stress. The meshing of these terms makes it very difficult to reliably measure these phenomenons in trauma workers. In addition to conceptual issues, there is a lack of strongly validated instruments for measuring these concepts, which further limits reliable research in this area. The development of well standardized instruments to

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measure secondary traumatic stress and compassion fatigue should be a priority for future research agendas. Finally, the conceptual differences presented in this paper between the terms secondary traumatic stress, compassion fatigue, and vicarious traumatization should caution researchers attempting to measure these phenomenon to be good consumers of research instruments and methodology (i.e. *caveat emptor*).

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Bookworm's Corner

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Book Review

Poulin, J. (2000). *Collaborative social work: Strengths-based generalist practice.* **Itasca, IL: F.E. Peacock Publishers, Inc.**

Reviewed by Trenette T. Clark, Doctoral Candidate, MSW
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The term *strengths perspective* seems to now be as popular in the social work field as *solution-focused* once was in the profession. However, according to Saleeby (1996), many practitioners that purport to conduct strengths-based practice, in fact, do not. In addition, although a focus on clients' strengths is a value of the profession, Saleeby adds that the strengths perspective is "a dramatic departure from conventional social work practice (p.3)." Therefore, social work texts that clearly and extensively discuss the use of practice models that emerge from the strengths perspective are warranted.

John Poulin and other contributors provide an engaging and dynamic review of a strengths based collaborative model. Although there are several authors, in general, the writing is clear, direct, and coherent. With the exception of one chapter, each chapter contains diagrams and tables to demonstrate the information covered, which will likely be valuable to visual learners.

All chapters maintain a consistent structure and begin with a relevant picture, a brief vignette, and a synopsis of the concepts and propositions that will be examined. Chapters end with a summary, a more detailed case example, and discussion questions. Additional case examples are presented throughout various sections of chapters and references are listed at the end of each chapter. This consistency in structure is easy to follow.

In part one of this book, Poulin presents the strengths-based collaborative model with an emphasis on the helping relationship. This book is valuable because it contains a thorough review of the specific phases of assessment, planning, and action for the collaborative model. It also includes numerous assessment tools that may be used in practice, such as the strengths-based assessment worksheet, bio-psychosocial assessment form, and mental status evaluation. Application of the model's interventions is demonstrated on micro, mezzo, and macro levels.

In part two of his book, Poulin invited eight of his colleagues whom he considers experts to author the remaining eight chapters on practice with special populations. These populations include persons with serious and persistent mental illness, older people, people of color, abused and neglected children and their families, gay and lesbian clients, people with HIV and AIDS, and survivors of natural disasters. In these chapters, the authors provide a comprehensive review that includes background information on each population, pertinent policy issues, micro, mezzo, and/or macro practice issues, and other salient issues. However, only a few authors distinctly demonstrate application of the collaborative model with the identified population. This text would be enhanced if the model was applied to each population, even if only briefly. Consistently applying the model to various populations would assist the learner to understand how the model can be useful in their practice with diverse clients and communities.

This book has numerous strengths, and two are noteworthy. One of the criticisms of the strengths perspective is the lack of clarity regarding practitioner tasks. Unlike many strengths

perspective texts, this book provides a clear and comprehensive review of the application of this model to multiple diverse populations. Typically, authors formulate abstract generalizations that the strengths perspective can be applied to any population because it is client driven. Few discuss practice with diverse populations as thoroughly as these authors.

Another strength is the inclusion of assessment tools. My colleagues have expressed uncertainty concerning how to conduct strengths based practice. The detailed assessment tools and the accompanied instructions should be appreciated by students and new practitioners using this model.

As with any material, there are limitations to this text. Poulin begins this book by discussing the role of the ecosystems perspective in generalist social work practice and the strengths perspective in strengths-based generalist social work practice. However, Poulin does not review these perspectives under the *theoretical and conceptual frameworks* heading, instead, they stand-alone. In addition, he does not connect these perspectives directly to the model. Instead, the reader is left with the burden of thinking critically about how these perspectives are associated with the practice model.

Poulin asserts that this model uses the scientific method for logical positivism and constructivism for postmodernism during the worker-client relationship. In this text, Poulin primarily uses a postmodernist perspective to guide practice; however, he uses logical positivism to evaluate the client's progress. Given that logical positivism and postmodernism are on opposite sides of the subjective-objective continuum, it would be helpful if Poulin clearly distinguished how the two work together. Poulin's position seems to be that there should be a partnering relationship between worker and client, but that a more traditional method for evaluating progress should be employed.

Another drawback is that although Poulin asserts that this book is suitable for use in senior BSW and foundation MSW courses, it is written slightly higher than the BSW level. He presumes that the reader will know certain terms (e.g. empiricism) and therefore they are not defined.

Further, this book ends abruptly without a conclusion or discussion section. It leaves the reader, the learner, craving for implications for social work practice, education, and research. Further, while Poulin states in the preface of this book that it was written because of an inability to find a textbook consistent with his approach to teaching, he never discloses his approach. Implications for teaching this model would significantly add to the quality of this text. Should instructors use the strengths perspective to teach their students? Which approach (e.g. active learning strategies, client centered vs. content centered) is most effective when teaching this model?

From my understanding, this text is widely used in undergraduate and graduate social work courses. I agree that this would be a great required or supplemental book to use in a social work practice course. I recommend that this book be used, but only after the strengths perspective, its concepts, and propositions are clearly understood. The student, practitioner, educator, and researcher will consider this a valuable resource, primarily because unlike many strengths perspective texts, it demonstrates application of the model to diverse populations.

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Book Review

Radford, L. & Hester, M. (2006). *Mothering through domestic violence.* **Philadelphia, PA: Jessica Kingsley Publishers.**

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In this compelling paperback, Lorraine Radford and Marianne Hester seek to provide a wide audience with an overview of the rough terrain navigated by women who are mothers and who have experienced intimate partner violence (IPV). Their experiences with the state are described, in particular with family court systems and child protection systems. The book's central theme is that state practices often replicate abusive power and control dynamics previously exerted over IPV survivors. Quotes throughout the book allow readers to hear women's voices describing experiences of violence, mothering, state systems, and areas where these intersect. Being a mother is seen as a key factor in entrapment of women experiencing IPV because of "the fundamental contradiction between woman as mother and woman as lover in the social construction of western femininities." (Radford & Hester, 2006, p. 47).

The book, organized thematically, draws on six multi-method studies conducted by the authors, mostly in England. Hester is Professor of Gender, Violence and International Policy at the University of Bristol. Radford is Head of Research in the Child Protection Research Department of the National Society for the Prevention of Cruelty to Children in the UK. These employment arenas have approached issues of mothering and violence differently, and Radford and Hester have created a fruitful collaboration. Their six studies examined state practices as well as personal experiences of abuse, most with in-depth interviews. Two focused on women's experiences with post-separation child visitation arrangements. Participants included mothers, shelter advocates, attorneys, child protection staff and mediators. A third study was a "meta-evaluation" of 27 IPV initiatives in different communities led by multi-agency partnerships. A fourth (participatory action) study focused on how multiple agencies in one community coordinated responses to IPV, exploring experiences of 484 women and 171 service providers. A fifth study surveyed court professionals, and the sixth examined 267 child protection cases. Rather than focusing on each study in isolation, Radford and Hester briefly overview each, and then structure the book along themes appearing across studies. Chapter titles illustrate emergent themes: "Mother Blaming in the Courts" and "Walking on Eggshells…" Structuring thematically allows an integrative approach and opportunities for the authors to recommend remedies for dismantling harmful practices. Although the focus is on the UK, cases from around the world are discussed, providing a transnational perspective. U.S. issues described include the growing role of experts and assessment protocols in family courts, and the 1999 introduction of *The Greenbook Initiative,* which seeks to decrease contradictions among organizations involved with IPV.

The power state systems exert over mothers managing IPV (and over children resisting visitation with batterers) creates double-bind dilemmas as women seek safety for themselves and their children. Using the metaphor of three planets, Radford and Hester present vastly different approaches used to intervene with IPV survivors and their children by public child protection agencies, IPV advocates, and the courts. Each planet conceptualizes violence against women differently, with its own

"history, culture and laws" (Radford & Hester, 2006, p. 143). Their planet metaphor powerfully illustrates how different a woman's situation can be depending on which planet she lands, and to which authority she is expected to conform. The experience of a woman situated in the middle of contradictory forces is made clear and is startling due to the complexity of the contradictions.

On the first of the three planets, IPV advocates and those in law enforcement conceptualize IPV as a gendered crime committed by male perpetrators. From this vantage point, a woman experiencing IPV is seen as a person in need of protection. On the second planet, the public child protection agency planet, the focus is on family pathology, and a mother experiencing IPV can be seen as culpable in exposing her children to violence and charged with failing to protect them. Notably, the data from Radford and Hester's interviews indicate that protecting children from IPV is often foremost in mothers' minds and drives their decision-making, consistent with other qualitative research (McGee, 2000). Women involved with child protection agencies lose autonomy over decision-making related to their children's welfare, which can be experienced as similar to how they have been controlled in intimate relationships. Batterers often use the threat of harming or taking children to control women, and state workers may also tell mothers that their children will be removed from their care if they do not fulfill requirements. The mother may be receiving contradictory ultimatums from the batterer and the worker about a choice she should make, often to stop contact with the batterer, with both of them using power over the children to control her actions. The batterer may be threatening harm to the mother and children if she leaves, making his ultimatum more powerful, at the same time that the state system is holding her rather than him accountable for the family violence.

The third planet, the family court system, attempts to judge whether a man is a "good enough father" (Radford & Hester, 2006, p. 142) to make visitation and custody decisions. It is primarily concerned with women overcoming "their fears… rather than challenging the violence of men" (p. 101). A man who has abused his partner may still be considered a good enough parent. This planet emphasizes each parent's relationship with her/his children, with preference for children maintaining both parental relationships. Radford and Hester view the dilemmas on this planet as especially problematic. After being urged to leave her abusive partner by those operating on the first two planets, a mother becoming involved with the family court system may be ordered the opposite: to maintain contact. A table provides 14 distinct examples of "How the family law reinforces the behavior of domestic violence perpetrators" (p. 105). Mothers describe instances in which their former partners deliberately, easily and successfully used the family court system to control and harass them. To give just two examples of the court replicating the dynamics of power and control present in IPV, by ordering the mother to make her child have contact with the batterer against the child's wishes, the court can interfere in the mother-child relationship as the batterer does, by damaging their emotional bond. Second, batterers' repeated litigation can harass women and control their finances and time.

A limitation of the book, which aims to keep power relations central, is lack of details on research methodology. It is not possible to discern the extent to which the experiences of women of color, or women of varied income levels, are included. At times individual quotations situate the speaker in terms of immigration status and race, but on a thematic level, the experiences of women of color are not delineated. Integration of these issues into the overall themes, and description of who comprised study samples, would be of interest. Women of color encounter further complexities in their experiences of IPV, and an added set of power dynamics in interactions with state systems, as illustrated for example in Bernard's (2001) qualitative interviews with black mothers in the UK whose children had been sexually abused. The lack of methodological detail is a disappointment to researchers who want to pursue similar lines of inquiry. The lack of exploration of variables related to

social location is even more concerning, because they result in a somewhat homogenized description of state practices with women mothering through IPV, while more varied experiences likely exist.

In spite of these weaknesses, the book is useful for scholars and a must-read for anyone working directly with women mothering through IPV. Social workers involved in child welfare practice, victims' services, legal aid or the battered women's movement may be intrigued by the portrayal of the system they are most familiar with, and they will certainly gain insight into the other "planets." The book may serve as foundation for lively debate across service areas about best practices with families experiencing IPV. Researchers will benefit from the overview of varied approaches and from the collaboration across traditionally disconnected fields modeled by Radford and Hester. *Mothering through Domestic Violence* contributes to filling a conceptual gap identified by Krane and Davies (2002). As part of their study of practices with mothers in a Canadian shelter, they critiqued feminist scholarship, finding that feminist analyses of mothering lacked discussions of intimate violence, and that mothering was "invisible" in anti-violence advocacy and shelter practices.

The book has particular relevance for those involved with community and state organizations. Community-level change is needed. One system cannot improve in isolation from another, and the authors challenge organizations to work in partnership. Earlier research by Radford and Hester has been used to dismantle abusive policies in England, being cited in court cases and in legislation addressing unsafe professional interventions. Social workers are uniquely qualified to accept the challenge to improve community collaborations with our strengths-focus, training in the ecological perspective, and skills in advocacy, group facilitation and community organizing.

The book meets its goal of planting seeds to "raise worthwhile debate and make some contribution, no matter how small, to challenging the labeling as inadequate parents of women who mother through domestic violence" (Radford & Hester, 2006, p.16). Their critical review nutshells fundamental questions about inherent contradictions operating in state practices: Can a man be a violent partner and also a good enough father? Can a system blame a mother and still act to support her? Sufficient international examples demonstrate the book's relevance beyond the UK. The three planets metaphor is supported, and provides an organizing framework for the key theme: mothers' experiences of state practices mirror their experiences in abusive intimate relationships. Those working in any arena to end violence in the lives of women or protect the interests of children must understand the interplay of systems impacting women, IPV, and mothering.

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