PRAXIS

Where Reflection Practice Meet

Editorial

Articles

Dissertation Abstracts

Mission Statement

The School of Social Work at Loyola University Chicago created *Praxis: Where Reflection & Practice Meet* to give voice to the scholarly work of students and alumni. Our mission is to encourage and support the development of social work knowledge that will enhance the lives of the clients we serve, embody the humanistic values of our profession, and promote social justice and care for vulnerable populations. *Praxis* respects and welcomes all viewpoints.

Editorial Policy

Praxis is published by students in the School of Social Work at Loyola University Chicago. The editorial board is composed of masters and doctoral social work students. The board encourages students and alumni of the School of Social Work to submit papers that provide insight into clinical, policy, research, education and other areas relevant to social work practice. Submissions are accepted throughout the year and the priority deadline for the annual Fall publication is the last day of January. The editorial board anonymously reviews submissions and edits accepted papers with permission from the authors. Papers should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

All inquiries, submissions and subscriptions should be directed to: Editorial Board, *Praxis: Where Reflection and Practice Meet*, School of Social Work, Loyola University Chicago, 820 N. Michigan Avenue, Chicago, Illinois 60611. Telephone: (312) 915-7005; website: http://luc.edu/socialwork/praxis/

Editorial

Two Truths

"On closer scrutiny, contradictions...often turn out to be antinomies—pairs of large truths, which though both may be true, nonetheless contradict each other. Antinomies provide fruitful grounds not only for strife, but also for reflection. For they remind us that truths do not exist independently of the perspectives of those who hold them to be so."

~ Jerome Bruner, The Culture of Education, 1996 (p. 66)

We know so much, and so little, all at the same time. That is what a year of study, teaching, and editing *Praxis* have impressed upon me.

I taught an introductory research course in the MSW program this spring, and the final assignment required students to submit original proposals for research. While anyone who teaches will tell you that grading is not often a pleasant task, reading students' papers nonetheless inspired in me a sense of wonder. I felt amazed each time I read one of the papers because they were impressively full of potential and creativity. Students are allowed to propose research on anything related to social work that they wish, and the variety expressed in their choices was tremendous. They asked questions that would have never occurred to me but which, if answered, would contribute significantly to the knowledge base of the field. I couldn't help but be aware of how much more there is to know, and how the knowledge to be gained is limited only by researchers' ability to ask questions and seek answers. Our students have this ability, as demonstrated not only by the papers I read but by this very journal.

Reviewing submissions for *Praxis* also engendered awareness, of both how much we know and how much is yet to be known. However, in *Praxis* the articles aren't limited to research proposals. They range from the application of psychoanalytic theory to characters in a critically acclaimed movie to analyses of complicated legislation. By the time I finish reviewing the 40-odd clinical, research, and policy papers that are submitted by students each year, I feel as though I've been educated. What a wealth of knowledge our students have to share with the social work community.

We know so much, and simultaneously so little. Perhaps the most powerful teacher of these dual truths has been my own experience preparing to do dissertation research. I strongly suspect that anyone who has conducted research has been similarly impresse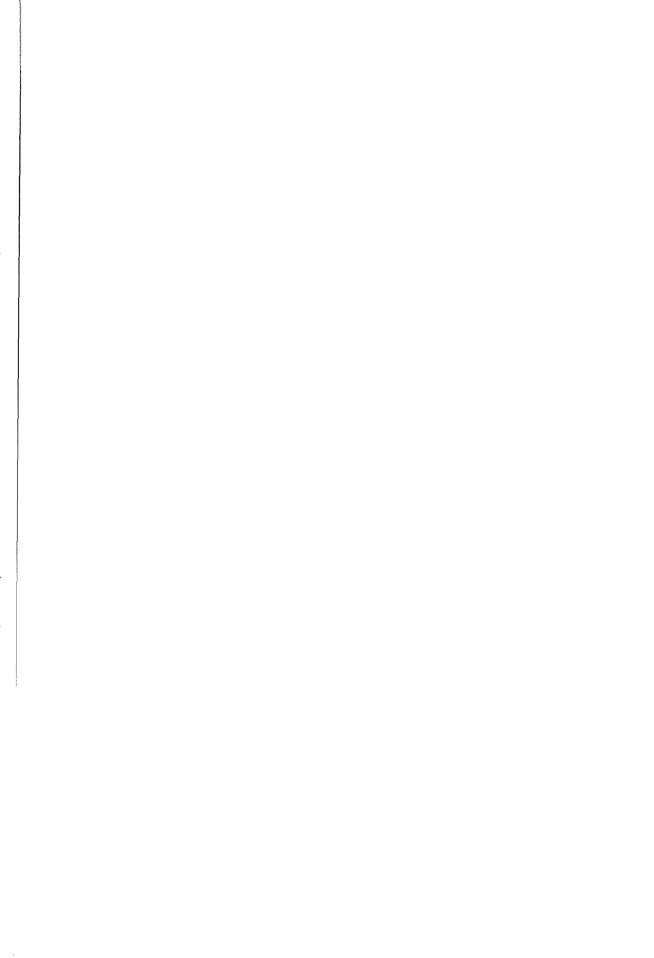d by both the vast amount of knowledge available in the field *and* how much more knowledge is needed. Research begins with a question-asking process that is limited, as I've said, only by the imagination of the researcher. There is much to know. But it proceeds with a review of relevant literature, which often overwhelms the researcher with existing studies and clinical works. How much we already know! Then comes selecting a methodology, which may be either overwhelming (because there are so many options from which to choose) or frustrating (because the operationalization of concepts requires them to be reduced in a way that limits the researcher's question). Data collection, which often generates a vast amount of information, can similarly make one aware of how much is known and yet how little, as all that data may yield fewer conclusions and generate more questions than are expected.

If these dialectical truths of knowing much and knowing little have not yet been your experience, it is my wish for you that reading this volume of *Praxis* will have that effect. I hope you will find the scholarship of the student authors and the hard work of the editorial board to be knowledge enriching. And I hope that reading these articles will spur you to ask questions of your own, shining light on the areas of the field in which more knowledge is needed.

To that end, allow me to introduce you to this year's *Praxis* journal. Volume 6 begins with Deanna M. D'Amico Guthrie, Rebecca Kaufman and Jennifer Rose's qualitative research article on social workers' views about outcomes in child sexual abuse cases, which is joined later by another qualitative research article, written by Gina E. Gehrke, Quincy D.H. Jenkins, Stephanie A. Miskovetz, and Pauline F. Wray on motivation for mentoring . Both articles illustrate the flexibility and depth made possible by qualitative methodologies, and both bring their subject matter to life in a way that quantitative research often struggles to do.

Next, Erin Aydt, Jennifer R. Lacoff, Joanna Miller, and Lauren Naset offer a summary and analysis of

the 2004 reauthorization of the Individuals with Disabilities Education Act. Their summary is accessible and enlightening if you are not already familiar with the Act, and they offer helpful suggestions for social workers implementing the Act's changes, making this well-written article worth reading.

Deanna D'Amico Guthrie and Elena L. Benetar author this volume's clinical pieces: Deanna writes about the use of Dialectical Behavior Therapy with adolescent clients diagnosed with or presenting with symptoms consistent with Borderline Personality Disorder, and Elena provides an engaging reminder of the culturally bound nature of mental illness. Both are thoughtful and informative, and both advocate for practices that best meet client needs in their respective areas.

The final pair of articles in Volume 6 comes to us from doctoral students Carol Jarvis and Kathryn L. Cornell. One writes about the history of divisions in the field between function and cause and argues for the need to achieve a more balanced integration of the two, while the other writes about the need for the person-in-environment perspective to be more fully integrated into social work practice. The similar-yet-different quality of the articles almost gives the reader the sense that she or he is in a classroom in which the same material is being discussed from differing perspectives. The historical summaries in both articles are also thorough and interesting refreshers on the profession's past. Read them, and you will be well-informed about the evolution of the concepts discussed by the authors.

In keeping with the theme of this editorial that there is much yet to be known, I'd like to mention that I am stepping down as Editor-in-Chief in order to pursue my own research. As much as I've enjoyed editing *Praxis*, I'm afraid serving in this capacity and making progress on a dissertation appear to be incompatible. Though I'm sad to end my time with the journal, I am pleased to welcome doctoral student, long-time Board member, and previously published *Praxis* author Jeffrey Bulanda as the new Editor. I know I'm leaving the journal in good hands.

Also, please join me in saying good-bye to Dr. Susan Grossman, who has been the faculty liaison for *Praxis* for the past three years. Susan is well known in the School for her responsiveness to and encouragement of students. *Praxis* and I have both benefited tremendously from these characteristics in recent years. Susan is responsible for prompting many of the submissions received by *Praxis* and also has coordinated the submission and review process for authors. She's been a tireless sounding board as decisions have been needed about Board meetings, publicity, reviews, and journal content. As her final act, she will be assisting new faculty liaison Dr. Janice Matthews Rasheed as she assumes to her new role. Dr. Rasheed brings extensive research experience to *Praxis*. I am sure she, Jeff, and next year's editorial board will continue the tradition of producing a volume of the best student scholarship from the School of Social Work. I'm looking forward to it.

Christie Mason, LCSW
Doctoral Student
Editor-in-Chief

Reference

Bruner, J. (1996). *The culture of education.*
    Cambridge, MA: Harvard University Press.

Social Workers' Views on the Differential Outcomes in Child Sexual Abuse Victims

by Deanna M. D'Amico Guthrie, Rebecca M. Kaufman, and Jennifer A. Rose

Abstract

Past research on outcomes for child sexual abuse victims has used quantitative measures to delineate risk and protective factors. This study sought to understand how social workers describe the differential outcomes they have observed in practice. Using a qualitative interview, five social workers experienced in working with victims were interviewed. The participants were asked for their opinions regarding what led to better and poorer outcomes for victims, as well as what factors could contribute to children presenting with a poor outcome despite the presence of protective factors, a question that had not been asked in previous research. Four themes emerged as accounting for differential outcomes: the ability of the victim to be connected, external resources, reactions surrounding the abuse, and psychopathology.

Statement of the Problem

Child sexual abuse is pervasive in the United States, and many victims come to the attention of social workers. Based on community samples, 12 to 35% of women and 4 to 9% of men report they were sexually abused as a child (Putnam, 2003). In the city of Chicago, 13,970 children under the age of 18 were reportedly victims of sexual abuse in the 1990s. Of these children, 9 out of 10 were minorities and 60% were girls (Chicago Children's Advocacy Center, 2005). Treating the victim of sexual abuse can be difficult because of the varying ways in which these clients present. The most frequently reported symptoms of child sexual abuse victims are fear, posttraumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem. However, no single symptom has been reported by the majority of victims, suggesting there is not a specific syndrome in children who have been victims of sexual abuse (Kendall-Tackett, Williams, and Finkelhor, 1993).

Since many victims receive clinical attention, it is important for social workers to understand the risk and protective factors that can lead to differential outcomes. Many of these factors can be targets of intervention in order to promote the healing process. So that they may best assist these clients, social workers should know what can help and what may hinder clients' progress. Numerous studies have examined the risk and protective factors associated with a differential outcome in child sexual abuse victims. The majority of these studies have relied on parent, therapist, and child reports through the use of standardized measures of symptoms (for examples see Berliner & Conte, 1995; Cohen & Mannarino, 2000; and Tremblay, Hébert, & Piché, 1999). Few of them directly asked social workers to share in narrative form their opinions of what these factors are; similarly, only a limited number of works have used qualitative methodologies. The present study sought to address these gaps. By using a qualitative interview, the researchers hoped to receive responses that may not have been captured by the standardized instruments used in previous studies. Additionally, there have not to the researchers' knowledge been any studies that have explored what can lead victims with many protective factors to still have a poor outcome. This study asked social workers to share their perceptions of why poor outcomes sometimes occur even for clients who do have many protective factors.

Literature Review

As noted above, a number of studies have been conducted investigating the effects of childhood sexual abuse and the factors that may put children at a greater risk for adverse outcomes or serve as protective factors (See, for example, Berliner & Conte, 1995; Cohen & Mannarino, 2000; Kendall et al., 1993; Tremblay et al., 1999). Reviews of existing studies suggest that the effects of sexual abuse on children are inconsistent. These works indicate that abused children present with more psychological symptoms than non-abused children, with the most frequently reported symptoms being fear, posttraumatic stress disorder, behavior problems, sexualized behaviors, and poor self-esteem. However, approximately one-third of the victims do not show any symptoms. This research suggests that clinicians cannot rely on a profile of the "typical" sexual abuse victim during diagnosis (Kendall et al., 1993).

Using samples of child victims as well as adult survivors of childhood abuse, studies that have examined protective factors have found that age of onset of the abuse, age of the child at the end of the abuse, the

relationship between the child and the abuser, family characteristics, including adaptability, as well as the extent to which the child is believed by those to whom he or she reports the abuse and the amount of social support provided by family and peers are related to outcomes (Steel, Sanna, Hammond, Whipple, & Cross, 2004; Cohen & Mannarino, 2000; Berliner & Conte, 1995; Tremblay et al., 1999; Romans, Martin, Anderson, O'Shea & Mullen, 1995; Spaccarelli, 1994; Conte & Shuerman, 1987).

While these studies relied on quantitative measure, at least one qualitative study (Nelson-Gardell, 2001), identified similar factors. Using focus groups of sexually abused girls to explore the factors that from the point of view of the victims maximize coping capacities, four themes emerged from the girls' responses. The first and strongest theme was that having someone believe them was equated with help and support. When the girls were asked who helped them, they responded by identifying those who had believed them when they disclosed the abuse. They perceived those who did not believe them as unhelpful or harmful. The girls also believed that talking about the abuse helped them and that therapists should try and get abused girls to talk about the abuse. Further, the girls thought talking about their feelings was important because they believed keeping feelings inside would lead to future negative consequences.

Finkelhor (1995) discusses the developmentally-based effects of victimization, which include the impairment of attachment, lower self-esteem, highly sexualized or highly aggressive approaches to interpersonal relating, failure to acquire competence in peer relationships, the use of drugs, dissociation, self-injury, or other maladaptive ways of coping with anxiety. When the child is more impacted by victimization, the likelihood increases that he or she will display developmental effects such as repetitive and ongoing victimization, victimization that dramatically changes the nature of the child's relationship with her primary support system, additional serious stressors, or victimization that interrupts a crucial developmental transition. Child victims are more affected when they believe they are going to die or be seriously injured or when they feel helpless and out of control.

Child victims' reactions to intervention and how they view clinicians have also been studied. Berliner and Conte (1995) interviewed sexually abused children and their families about their experiences with disclosure and intervention. Overall, the children reported having a positive view of their therapists and feeling better after an interaction with a therapist.

Many of the positive experiences the children had with their therapists were due to the personality and performance of the therapist (such as being understanding, concerned, sincere, and treating the child in a respectful and personal manner). The children reported a negative experience when they felt as though they were one of many clients instead of a unique child facing a very difficult situation.

Because nearly all studies on child sexual abuse have been quantitative, the authors of this study sought to explore treatment outcomes for victims from a qualitative perspective. Much has been learned from quantitative studies of child sexual abuse, but the use of standardized instruments inevitably limits results to what is included in the instruments themselves. By using a qualitative interview, the researchers hoped to receive responses that were not captured by the standardized instruments used in previous studies. Additionally, because they were responding to open-ended questions therapists were able to respond in their own words, which the researchers thought might generate different or richer understandings than can be gained using standardized measures. Finally, in much of the previous research therapist study participants have been psychologists. The current study interviewed social workers in an attempt to see whether their perspectives would produce to unique responses.

In this study, child sexual abuse was defined as sexual activity before age 18 with an individual three or more years older, a sibling or other family member, or someone using threat, force, or coercion. Sexual activity ranges from physical contact (anal, oral, genital, or breast contact) to penetrative sexual intercourse. Four research questions were investigated: 1) What do social workers believe puts child sexual abuse victims at risk for a poor outcome? 2) What do social workers believe protects child sexual abuse victims and leads to a better outcome? 3) What do social workers believe accounts for children with some of the mentioned protective factors still presenting with a poorer outcome? and 4) What therapist characteristics do social workers believe lead to a better outcome in sexual abuse victims?

Method

Participants

In order to obtain a sample, the researchers sent letters explaining the study to the directors of Chicago-area agencies that specialize in treating child sexual abuse victims, along with contact information for the researchers so that therapists who

were interested in participating could reach them. The directors were asked to distribute the letter to their social work clinicians. The response to this method of sampling was low; therefore, the researchers solicited participants by networking with clinicians at their field placement agencies. In the end, five social workers consented to participate in one-on-one tape recorded interviews (see Table 1). All five participants were licensed clinical social workers, four of whom were master's level clinicians and one of whom possessed a doctoral degree. In addition, four of the five participants were working with child sexual abuse victims at the time of the study. The fifth clinician worked in academia but had previously worked directly with victims of childhood sexual abuse. Four of the participants were female and one was male. Although this convenient, non-random sample was small, the therapists did represent a variety of work settings that served clients from diverse socioeconomic and racial backgrounds. Therapists who participated also informed the researchers of other social workers who had expertise in the area being studied. Had time not been a constraint in this study, more interviews could have been conducted using the snowball sampling method in order to obtain a larger sample.

Measure

This study was conducted using a qualitative, exploratory approach. The purpose of conducting a qualitative study was to give therapists the opportunity to discuss factors that may not have been captured in quantitative studies and to expand on ideas in a format where they did not feel limited or constricted by the measurement tool. A 15-question, semi-structured interview that addressed the participants' experiences and perceptions about poor and good treatment outcomes for child sexual abuse victims was created for use in this study. All 15 questions were open-ended. The participants were asked to report on their experience working with individuals who had been sexually abused while not revealing any confidential information about these clients. The questions were based on variables that have been researched using standardized measures in previous studies. In order to operationally define "better outcome" and "poorer outcome," the researchers asked the participant to explain the meaning of these terms. Participants were also asked to define characteristics of a therapist that they believe lead to "better outcomes" in sexual abuse victims, as well as the characteristics of the abuse experience, the family environment, and the victim that lead to a "poorer or

Table 1
Demographic Characteristics of Participants

	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Gender	Female	Male	Female	Female	Female
Age	38	37	29	60	34
How long they have been in the field	15 years	13 years	7 years	30 years	10 years
Length of time they have worked with child sexual abuse victims	9 years	13 years	3 years	30 years	10 years
Percentage of clients that are child sexual abuse victims	85%	Currently 3-5%	85%	Currently work with adult survivors, past experience with children	N/A
Preferred theoretical orientation with this population	"Feminist orientation," cognitive behavioral, family systems	Structural family therapy, family systems	Cognitive behavioral, play therapy, family systems	"Integrative ecological model"	"very eclectic"

better outcome." Finally, they were asked what factors account for children with protective factors still having a "poor outcome."

The interview developed for this study has face validity because it appears to ask about what the study is attempting to measure. The measure also appears to have content validity. The questions, which seem to cover the factors associated with differential outcomes, were based on variables other researchers have examined regarding the differential outcome in victims (the characteristics of the abuse experience, the child, the family environment, and the therapist). These variables were explored via the use of open-ended questions in order to gain a deeper understanding of them. A limitation of this measure is that reliability has not been established because the interview had not been used before.

Procedures and Data Analysis

One-on-one interviews were scheduled with the social workers who agreed to participate in the study. The researcher who conducted the interview accommodated the participant by traveling to his or her agency for the interview. Due to time constraints, one interview was conducted via telephone at a time convenient for the participant. The participants were asked to read and sign the consent form and the consent to audiotape. In order to account for threats to reliability, interviewers only asked the designated research questions. Any additional comments made by the interviewers during the interviews were transcribed from the interview audiotapes for the other researchers to note. The interviews took approximately 25 minutes to complete. After the interview questions were asked, the interviewer turned off the tape recorder and then thanked the participants for their contribution to the study and asked if they would like a copy of the results.

After each interview was completed, the researcher who conducted the interview transcribed it and provided the other researchers with a typed copy. Each researcher then coded the data individually by reviewing the data twice. The first read of the data was literal, looking at the quotes and the content of what was said. The second read was interpretive, as each researcher looked for common themes among the responses. Each researcher put together a list of themes with quotations that she considered to be a part of the theme. Once each of the researchers had examined the data, commonalities in how themes were interpreted within and across the questions were identified. When all of the coded data was compared, four overarching themes emerged.

These themes, which were arrived at by consensus, were found across interviews and across questions. In order to determine the overarching themes, a standard was agreed upon that themes needed to be in at least four out of the five interviews and in response to different questions within interviews. Two additional themes emerged as being specific to social work ethics and values, and as a result these were included in the results as well. Due to the subjective nature of determining themes, the researchers used direct quotes from the interviews to further clarify their understanding of each theme. The biases that the researchers encountered dealt with expectations. Specifically, based on the previous research, there may have been certain answers that the researchers expected to be given, which may have influenced what researchers identified as the most important statements. In addition, data were coded as the researchers went along. Therefore, it is possible that as more data were collected, the analysis of the data began to be skewed to fit themes that the researchers identified in earlier interviews.

Results

Through the analysis of the results, four themes emerged: the ability to be connected, reaction to the abuse, external resources, and psychopathology (see Table 2).

The Ability to be Connected

In all of the interviews, the therapist stated that the child's ability to connect to another person could lead to a better outcome:

> If the victim is able to have a solid connection with pretty much anyone, that makes a huge difference in whether or not they can get through.... whether the victim is able to connect with somebody...able to open the door far enough to let somebody that close.

One of the reasons mentioned for the impact of this ability to form relationships is that these relationships can demonstrate to the victim what an appropriate relationship is between an adult and a child. These can serve to show the child that it is possible to have a relationship with an adult in which he or she will not get hurt:

> The kind of solid connection that would refute all of the things that the abuse broke down...that adults aren't supposed to do this. In relationships that are solid, these things don't happen.... They are effectively corrective experiences.

Similarly, when asked what characteristics of the

Table 2
What Accounts for Differential Outcomes among Child Sexual Abuse Victims: Themes and Categories

1. **Ability to be Connected**
   - Able to form relationships and let someone in
   - Able to establish a relationship with a therapist
   - Having a solid connection to refute what the abuse broke down
   - Poor outcome associated with an increased struggle in relationships
   - Poor outcome associated with being too afraid to talk

2. **Reaction to the Abuse**
   - Whether the child was believed, supported, and protected
   - Whether immediate action was taken after disclosure
   - Recognition that the abuse was not the child's fault
   - Level of blame, guilt, and shame within the family system

3. **External Resources**
   - Whether family has outside supports
   - Whether healthy extended family is available for support
   - Family's level of isolation
   - Whether resources are available within the community
   - Whether older children have a strong friend base and social network

4. **Psychopathology**
   - Genetic vulnerabilities – such as to mental illness or learning disabilities
   - Whether self-destructive coping mechanisms are adopted such as cutting
   - Presence of depression or eating disorders

victims can lead to a better outcome, one therapist responded:

> Any semblance of a healthy relationship…. By virtue of her ability to connect to another human being she was able to feel that and internalize that and realize there was another way that life and a relationship could be.

When asked to define a good and poor outcome, some of the therapists defined a poor outcome as an increased struggle in relationships, while others said that a good outcome is the ability to form relationships:

> A good outcome would be someone who could integrate that it was an experience of abuse for which they held no responsibility and then could move on into constructive, healthy relationships.

Some responses also stated specifically that the child's ability to have a solid connection with the therapist could also contribute to a better treatment outcome:

> Victims who are either too afraid or too afraid to talk…if they don't feel like they can confide anything with their therapist…then that leads them to a poorer outcome…all of the kids are afraid, but the kids that have been believed and supported and protected and they are still so afraid to tell someone or they are still so afraid they can't talk or they are so immersed in self-blame that they just can't get past any of that, that makes the biggest difference.

Reaction to the Abuse

After looking across all of the interviews, the data suggested that the therapists believed the most important factor contributing to the child's treatment outcome was the reaction she or he received regarding the abuse. Many different aspects of reaction were included in this theme, which was noted in four interviews. The most common response was whether the child was believed, supported, and protected:

> It is the family's reaction to the abuse that makes the biggest difference rather than the actual characteristics of the abuse itself. And you know there are exceptions to that rule, but I would say that believe, support, and protect make more difference than what actually happens to the child.

Another commonality within this theme was the idea that familial blame, guilt, and shame contributed to a poorer treatment outcome:

> One of the things I see is when the family of the child (and the child included) experience a lot of shame and guilt and they want to contain it as a secret. It really creates a risk that the child

and the family are unable to process it...to get some sense that this did happen to me and it's not okay.

Equally as important to treatment outcome was the level of blame, guilt, and shame the child felt. Self-blame was also used to define a poor or better outcome in the interviews:

> Good treatment outcomes are usually about recognition of the abuse as a crime that was not the child's fault.

> I think a poor treatment outcome for a child would be where the child remains having experiences and/or beliefs that reinforce the experience as their fault.

The therapists also felt that immediate action taken by the parents after disclosure was important:

> I think the response time is important. I think it leaves a child with less time on their own to really try and move beyond and to not live in fear and guilt and shame and all of the other things that come from being victimized.

External Resources

A third theme that emerged from the interviews was that the external resources available to a child and family influence the treatment outcome. When asked what characteristics of the family led to a better outcome, two of the therapists replied:

> Supportive family and a family that has outside supports.... [If] they are isolated, it is another huge thing because with outcomes, there is a much higher risk. I have seen families that are dealing with it by themselves without any support, which can be so much more stressful, and there can be a breaking point that there is only so much they can do.

The therapists also discussed that the child's external resources can lead to a better outcome, such as the child having a strong friend base and a social network in which they feel self-confident.

Psychopathology

All five of the therapists interviewed mentioned the effect psychopathology could have on treatment outcome. The presence of mental illness before the abuse can put the child at risk for a poorer outcome, as can psychopathology that develops after the abuse. The therapists mentioned some common psychological problems that can result after a child has been abused that make treatment more difficult:

> Kids that might be delayed in some way or learning disabled or that have mental illness or depression already or kids that have developed

more severe reactions like depression as a result of it or eating disorders. Eating disorders is huge, it is a result of sexual abuse. They are so difficult to recover from, you have to go through abuse counseling and for anorexia, depending on how severe the eating disorder has gotten. Their outcome is hugely in question. There is a big correlation between those two, sex abuse and eating disorders.

They also mentioned self-destructive coping mechanisms:

> Some clients...can't, for a variety of intrapsychic reasons, stop self-harming (cutting, tearing) and while it's not active suicidality, it's terribly debilitating behavior and it keeps them from moving on in any other kind of relationships.

Psychopathology can also become more severe over time, so as the children become adults, they may have an even poorer prognosis:

> By virtue of their own vulnerabilities, personality characteristics, they might have borderline characteristics because it is pretty much an adaptive mechanism when people who are close to you hurt you to not have long-term relationships and to make sure you sort of move away from relationships fairly quickly. For most of these women, they have full blown borderline personality disorder and other kinds of psychopathology that make it much more difficult for them to establish interpersonal relationships with anyone and therefore the relationship with the clinician becomes paramount to help them work through this in some way. I do think it is possible to work through these things, but the time frame required is enormous. The longest I worked with someone was 13 years.

Some children will also develop severe psychopathology that may not have been a direct result of the abuse, and this has been attributed to a genetic vulnerability:

> In some ways I think genetics [can lead to a poorer outcome]. You know they just got a bad genetic deal. You know we have a girl who I think will end up with paranoid schizophrenia and it doesn't matter how helpful her family is. She is going to have a tough road no matter what.

Themes Specific to the Field of Social Work

Two additional themes emerged across the interviews as being specific to social work ethics and values and the "person-in-environment" perspective: "being where the child is" and society's effect on sexual abuse. In every interview, therapists spoke of "being where the child is," which included developmentally appropriate reactions to the child and

intervention strategies based on the child's current needs. Therapists also discussed the importance of the family being aware of where the child is developmentally and emotionally:

> The other thing that I've seen is where the family seems motivated to respond to the situation, but it's beyond the child's time of processing or what the child needs to get through this…. They try to get their hands around it and make sure everything is okay and then move forward. But the child, depending on where they are at, can't do that for whatever reason and that can become a risk factor that they internalize that something is wrong.

Four out of the five therapists also felt society has an impact on child sexual abuse. One therapist stated:

> I think children in general in America are glamorized and they are made into celebrities way too young and they are sexualized. They are making a lot of money by doing that. It's a trap. When you live in a culture that says you can make a lot of money if you are young and attractive, it puts a lot of pressure on children to be a certain way. I think it's real subtle, but I think there is a connection.

Discussion

There were several limitations in this study. One of the most significant limitations was the small sample, consisting of only five participants. A larger sample size may have elicited different results, but the high degree of consensus among the responses of the participants casts doubt on whether a larger sample would have resulted in more findings. In addition to being small, the sample was also nonrandom and thus not representative of all social workers who work with child victims of sexual abuse. Only social workers in the Chicago area were interviewed, and even though they came from a variety of agencies in Chicago and the suburbs, the study cannot claim to represent the views of all social workers. There was also only one male participant. The results of this study may not be able to be generalized to all childhood sexual abuse victims, but this is commonly the case as the aim of qualitative research is usually to gain a deep understanding rather than to achieve generalizability.

Taking into account these limitations, certain conclusions can be drawn from this study. The study supported the idea that numerous factors contribute to treatment outcome in child sexual abuse victims. The reactions of the family and the resources available to them are important, as are factors within the child

such as the ability to connect to another person and a vulnerability to psychopathology.

The qualitative nature of this study did lead to some responses that differ from those found in quantitative research. According to previous quantitative literature, a poorer outcome can result from the characteristics of the abuse experience itself (such as penetration, duration/frequency of abuse, number of offenders, age at onset/end of the abuse, helplessness or fear of being hurt or dying during the abuse, and a close relationship to the abuser – see for examples Berlinger & Conte, 1995; Kendall-Tackett, et al., 1993; Steel, Sanna, Hammond, Whipple, & Cross, 2004; Tremblayet et al., 1999). In four out of the five interviews, however, the therapists did not feel the characteristics of the abuse itself were important to the outcome, except for the relationship of the victim to the abuser. Overall, the therapists thought that the reaction of the parents when the child told was more important than what actually happened to the child during the abuse experience.

Several different reasons were given for the therapists' belief that the relationship to the abuser could make a difference. One of the therapists stated that it could be difficult for the child if a breadwinner in the family was removed as a result of the abuse because the child could experience guilt due to the resulting financial hardship for the family. Another response was that it could be harder for children to say no to a family member or parent perpetrating abuse if they had been taught to obey their elders. A third therapist also said that it may be more difficult for a child to heal after being abused by a parent if this parent was also loving or nurturing because then the child would have a more difficult time seeing the perpetrator as bad. These three different explanations illustrate the role that qualitative studies play in expounding on previous quantitative research.

Steel, Sanna, Hammond, Whipple, and Cross (2004) found that those who had several perpetrators of abuse in childhood had more psychological distress because more people in their life perpetrating abuse limited the amount of people the child could disclose the abuse to or seek social support from. The therapists in the present study felt that the ability to seek social support and disclose the abuse was more important than the number of perpetrators. In Steel et al.'s study, the duration of the abuse was also found to be mediated by the internalization of the abuse. If a child experienced more abuse, he or she was more likely to attribute the abuse to

something within him or herself, whereas if it was a one-time event she or he was more likely to attribute it to chance. Even though the current study suggested that the self-blame the child experienced was a greater risk factor for a poor treatment outcome than the duration of the abuse, a longer duration may have led to greater self-blame in the victim.

Due to the qualitative nature of this study and the flexibility of the interview format, two additional themes that are consistent with the person-in-environment perspective emerged across the interviews. In every interview, participants discussed the importance of "being where the child is," which included developmentally appropriate reactions to the child and intervention strategies. Social workers value a client-centered approach to treatment, so it is not surprising that this idea was present in all of the interviews and across questions. Additionally, the person-in-environment perspective held by social workers naturally leads to thinking about the larger context and the influence society has on the issue of child sexual abuse. The therapists spontaneously incorporated their thoughts about the significance of macro-level influences into their answers of other questions, such as those about their theoretical backgrounds and the qualities of the victim that lead to poorer outcomes.

Some of the results of this study did support the previous research in the field. Previous research has suggested that better functioning families (more specifically, those who believe the child, are supportive, and act in a productive way after the abuse is disclosed) contribute to a better treatment outcome for that child (Kendall-Tackett, et al., 1993), which is consistent with the views of the therapists in this study. According to the interviews in this study, belief and support were the most important protective factors for an abused child. This is similar to the findings of other works, both quantitative and qualitative in nature (see Spaccarelli, 1994; Conte & Schuerman, 1987; and Nelson-Gardell, 2001). Taken together, the results show how important it is for therapists to look at the support system in place for the child, and attempt to intervene if this is lacking in the child's life.

The present study also produced some results similar to quantitative research regarding the child factors that can lead to a differential outcome. According to the previous research, the child's ability to seek support from others and be able to disclose and talk about the abuse can lead to a better outcome, but feelings of self-blame and not feeling believed can lead to a poorer outcome (Tremblay, et

al., 1999; Steel et al., 2004). A theme found among these interviews is that self-blame can contribute to a poorer treatment outcome. According to one interview, the child's ability to see the perpetrator as bad can lead to a better outcome. Also, a child who believes the abuse is her fault is likely to experience more internalizing symptoms, such as low self-esteem and depression, which could lead to a poorer outcome.

The therapists in this study believed that the child's ability to connect to another person was important to the child's outcome. Thus, even if the parents and therapist are attempting to support and help the child, that support will not be an effective protective factor if the child is not able to accept that support or connect to those trying to help. There is more to treatment outcome than simply those in the child's environment being supportive. The child needs to either accept that support or perceive that it is there in order for it to make a difference.

This study asked the exploratory question, "What could account for children possessing many protective factors still presenting with a poorer outcome?" The initial response of several of the therapists was that they were not sure because they had not thought about outcomes in this way before; most then generated a response based on their experiences. Answers to this question could also be teased out of the responses the therapists gave to other questions. In general it was found that poorer outcomes in spite of the presence of protective factors were related to the complex issue of psychopathology, which included a discussion of predisposition to mental illness before the abuse and a more severe psychopathological reaction after the abuse. Before the abuse, children were at greater risk for a poorer outcome if they had learning disabilities or mental illness such as depression. The more severe reactions to the abuse included depression, eating disorders, cutting and other self-harm behaviors, schizophrenia, and borderline features.

This greater risk for psychopathology may be able to be attributed to a genetic vulnerability. According to the diathesis-stress model of the development of psychopathology, those who have a greater vulnerability to develop a disorder need a lesser amount of life stressors to reach the threshold for that disorder. For some children, the experience of any type of sexual abuse, regardless of the severity, is enough for them to develop psychopathology that poses greater treatment difficulties and therefore increases the risk of a poorer outcome. When looking at the differential outcomes in child sexual

abuse victims, it is important to consider vulnerabilities within the child in addition to what is present in the environment. Cohen and Mannarino (2000) found that children's psychological symptoms were strongly impacted by their own cognitions and perceptions related to the abuse, parental support, and family stability and predictability.

Conclusion

The authors conducted this study with the intent of exploring via qualitative interviews therapists' perceptions of factors associated with better or poorer treatment outcomes. While a number of the findings were consistent with the quantitative literature (e.g., the importance of the child being believed about the abuse), the therapists interviewed did have a different perspective on the impact of abuse characteristics on outcome. Specifically, they thought the responses of parents and the child's support system to the abuse were more predictive of outcome than the nature of the abuse itself. Future research—particularly qualitative interviews with individuals other than therapists, such as children, parents and teachers—is important in order to further increase knowledge in this area.

References

Berliner, L., & Conte, J.R. (1995). The effects of disclosure and intervention on sexually abused children. *Child Abuse & Neglect, 19*(3), 371–384.

Celano, M.P. (1992). A developmental model of victims' internal attributions of responsibility for sexual abuse. *Journal of Interpersonal Violence, 7*, 57–69.

Chicago Children's Advocacy Center (2005). Retrieved on September 27, 2005 from http://www.chicagocac.org.

Cicchetti, D., & Lynch, M. (1993). Toward an ecological/transactional model of community violence and child maltreatment: Consequences for children's development. *Psychiatry: Interpersonal & Biological Processes, 56*, 96–118.

Cohen, J.A., & Mannarino, A.P. (2000). Predictors of treatment outcome in sexually abused children. *Child Abuse & Neglect, 24*(7), 983–994.

Conte J.R., & Schuerman, J.R. (1987). Factors associated with an increased impact of childhood sexual abuse. *Child Abuse & Neglect, 11*, 201–211.

Finkelhor, D. (1995). The victimization of children: A developmental perspective. *American Journal of Orthopsychiatry, 65*(2), 177–193.

Kendall-Tackett, K.A., Williams, L.M., & Finkelhor, D. (1993). Impact of sexual abuse on children: A review and synthesis of recent empirical studies. *Psychological Bulletin, 113*, 163–180.

Nelson-Gardell, D. (2001). The voices of victims: Surviving child sexual abuse. *Child and Adolescent Social Work Journal, 18*(6), 401–416.

Romans, S.E., Martin, J.L., Anderson, J.C., O'Shea, M.L., & Mullen, P.E. (1995). Factors that mediate between childhood sexual abuse and adult psychological outcome. *Psychological Medicine, 25*, 127–142.

Spaccarelli, S. (1994). Stress, appraisal, and coping in child sexual abuse: A theoretical and empirical review. *Psychological Bulletin, 116*(2), 340–362.

Steel, J., Sanna, L., Hammond, B., Whipple, J., & Cross, H. (2004). Psychological sequelae of childhood sexual abuse: Abuse-related characteristics, coping strategies, and attributional style. *Child Abuse & Neglect, 28*, 785–801.

Tremblay, C., Hébert, M., & Piché, C. (1999). Coping strategies and social support as mediators of consequences in child sexual abuse victims. *Child Abuse & Neglect, 23*(9), 929–945.
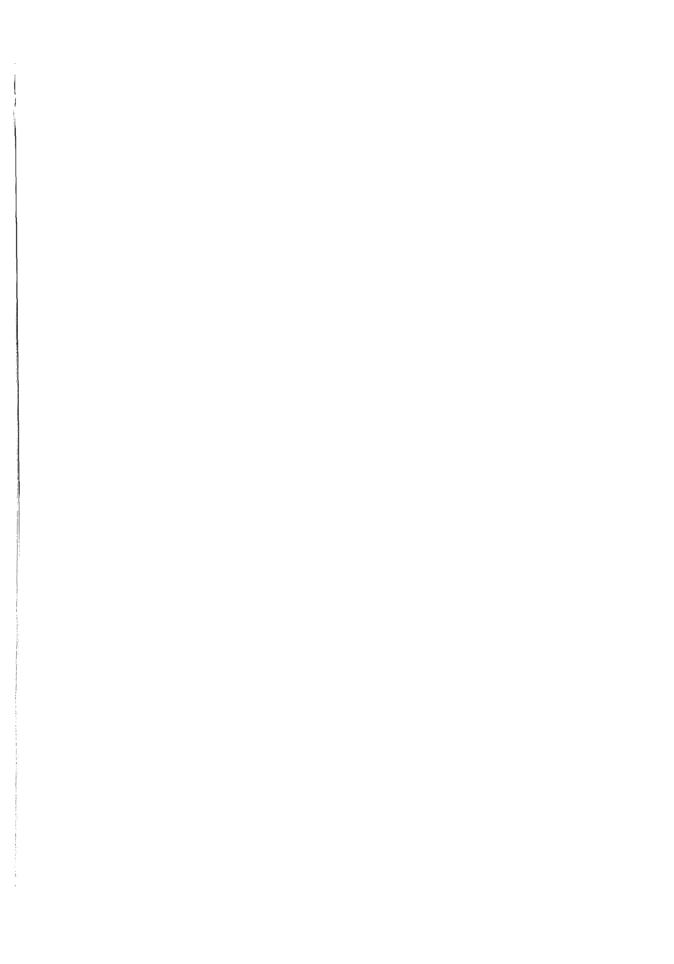
Deanna M. D'Amico Guthrie received her MSW from the School of Social Work in May 2006. Her first-year internship was at Northwestern University Legal Clinic, where she served as a legal advocate for children and adolescents facing juvenile delinquency cases. In her second-year internship she provided long-term individual therapy to children, adolescents, and adults at Niles Family Services, where she now works as a social worker.

Rebecca M. Kaufman received her MSW from the School of Social Work in May 2006. She completed her first-year internship at Edward Hospital in Naperville. Her second-year internship was at Hanover Township Youth and Family Services, where she performed screening assessments and provided long-term family therapy services.

Jennifer A. Rose is a MSW graduate from Loyola University Chicago School of Social Work. She completed her two-year internship at The Josselyn Center in Northfield. Her clinical experience includes long-term individual therapy with adults, adolescents, and children; psychosocial assessments; case management; and an anger management group she launched for children.

Free and Appropriate Public Education for All: An Analysis of the 2004 Reauthorization of the Individuals with Disabilities Education Act

by Erin Aydt, Jennifer R. Lacoff, Joanna Miller and Lauren Naset

Abstract

The reauthorization of the Individuals with Disabilities Education Act in 2004 introduced several changes, including aligning the Act more closely with the No Child Left Behind legislation; attempting to reduce frivolous lawsuits against schools; targeting the over- and misidentification of non-disabled students, especially minorities; requiring that students be disciplined in the same manner as their non-disabled peers; and outlining a plan for Congress to follow through on its promises to increase funding to states for the education of students with disabilities. This article traces the history of the Act, summarizes and analyzes the changes initiated in its 2004 reauthorization, and offers recommendations to social workers for implementing the Act in ways that are consistent with social work values and practice.

Introduction

Students with disabilities have historically had a difficult time accessing formal educational systems. The United States Congress attempted to rectify the situation with the passage of the Education for All Handicapped Children Act in 1977, which in subsequent revisions became the Individuals with Disabilities Education Act (IDEA). This article will examine the Act (particularly its reauthorization in 2004), focusing on the problem behind the legislation, its historical background, the law's implications, its strengths, and the deficiencies that require additional consideration.

The Problem

The Individuals with Disabilities Education Act was developed to address inequality in the U.S. educational system. Hardman, Drew and Egan (1999) assert that "it is often overlooked that the rights of individuals with disabilities came to the public forum as part of a larger social issue: the civil rights of all minority populations in the United States" (p. 20). The civil rights movement brought into public consciousness the issue of discrimination that pervaded all areas of society, including employment, housing, public facilities and education. In the same way that the Civil Rights Act of 1965 addressed these inequalities, IDEA attempted to give equal educational opportunities to all children, regardless of disabilities. Particularly, the law aimed to provide the best free public education to all in the "least restrictive environment." In other words, it was thought that disabled children should be included as much as possible in the general public education system.

In order to understand the evolution of IDEA, it is important to note that government attention to individuals with disabilities and to the special education movement, in particular, is relatively recent. As Martin, Martin and Terman (1996) point out, "Persons with physical and mental disabilities have been the target of discrimination across cultures for thousands of years" (p. 26). Well into the 20th century, disabled persons were highly marginalized and frequently subject to sterilization and institutionalization. The U.S. Department of Education reports that in 1967, "state institutions were homes for almost 200,000 persons with significant disabilities" (U.S. Department of Education [U.S. Dept. of Ed.], 2000). Often these institutions were dehumanizing and restrictive, with only the most basic provisions for food, clothing and shelter. Maintenance was their sole purpose, and very little was done in the way in of education and rehabilitation for those who were isolated in such conditions.

Disabled children were also discriminated against in the public school system for much of the 20th century. "Until the mid-1970s, laws in most states allowed school districts to refuse to enroll any student they considered 'uneducable,' a term generally defined by local school administrators" (Martin et al., 1996, p. 26). State and local governments had the power to exclude students from their schools, or to admit them without accommodation for their special educational needs. In fact, before the first federal legislation to address the problem was enacted in 1975 (Public Law 94-142, which forms the basis for the current IDEA law), one million children with disabilities were totally excluded from schools, and fifty percent of children with disabilities received an inappropriate education, either through placement in general education classrooms with no special services, inadequate provisions for such services, or unnecessary isolation in schools (Silverstein, 2005). Many children were excluded because they were thought to have "discipline" problems, and most that were served

were taught with low expectations for achievement (Silverstein, 2002). Each successive revision of the 1975 law has more clearly defined and addressed the issues surrounding the treatment of disabled children in our educational system, increasing public awareness and making strides towards providing such students with access to an educational experience that is relevant and appropriate to them.

Historical Background of IDEA

Since the 1960s, there have been many federal and state laws that directly or indirectly relate to individuals with disabilities and special education. Typically heralded for striking down racial segregation in education, the landmark Supreme Court case *Brown v. Board of Education of Topeka, Kansas* (1954) had a tremendous impact on the future of special education legislation, setting a precedent that education must be made available to all students on an equal basis. However, it was 20 years before this ground-breaking case was referenced in support of such "free and appropriate education" for disabled students (Hardman et al., 1999).

In the 1960s, the Federal government began to address the issue of inequality for disabled students. The Bureau for Education of the Handicapped was established in 1966 under the Elementary and Secondary Education Act (ESEA), outlining a number of initiatives that earmarked small amounts of funding for serving disabled children (U.S. Dept. of Ed., 2003). Parents had also begun to push for state legislation that would require and fund special education services. By 1973, forty-five states had passed laws to educate children with disabilities (Martin et al., 1996). However, many children still remained neglected or underserved. It was clear that further legislation was necessary to ensure that students with disabilities would be provided with access to a free and appropriate public education. At the same time two court rulings – *Pennsylvania Association for Retarded Citizens v. Commonwealth of Pennsylvania* in 1971 and *Mills v. District of Columbia Board of Education* in 1972 – required free public education of students with disabilities through individualized programs and services. Citing *Brown v. Board of Education*, these cases established the 14th Amendment equal protection rights for students with disabilities (U.S Dept. of Ed., 1995a, p. 1, as cited by The Council on Special Education, 2003). Furthermore, the Supreme Court interpreted the 14th Amendment's due process clause to provide parents with rights that include prior notice, the opportunity to discuss changes in a child's educational plan before they are implemented, and the ability to appeal decisions made by school districts (Martin et al., 1996).

Through this combination of state laws and federal court decisions, states became required to provide a free, appropriate, public education to all children. Recognizing this responsibility, state leaders joined local advocates in promoting federal legislation to provide consistency, federal leadership, and federal subsidy of special education (Martin et al., 1996). In response, Congress addressed the inequality in education through two distinct approaches: nondiscrimination legislation and an educational grant program to the states. Nondiscrimination legislation came through The Rehabilitation Act of 1973 (more specifically, Section 504), which provided that "any recipient of federal financial assistance (including state and local educational agencies) must end discrimination in the offering of its services to persons with disabilities" (Martin et al., 1996, p. 29). Unfortunately, it was virtually ignored by state and local educational agencies because it lacked funding and monitoring. The Education for All Handicapped Children Act program (Public Law 94-142), which took effect in 1977 and provided grants to the states, was seen as a more powerful means to combat educational inequality. This act "required that all students with disabilities receive a free, appropriate public education and provided a funding mechanism to help with the excess costs of offering such programs" (Martin et al., 1996, p. 29). The original law included provisions for students between the ages of 6 and 21 and required that all eligible students, regardless of the type or extent of their disability, receive special services to meet their individual educational needs. Specific requirements included specially designed instruction in all settings as well as any related services (e.g., transportation, speech-language pathology and audiology, counseling) necessary to ensure that students would benefit from their educational experience (Hardman, Drew, & Egan, 1999). Public law 94-142 was also prescriptive of certain procedures that states needed to follow to receive funds, which included five basic elements: a system to locate students with disabilities, evaluations to determine the effects of the disability on the educational process, parental safeguards and involvement on behalf of the child, annual meetings that produced individualized education programs (IEPs), and assurance that the plan was carried out in the "least restrictive environment" (Hardman et al., 1999; Martin et al., 1996). States and local authorities were responsible for carrying out the law, with only

the broad protections outlined by the federal government. Individual states could opt to go beyond what was required in the regulations, as long as they remained consistent with the federal guidelines (National Information Center for Children and Youth with Disabilities, n.d.).

Although key tenets of the Education for All Handicapped Children Act (Public Law 94-142) have remained intact, the law has undergone many revisions and reauthorizations over the past three decades, adding provisions to further define eligibility criteria for students, extend the range of services to younger age groups, and improve the quality of services provided (U.S. Dept. of Ed., 2003). The 1986 amendments expanded the scope of the law to include services for preschoolers and early intervention for infants. The 1990 amendments, which renamed the law the Individuals with Disabilities Education Act, mandated that transition services from school to work be provided no later than age 16, added autism and traumatic brain injury as eligible disabilities, and also defined assistive technology devices and services. Further amendments in 1997, commonly referred to as "IDEA '97", expanded the emphasis on improving educational outcomes, established a mediation system to resolve conflicts between parents and school personnel, and outlined procedures for dealing with discipline issues to ensure that schools would be "safe and conducive learning environments for all children" (Silverstein, 2002, p. 4). These discipline provisions were important because they established that there could be no cessation of services to children with disabilities due to discipline problems. Instead, such problems had to be dealt with by changing the child's placement for some interim period of time comparable to disciplinary actions that would be taken for non-disabled students. IDEA '97 remained the active law until the most recent reauthorization of the Act in 2004.

The Policy: IDEA 2004

In 2004 President Bush signed into law the "Individuals with Disabilities Education Improvement Act of 2004," which went into effect on July 1, 2005, and extends until 2010 (National Center for Learning Disabilities, n.d.; "IDEA Reauthorization," 2005). The 2004 act was based on the findings of the President's Commission on Excellence in Special Education and constituted a push to align IDEA with the 2002 No Child Left Behind Act (NCLB). The four major areas targeted in the 2004 revision include: a greater focus on student academic outcomes (specifically aligning IDEA to NCLB);

parental choice; over-identification or misidentification of special education students; and paperwork reduction ("IDEA Reauthorization," 2005). Additionally, the new law further defines the IDEA '97 discipline provisions and develops a plan to achieve the full funding that Congress intended it to have in the original 1975 law.

Area 1: Academic Results

IDEA 2004 hopes to improve academic results for students in a number of ways, specifically aligning it in definition and philosophy with NCLB. Under NCLB, schools, school districts, and states are asked to show progress in educating children, including children with special needs. If expectations are not met, both parents and schools qualify for additional options and emergency help (House Education Workforce Committee, 2003). As the President's Commission urged, the new IDEA legislation also includes provisions to improve educational gains made by students with disabilities by assuring that states' accountability systems and provisions for disabled students parallel that of NCLB. States must now create their own plans of how education of students with disabilities will comply with the law and meet criteria used to determine NCLB's required adequate yearly progress (AYP). States must report AYP, and those having difficulty will be eligible for extra assistance. However, states will not be penalized for failing to meet subjective goals ("IDEA Reauthorization," 2005).

Changes to the Individual Education Program (IEP) outlined in IDEA 2004 also target students' academic achievement, giving local school districts greater flexibility in reviewing the progress of a child by replacing benchmarks and short-term objectives with the regular reporting requirements of NCLB ("IDEA Reauthorization," 2005). Special education teachers have noted that implementing a multitude of yearly goals with specific corresponding objectives can be unrealistic within an already crowded curriculum, thereby undermining the administration and decreasing the efficacy of the IEP (L. Naset, personal communication, December 1, 2005). By creating broader special education goals that are measurable (e.g., "Johnny will utilize reading comprehension strategies with 75% accuracy throughout the curriculum"), the newly revised IEP format is intended to produce more genuine results.

As with NCLB, Congress developed a definition of a "highly qualified" special education teacher for IDEA 2004. First, special education teachers are required to be certified in special education.

Teachers who work with severely cognitively disabled children (determined by whether or not they take alternative assessments) must also have an elementary certification or an equivalent degree if they are teaching at a higher level. In addition, special education teachers who teach multiple subjects must meet the NCLB requirements for high qualification in at least one core subject area (language arts, math, or science). These teachers are required to take the High Objective Uniform State Standard of Evaluation (HOUSSE) within two years of employment to demonstrate this proficiency. Experienced special education teachers may also elect to take the HOUSSE to demonstrate their competence ("IDEA Reauthorization," 2005). Thus, through heightened accountability provisions, new IEP formats, and more demanding qualifications for teachers, IDEA 2004 attempts to address the challenge of improving academic performance for students with disabilities.

Area 2: Parental Choice

With IDEA 2004, parents gain more rights and choices than they had under the previous law. Parents and local school districts are now able to agree to change IEPs without having to have a formal IEP meeting. In addition, if a student with a disability is not making adequate yearly progress and attends a school that has been targeted for improvement by NCLB, IDEA gives parents leverage to demand that the school district receive state funds to support supplemental education services for their children. The policy focuses on the continuation and improvement of Community Parent Resource Centers, which provide information to all parents of children with disabilities but which specifically target parents of low socioeconomic status, families of color, and those with limited English proficiency. This latest reauthorization also allows parents to choose to keep their children in the same program from birth until kindergarten ("IDEA Reauthorization," 2005).

Under IDEA 2004, if parents have a complaint, the district is required to hold a pre-hearing meeting with the parents to discuss their concerns and attempt to work together toward resolving the issue. If a consensus cannot be reached within 30 days of filing the complaint, the district must then hold a hearing. Complaints are required to be clear and detailed, and become obsolete after 2 years from the filing date. However, attorneys now are held responsible for frivolous, unreasonable or unfounded lawsuits. Through provisions like these, parents have gained a stronger voice in advocating for their children, particularly in instances when they feel that their specific needs are being overlooked or underestimated.

Area 3: Over-identification/Misidentification of Special Education Students

The issue of over-identification of special education students is also addressed by IDEA 2004. First, local school districts can now use up to 15% of their funds for early intervention services to help students before they are identified as needing special education, reducing the inaccurate labeling of children with reading problems as special education students. These funds can also be used to strengthen reading programs in general (National Center for Learning Disabilities, n.d.). The addition of early support is intended to remedy problems before students begin to demonstrate a processing deficit or other specific learning disability.

Based on current trends and research about the diagnosis of a learning disability, another provision to reduce over- and misidentification of students requires districts to eliminate the out-dated "IQ-discrepancy" model that is based upon a "wait to fail" approach for identification of particular learning disabilities. By the time a child's academic achievement is low enough to indicate a significant deficit between achievement and intelligence (IQ), he or she is often already bottoming out in the general curriculum, creating a cycle that is difficult to reverse. IDEA 2004 calls for a "response to intervention" model that identifies students with specific learning disabilities *before* they are failing at grade level (House Education and Workforce Committee, 2003).

Additional concerns regarding the over-identification of minority and at-risk students for special education services are tackled by IDEA 2004, which requires each state to create policies and procedures designed to prevent the disproportionate representation of minority children as disabled. New requirements for the collection and examination of data will help states determine if, indeed, a disproportionality problem exists. If such problems are found, states will be required to review their identification policies and practices, making any revisions necessary to minimize over-identification on the basis of race and socioeconomic status. Local education agencies will be required to use the maximum allowable funds to provide early intervention services for students who have been improperly identified (Office of Special Education Programs, n.d.).

Area 4: Paperwork Reduction

A fourth issue addressed by IDEA 2004 concerns the reduction of required paperwork. The Act created a 15-state pilot program that allows school districts to offer parents the option of a three-year IEP instead of the yearly program. A similar pilot paperwork reduction program uses teleconferencing rather than in-person IEP meetings ("IDEA Reauthorization," 2005).

Area 5: Discipline

Elaborating on the 1997 disciplinary provisions, IDEA 2004 requires that students be held responsible for their actions while ensuring safety and the protection of rights. Disabled and non-disabled students must be disciplined in the same manner unless the conduct violation is directly related to the student's disability. In situations where the student is suspended for more than 10 days, the child will continue to receive educational services in working towards the goals of his or her IEP ("IDEA Reauthorization," 2005). In the meantime, within 10 school days of any decision to change the child's placement because of a violation of a code of student conduct, the local education agency (LEA), the parent, and members of the IEP team must hold a manifestation determination, which is a hearing to determine if the infraction was a result of the child's disability or the direct result of the LEA's failure to implement the IEP (Office of Special Education Programs, n.d.). If it is determined that the infraction was, in fact, a result of the student's disability, the new law states that the LEA will then conduct a Functional Behavioral Assessment and implement a behavioral intervention plan. If such steps have already been taken prior to the infraction, then the team must review the plan in place and make any necessary adjustments. Following the interim period the child is to be returned to the original placement unless the parents and LEA agree to a permanent change as part of the modifications of the behavioral intervention plan (Office of Special Education Programs, n.d.).

Area 6: Funding

While the IDEA '97 law "authorized the federal government to provide up to 40 percent of the average cost that schools nationwide spend to educate a student," the government currently only pays 18% of the total costs through $8.9 billion in direct grants to the states (Swindell, 2003, p. 829). The 2004 reauthorization establishes a 7-year plan for gaining full funding of 40%, with Republican Congressional leaders promising that they will continue to give $1 billion increases to IDEA each year on a "glide path" to full funding ("IDEA Reauthorization," 2005; National Education Association, n.d.). The plan also gives states the option of creating accounts for high-risk, unpredictable situations to use up to 10% of the state-level activities funds to reimburse districts. In the past, Democratic leaders have pushed for mandatory allocations for special education, but their proposals have been repeatedly rejected. As such, IDEA funding is still up for consideration as part of the annual budget appropriations process.

Summary of Provisions

In summary, IDEA 2004 extends the Act through 2010 and includes the following: an alignment with the No Child Left Behind Act with a focus on improving the academic achievement of special education students and requiring all special education teachers to be licensed and "highly qualified"; new litigation provisions to decrease the number of frivolous lawsuits; new provisions to reduce the misidentification and over-identification of non-disabled students, especially minorities; a pilot program that allows for 3-year IEPs instead of the yearly program; a requirement that students be disciplined in the same manner as their non-disabled peers, unless the infraction is due directly to their disability; and a 7-year plan to reach the 40% funding goal.

Analysis of IDEA 2004

Goals

Generally speaking, the IDEA 2004 reauthorization includes honorable, just goals aimed at improving the quality of life for those individuals with disabilities and those serving them. According to Boehmer (n.d.), this most recent revision attempts to improve a system that has often over-focused on compliance with complex rules rather than producing the academic results that children with disabilities deserve. Several groups, however, remain skeptical about the feasibility of some of the revised law's provisions. The Disability Rights Education and Defense Fund questions how the "measurable annual goals" and quarterly progress reports will compare with previously required short-term objectives and benchmarks (National Alliance for the Mentally Ill [NAMI], 2004). These opponents fear that longer IEP terms could reduce the accountability of schools regarding progress, despite teachers' claims that this revised method offers authentic, manageable data, rather than often-assumed or fabricated percentages. Both the social work community (National Association of Social Workers, 2002) and the

Disability Rights Education and Defense Fund (2004) have expressed concern at the possible lack of accountability for responding to changing student needs.

Since school social workers are an integral part of the IEP team and one of the groups of related service providers identified in the IDEA legislation, the School Social Work Association of America (SSWAA) and the National Association of Social Workers (NASW) played a vital role in the 2004 IDEA reauthorization process. These organizations noted a number of positive changes, including a clearer definition of "specially designed instruction," an emphasis on participation in the general education curriculum, flexibility in the triennial evaluation, and positive behavioral support strategies. Both SSWAA and NASW are optimistic that the 2004 IDEA will provide a solid framework with the incorporation of their suggestions for a more comprehensive system of personnel development, the provision for highly qualified personnel, and the allowance for new and innovative strategies, making education for the disabled an element in overall education reform (NASW, 2002). Despite these positive responses to the new legislation, however, SSWAA and NASW continue to advocate for changes in the law in order to better represent the values of social work.

Political Goals

Politically, the 2004 law incorporates the Republican goal of devolution, shifting power to the states and schools. Additionally, it aligns IDEA with the No Child Left Behind Act, the centerpiece of President Bush's educational reform. NCLB paved the way for IDEA 2004 by making reforms that were *intended* to ensure children with special needs get the education they deserve.

The National Education Association (NEA, 2005) gave qualified support to IDEA 2004, indicating an overall positive impact for students with disabilities and special education professionals. The Learning Disabilities Roundtable (2005), representing 12 national organizations concerned with specific learning disabilities, argued that the bill provided a framework that would enhance early identification and provide effective intervention. Although parents and advocates made their views known during consideration, advocates for disabled children were concerned that the law might make it harder for dissatisfied parents to take legal action to obtain services for their disabled children because they will have to submit to mediation or other meetings that give

school officials a last chance to resolve disputes before the courts may intervene (NAMI, 2004). And, if the courts deem a suit frivolous or harassing to a school system, the bill allows school districts to recover legal costs from parents or their lawyers (Schemo, 2004). Overall, though, education organizations and advocates view the IDEA reforms in a generally positive light, particularly in its efforts to clarify more complicated provisions and streamline paperwork requirements (National Association of School Psychologists [NASP], n.d.).

Economic Feasibility

The quest for full funding is a central part of the IDEA debate. As discussed in the NEA's article on the IDEA Funding Coalition, when PL 94-142 was passed in 1975, Part B originally authorized Congress to contribute up to 40% of the average per pupil expenditure (APPE) for each special education student (NEA, n.d.). This percentage has not yet been reached, although the past ten years have seen a 360% increase in spending for IDEA Part B Grants to States, which fund direct services to students, demonstrating a federal share of funding increase from 7.3% (1996) to 18.7% (2005) (National Association of School Psychologists, n.d.). While the goal is to reach the promised 40% of per-pupil funding by 2011, NASP notes skeptically that the current level of funding (19%) is still less than half that.

Regarding IDEA's push for full funding, the Committee for Education Funding demonstrated public support for increased federal funding in its national education funding opinion poll (National Committee of Teachers of Mathematics, 2003). Based upon a representative sample of 527 adults, the poll found that 77% of Americans felt a significant increase in federal education funding would positively impact the growth of the U.S. economy. Even more impressive were the 82% who believed that increases in federal education spending would yield better access to higher education. Seventy-nine percent believed that increases in federal spending would help states avoid cuts to education at the state and local levels.

As stated in the National Association of School Psychologists' IDEA annual summary (n.d.), the 2004 law authorizes funding increases per year of about $2.3 billion, a disappointment to Democrats. This authorization level also contradicts the NEA's Coalition Funding Proposal, which advocated gradually raising federal spending over the next six years through annual increases of $2.45 billion and

switching IDEA funding from discretionary to mandatory spending, increasing the federal share of APPE by an average of 4.2% each year (NEA, "IDEA Coalition Funding," n.d.). By contrast, the current Republican congressional leaders' "glide path" promise is already falling short. Final funding for IDEA, Part B, State Grants, 6 for fiscal year 2005 was $10.7 billion. This $520 million increase above fiscal year 2004 was still $480 million short of the administration's $1 billion request and $1.7 billion less than authorized under the new IDEA, which was signed into law only days before this funding was finalized. Hence, the margin between current and full federal funding for IDEA is narrowing, but very slowly.

Administrative Feasibility

Wrightslaw's *10 Tips to Improve Your Child's Special Education* is a document that offers practical advice explaining how the new IDEA document can and will accomplish its goals of improving services and the coordination of the target groups. These tips include: using the findings and purposes in IDEA 2004 to establish a higher standard for defining a free and appropriate education; using IDEA 2004 and NCLB to improve IEPs by including research-based methodology and ensuring goals are comprehensive, specific, and measurable; allowing parents to give consent only for evaluations or portions of the IEP to which they agree; and challenging suspension or expulsion if a child's behavior was a manifestation of the disability or if the alternate placement does not provide what qualifies as a free and appropriate education (Butler, 2004). These are all good examples of ways in which the policy can, in fact, accomplish many of its goals.

There are, though, some goals of IDEA that potentially contradict one another. The decision to avoid over-identification of students may be challenged by new learning disabilities guidelines. Taking out the discrepancy model may potentially open the door to a slew of children whose parents feel they are having academic troubles and have "resisted intervention," thereby meeting the LD qualifications (NASP, n.d.). This also may increase the number of due process hearings and exacerbate the overall tension between parents and school personnel. As witnessed through the student services department in Wilmette, parents will dissect new legislation with a fine tooth comb, often looking for an "in" to allow their child more support in order for them to acquire additional educational gains and/or accommodations (most often extended time) for standardized testing (L. Naset, personal communi-

cation, December 1, 2005). Many psychologists offer mixed reviews as to both the positive and negative implications of the learning disability criteria. Limited paperwork is also a difficult goal to actualize within the world of special education, especially when NCLB guidelines call for increased accountability in a variety of areas. Also, many special education teachers agree that a 3-year IEP would only exacerbate the need for random IEP meetings to address the needs of developing children and the hurried paperwork accompanying that (L. Naset, personal communication, December 1, 2005).

IDEA and School Social Workers – Easing the Transition and Advocating Change

IDEA 2004 has many implications for the school social work profession. Knowledge of this legislation offers social workers the power to better incorporate a student's social and emotional needs into an IEP and a school's programming, widening the impact of our field in schools. Furthermore, as an integral part of a child's special education services team, school social workers have an opportunity to facilitate the transition to new IDEA standards, provide a voice for the children they serve, and advocate en masse for changes to the current legislation.

To begin, social workers may provide a new avenue for referring a student for possible LD criteria under the "resistance to intervention" approach. No longer limited to the psychological battery that identifies the IQ/achievement discrepancy, the social worker may be an additional resource for identification of students who face academic struggles that may represent such resistance, as often the frustrations of academic difficulties find their way into social work sessions. Additionally, as schools begin with 3-year IEPs, social workers can advocate for appropriate programming and accommodations. Knowing the child's changing developmental needs, the social worker can alert the student services team when the IEP needs adjustment. Social workers' involvement can mitigate the risk of teachers implementing IEPs that do not fit a child's current level of functioning. Along with special education teachers, social workers are required to write goals that are required to be comprehensive, specific, and measurable. As such, they should advocate for proper training, models, and any other information on how to best do so. As the new legislation pushes for personnel development, innovative strategies, and specifically designed instruction, social workers should find themselves a place within the construction and application of these programs in order to

promote educational equity, appropriateness, and differentiation from the social work perspective.

The social worker's person-in-environment approach extends beyond the student to consider the entire family system, which places him or her in a unique position to help parents understand the background of IDEA and reasons for changes in programming. Since parents often perceive their experience with special education services as a barrage of confusing language and directives, social workers can use their clinical skills in order to help families sort out their concerns and mediate solutions that could avoid legal action.

School social workers have commented on the improvement of students' behavior due to the use of positive behavioral supports. They see the Functional Behavioral Assessment (FBA) and the Behavioral Intervention Plan (BIP) to be excellent preventative tools and advocate that, if completed *during* the IEP process (rather than after a violation occurs), they may preclude the need for more intensive disciplinary measures. Although the current legislation does not require a FBA/BIP at the time of the IEP, it does not prohibit it, either. An adept social worker will advocate for its inclusion and be proactive through this form of intervention.

As advocates for improvement of the law, school social work organizations such as NASW and SSWAA should continue to advocate for statutory language to ensure that students receive appropriate mental health and related services through collaboration and coordination with agencies outside the schools (NASW, 2002). These organizations argue that the current law's stance is more reactive than proactive in managing children's behavior. They should also push for firmer wording in the legislation surrounding such social/emotional aspects of the child's educational experience, as the law *mandates* the use of research-based interventions regarding academic issues, but language used in the reauthorization simply asks that the team *consider* (rather than *mandate*) the use of positive behavioral interventions for dealing with conduct issues.

Conclusion

It remains to be seen whether the 2004 IDEA reauthorization will be able to reach its goals. Since it is now so closely aligned with No Child Left Behind, the law is poised to ride the coattails of the success or failure of those initiatives. If research and follow-through on NCLB initiatives fall by the wayside or fail, this will undoubtedly affect IDEA implementation. Furthermore, it is still early in the crucial

7-year period intended to fully fund IDEA to determine its efficacy. Most likely, the greatest barrier to this Act's success is the possibility that Congress may not make good on funding promises, leaving it to fall short once again on carrying out its provisions. With more than 6 million children with various disabilities currently being served in the public school system (NEA, 2005), it is essential that we keep a close eye on this legislation, continually reevaluating and refining it to ensure that it effectively meets their needs, providing them with an education that is both free *and* appropriate.

References

Butler, J. (2004, November). Conference Committee Votes on IDEA Reauthorization: The inside story. *Wrightslaw*. Retrieved from: http://www.wrightslaw.com/news/04/idea.1118.htm

Disability Rights Education and Defense Fund (DREDF) (2004, November 21). *Analysis of IDEA Authorization*. Retrieved from: http://www.namiscc.org/Advocacy/2004/Fall/AnalysisOfIDEAReauthorization.htm

Hardman, M.L., Drew, C.J., & Egan, M.W. (1999). A multidisciplinary view of exceptionality. In *Human exceptionality: Society, school and family* (6th ed., pp. 1–45). Boston: Allyn and Bacon.

The Council for Exceptional Children. (2003). *History of Special Education*. Retrieved November 28, 2005, from The Council for Exceptional Children, Information Center on Disabilities and Gifted Education website: http://ericec.org/faq/spedhist.html

House Education and Workforce Committee. (2003). *Bill Summary: The Improving Education Results for Children with Disabilities Act*. Retrieved from: http://www.edworkforce.house.gov/issues/108th/education/idea/billsummary.htm

IDEA Reauthorization: Conference report summary. (2005). *Congressional Digest, 84*(1), 10–12, 32.

Learning Disabilities Roundtable. (2005). *Comprehensive recommendations to the U.S. Department of Education for the development of IDEA 04 federal regulations related to the identification and eligibility of students suspected of having a learning disability*. Retrieved from: http://www.ld.org/advocacy/IDEAwatch.cfm

Martin, E.W., Martin, R., & Terman, D.L. (1996). The legislative and litigation history of special education [Electronic version]. *Special Education for Students with Disabilities, 6*(1), 25–39.

National Alliance for the Mentally Ill (2004). *Analysis of IDEA Reauthorization.* Retrieved from: http://www.namiscc.org/Advocacy/2004/Fall/An alysisOfIDEAReauthorization.htm

National Association of School Psychologists. (n.d.). *IDEA Final Summary.* Retrieved from: http://www.nasponline.org/advocacy/IDEAfinals ummary.pdf

National Association of Social Workers (2002, November). *IDEA Reauthorization Bill on "Fast Track" - School Social Workers, Teachers, and Parents Need More Time to Review It.* Retrieved from: http://www.naswdc.org/advocacy/alerts/ 2003/040103.asp

National Center for Learning Disabilities. (n.d.). *IDEA 2004.* Retrieved from: http://www.ld.org/ advocacy/IDEAwatch.cfm

National Committee of Teachers of Mathematics (2003). *Legislative and Policy Update for the Week.* Retrieved from: http://www.nctm.org/ advocacy/update/200309-05.htm#five

National Education Association. (n.d.). *Congress Reauthorizes IDEA; NEA Wins Key Changes.* Retrieved from: http://www.nea.org/specialed/ reauthorization.html

National Education Association. (n.d.). *IDEA Funding Coalition Offers Proposal Plan would make funding mandatory.* Retrieved from: http://www.nea.org/specialed/coalitionfunding2 002.html

National Education Association. (n.d.). *Summary of Final IDEA Reauthorization.* Retrieved from: http://www.nea.org/specialed/ ideareauthsummary05.html

National Education Association. (2005). *Special Education and the Individuals with Disabilities Education Act.* Retrieved November 29, 2005, from the National Education Association website: http://www.nea.org/specialed/index.html

National Information Center for Children and Youth with Disabilities. (n.d.). *Module 3: The History of IDEA.* Retrieved November 20, 2005, from the National Information Center for Children and Youth with Disabilities website: http://www.nichcy.org/Trainpkg/traintxt/3txt.htm

Office of Special Education Programs (OSEP), U.S. Department of Education. (n.d.) *IDEA 2004 Resources, Topic Briefs.* Retrieved from: http://www.ed.gov/policy/speced/guid/idea/ idea2004.html

Our Children Left Behind. (n.d.). *IDEA Reauthorization.* Retrieved from: http://www.ourchildrenleftbehind.com

Schemo, D.J. (2004). Parts of special-end bill would shift more power to states and school districts. *The New York Times,* p. A22. Retrieved from: http://www.nytimes.com/2004/11/22/education/ 22special.html

Silverstein, R. (2002). *Framework for understanding IDEA in general and the discipline provisions in particular.* Retrieved November 20, 2005 from: http://www.disabilitypolicycenter.org/idea.htm

Silverstein, R. (2005). *Using the Emerging Disability Policy Framework to Understand The Influence of IDEA.* Retrieved November 29, 2005, from: http://www.disabilitypolicycenter.org/docs/Using _EDPF_IDEA_Jan05.doc

Swindell, Bill. (2003). Special education reauthorization dodges voucher debate. *CQ Weekly, 61,* 707–708.

U.S. Department of Education. (2000). *History of the IDEA.* Retrieved November 28, 2005, from: http://www.ed.gov/policy/speced/leg/idea/ history.html

U.S. Department of Education. (n.d.). *Special Education & Rehabilitative Services: IDEA 2004 Resources.* Retrieved from: http://www.ed.gov/ policy/speced/guid/idea/idea2004.html

Erin Aydt has completed her first year of the dual degree MSW and MS in Child Development program in the School of Social Work and at the Erikson Institute. She has worked with teenagers with autism in the past and will be interning in the Foster Care and Adoption program at the Little City Foundation beginning Fall 2006. After graduation, Erin plans on continuing her work with children and families in the mental health field.

Jennifer Lacoff has completed her first year in the dual degree MSW and MS Child Development program in the School of Social Work and at the Erikson Institute. She has worked for the past five years at Horizons for Youth, an agency that provides access to quality education, mentoring, and enrichment opportunities for low-income elementary school children across the city of Chicago. She looks forward to interning at the Children's Research Triangle's Child Study Center this fall.

Joanna Miller is currently working on her MSW from the School of Social Work and her MS in Child Development from the Erikson Institute. She will begin interning Fall 2006 in the pediatric unit at Cook County Hospital. After graduation, she plans to continue her work with children in the mental health field.

Lauren Naset has also completed her first of the three-year MSW and MS Child Development dual degree program. Her first-year internship will be working for Teen Living Programs, supporting Chicago's homeless teens. Having spent 3 years as a high school and middle school special education teacher, Lauren plans to reenter the school system as a school social worker.

Why Mentor?: A Qualitative Study of Men's and Women's Reasons for Becoming Mentors

by Gina E. Gehrke, Quincy D.H. Jenkins, Stephanie A. Miskovetz and Pauline F. Wray

Abstract

The number of at-risk youth in America is steadily increasing, yet there is a gap in services for this population. This gap is most noticeable for at-risk male youth. Mentoring programs are an excellent option to reach youth and improve their chances for life success. However, more male volunteers need to be recruited for mentoring programs. This Chicago-based qualitative study examined 9 subjects (3 females and 2 males who are mentors, and 1 female and 2 males who inquired about mentoring but did not become mentors). The authors explored the topic of mentoring in an effort to elucidate the reasons men and women choose to become mentors, and what might lead more individuals (particularly men) to the field of mentoring. The findings of this study indicate that both males and females become mentors as a way to contribute to society and to support their beliefs about the importance of families. The study also found differences across gender lines in the level of personal gratification gained through the mentoring experience. These differences should be considered for recruitment strategies of future mentors and program structures for mentoring programs.

Introduction

In America, the number of at-risk youth is steadily growing. At-risk youth are defined as adolescents who have a potential for becoming excessively disobedient, or who are already exhibiting signs of disobedience by running away from home or not attending school (Gur & Miller, 2004). These youth face problems such as low self-esteem, low school performance, and difficulties interacting with law enforcement or other authority figures (Sipe, 1996). Furthermore, Sipe has determined that at-risk youth often live with parents who are unavailable to provide guidance due to personal and financial problems (1996). However, one way to help troubled youth is through mentoring.

In this study mentoring is defined as a one-on-one relationship between an adult (age 18 or older) and a youth (under 18 years of age). Using the same definition, a recent survey of research shows that "mentors believe that their mentoring is invaluable in helping youth increase self-esteem, solve life problems, and improve relationships and school performance" (Sipe, 1996). Moreover, mentoring offers a rich developmental opportunity for children to have an empathic adult role model (Gur & Miller, 2004).

Prior research demonstrates the positive effects of mentoring youth. In a randomized study by Holland (1996), students who participated in a mentoring relationship had significantly higher GPAs and test scores than students who did not have a mentor. Further details of the Holland study revealed that 85% of adolescent male subjects who were assigned a mentor were at or above grade level in almost every subject area, compared to only 15% of the boys not assigned a mentor (Holland, 1996). Hence, research indicates a strong connection between the presence of a mentor and school performance.

Mentoring not only benefits young people but also their mentors. Ninety-seven percent of mentors report having a positive experience mentoring (Sipe, 1996). Eighty-four percent of individuals who mentor report they are likely to mentor again in the future and 91% report they are likely to recommend mentoring to a friend (Sipe, 1996).

Despite the positive findings regarding mentoring, fewer mentoring services than needed are available. At one Chicago-area mentoring program investigated for this review, approximately 100 youth were on a waiting list for a mentor. The Program Coordinator reported the number of waiting children continues to grow (Program Coordinator, Personal Communication, March 30, 2005). In addition, approximately 70% of youth awaiting a mentor are boys (Program Coordinator, Personal Communication, March 30, 2005). Complicating the difficulty of matching a waiting mentee with a mentor, 18% of mentor-mentee matches terminate prematurely and 70% of people who inquire about the program do not complete the screening and training process to become a mentor (Program Coordinator, Personal Communication, March 30, 2005). The present study is designed to begin addressing this gap, by determining the reasons why people choose or decline to mentor, and how these reasons may differ by gender.

Literature Review

Current research shows that there is a lack of participation in formal mentoring organizations. Eighty-three percent of mentoring relationships are formed through informal connections such as older family members spending time with younger family members, or coaches, religious leaders, or neighborhood elders choosing to spend time with hand-selected youth that do not belong to formal mentoring organizations (Sipe, 1996). Only 17% of mentors participate in formal mentoring organizations (such as Big Brothers/Big Sisters of America), despite research studies that demonstrate a positive correlation between formalized mentoring and its positive impact on youth (Sipe, 1996). Previous research indicates the most crucial aspect to creating a successful mentoring relationship is "providing mentors with support in their efforts to build trust and develop positive relationships with youth" (Sipe, 1996, p. 9). Moreover, Sipe indicated the significance of formal mentoring programs in stating that "most volunteers and youth cannot be simply matched and then left to their own devices; programs need to provide some infrastructure that fosters and supports the development of effective relationships" (p. 9). In order for a mentoring relationship to have a significant chance of success, formal supervision and monitoring of the relationship need to be available to the match. Another motivating factor to increase usage of formal mentoring programs is evidenced by the large number of boys on waiting lists and the lack of male volunteers in the formal programs.

Youth service-related organizations account for the second largest group of volunteers, at 27.2% of the volunteering population during the 2001-2002 year (Boraas, 2003). Despite the high level of volunteerism in this area, there is a discrepancy between the number of males and females who participate in mentoring programs. Women volunteer at a rate that is almost 8% higher than that of men (Boraas, 2003). Further, this relationship holds true across all age groups, education levels, and major demographic characteristics (Boraas, 2003). The biggest gender gaps are among Whites, and highly educated individuals.

Being a mentor requires a substantial amount of time. Despite this fact, there has been an increase in the level of volunteerism in general, as well as an increase in the number of hours devoted to mentoring (Boraas, 2003). Nonetheless, it is not only volunteers who must make a commitment in order for the mentoring relationship to be helpful. Youth involved in these mentoring relationships must maintain a high level of commitment, as well. Ruark (2003) found that children and adolescents in the Big Brothers/Big Sisters program whose mentor pairing lasted less than 6 months did not receive the full benefits of the mentoring relationship. Youth in this study had already faced adverse situations and hence were at risk for increased suffering due to the loss of a significant adult figure. Time is needed to develop a relationship between mentor and mentee so that appreciation, disclosure and connection may emerge from the relationship (Ruark, 2003). Sipe cited an additional study, which emphasized the importance of a commitment of at least 2 years for the mentoring relationship to be mutually beneficial (1996). "Mentors in relationships that last at least 2 years are more likely than those whose relationships last less than 2 years to feel they have a positive influence on the life of the youth" (Sipe, 1996, p. 73). The most common reason for not mentoring, reported by 61% of the people polled in a study on volunteerism, is "that they did not feel they had enough free time" to give to the programs (Holland, 1996).

Given the apparent need for mentoring relationships for youth, the authors of this study sought to explore the reasons men and women choose to become, or not to become, mentors. We asked these questions in an effort to elucidate what draws certain types of people to mentoring programs, to gain knowledge about gender patterns in mentoring, and to learn more about what may attract people to mentoring programs, with special attention to males.

Method

This study used a qualitative research design, which included a case study of mentors utilizing a semi-structured interview carried out by three interviewers. Based on a review of existing literature, the authors sought to explore reasons males seem not to be as inclined to mentor as women, gender differences in the reasons men and women mentor as well as their reasons for declining to become mentors, and universal reasons why people mentor. The authors chose to interview males and females who had participated in an informational meeting at a local area mentoring program. Study participants included men and women who decided to mentor after attending the meeting as well as those individuals who opted not to become mentors. The authors did not try to prove causality with a series of pre-stated reasons as to why we feel men and women choose or decline to mentor; rather subjects were asked for subjective data about their experiences.

Sampling and Study Subjects

The researchers approached the Program Coordinator of a Chicago-area mentoring program and enlisted her help in obtaining a sample of mentors and non-mentors for the study. Due to time constraints, only one agency was used to obtain a sample for this study, thereby limiting the generalizability of the study findings. However, the authors believe that the program used to obtain subjects is representative of many other mentoring programs. The program matches mentors and mentees in similar ways to other programs, and it also recruits new mentors in ways similar to other mentoring programs (such as through the media, newspaper, Internet, word of mouth, etc.). Additionally, this program shares similarities in structure with other mentoring programs, such as being community-based (activities generally take place in the surrounding community and not at the program office), hosting organized events for mentoring matches, same sex matching, an extensive screening process for potential mentors, training and support structures, a commitment to one-on-one relationship building that is unique to mentoring programs, and a more long term volunteer commitment.

As part of the sampling process, the coordinator of the mentoring program provided the researchers with two lists. The first was composed of individuals who attended an informational meeting at the agency more than six months ago and did not complete the process of becoming a mentor. The second included mentors who had been active in a mentoring program for less than 1 year. Individuals on the lists were contacted by phone or e-mail and then voluntarily enrolled into the study by contacting the researchers. Interviews were conducted with the first 9 subjects who met the sampling criteria, which were to have study participants of both genders and mentoring statuses. Three of the subjects were women who were active in a mentoring program, and 3 were men active in a mentoring program. One male and 2 female subjects had inquired about a mentoring program and attended an information session but chose not to become mentors. Due to time constraints, it was necessary for the authors to discontinue the interview process after 9 subjects had been located instead of the 12 that had originally been intended. Having 12 subjects would have split the sample evenly by gender, but even without achieving this each possible combination of gender and mentoring status was represented in the study.

The sample is also somewhat representative of the age and ethnicity of program participants. Study participants ranged in age from 23 to 55 years. Seven of the participants were Caucasian, one was African American, and one was of Middle Eastern descent. Comparatively, the age distribution of mentors at the Chicago based program ranged from 21 to 76 years. Seventy-eight percent of the program participants at the time of this study were Caucasian, 15% were African American, and 7% identified themselves as Hispanic or Asian (Program Coordinator, Personal Communication, November 28, 2005).

Variables

The current research included variables such as gender, age, ethnicity, volunteer history, family relationships, level of education, mentoring status, and reasons for mentoring. The latter variable was subdivided into a) experiences in peer and social situations, b) personal gratification, c) family constitution and experiences with family members, d) experience with the information given by the mentoring program, and e) impressions of the program structure. The variables were primarily pre-defined by the interview questions but also emerged in the coding of the interview data post-transcription.

Data Collection and Procedures

Data were collected via audio-taped face-to-face interviews. The interviews were conducted by three researchers, all of whom were graduate students at the Loyola University Chicago School of Social Work. Each interview was conducted by one researcher, with the subjects divided among the researchers based on geographical location and scheduling needs. In two cases, a second researcher was present to observe the interview but did not participate in the interview process. The fourth researcher was responsible for transcribing interview tapes. All four researchers were students in an advanced research methods course.

Measures

The study used two sets of semi-structured interview questions: one for those who decided not to become mentors after attending an informational meeting and another for those who were actively mentoring (See Appendix A for a list of questions). The questions were created specifically for this study by the authors, in consultation with the coordinator of the mentoring program and a research professor from the School of Social Work. Due to the qualitative nature of the data, the authors were unable to directly test for reliability. Instead, an assumption was made that the individuals who participated in this study spoke truthfully and openly about the

questions being asked of them. Additionally, the authors attempted to ensure that the questions were presented in a way that was free of bias, were stated in a manner that was not leading, and were not derogatory or hurtful towards any group. The authors also received training on interviewing from more experienced researchers and by reading materials on culturally sensitive interviewing techniques. In order to ensure consistency, each interviewer was trained in the sequence of questions to be used. The authors discussed and reached a consensus on when and how probes were to be used to elaborate on information given in the interview. An interview guide developed from the author's thematic categories is included in the table below.

One limitation of the data collection was that audio taping may have led subjects to be uncomfortable or guarded in their responses. Additionally, using a face-to-face interview process was time consuming because of the time it took to contact potential subjects, wait for responses, and coordinate schedules. The authors' choice of methodology ultimately limited the number of subjects who participated in the study. Finally, using an interview process did not allow the subjects to remain anonymous to the interviewers, which could have made some potential subjects less willing to participate in the study and contributed to the inability to interview more people.

Analysis

The data from the face-to-face interviews was audio recorded and subsequently transcribed by a single researcher. Transcribed interview responses were then coded by all the researchers using thematic categories identified by the authors during the data collection process. To arrive at a consensus for the coding categories, at least two researchers initially coded the interviews, and then the researchers discussed their findings until a consensus was reached regarding the appropriate category for each item of data. Data that could be coded in more than one category was coded as both and overlap was noted. However, overlap was only noted by the researchers in three instances (primarily in the area of program structure). Table 1 indicates the thematic categories used in coding the data.

Once the transcribed interviews were coded, the authors explored the differences and similarities between the four different types of participant groups (females who were mentors, males who were current mentors, females who were not mentors, and males who were not mentors). The authors expected that examining the frequency, distribution, and content of comments made by participants in each of the question categories would reflect differences in participants' reasons for choosing or declining to become a mentor. Analysis focused exclusively on counting the number of times a participant mentioned a particular category (such as experiences with family members, social contribution or personal gratification) as a reason for choosing or declining to become a mentor. The authors combined this frequency with the content of participants' comments in a particular category as a way to illuminate a participant's feelings about the mentoring process.

Table 1

Category	Definition
Level of Education	the highest level of education a participant completed
Volunteer Background	any previous experience volunteering, as well as any participation in current volunteer projects
Experience with the Agency	any interactions, positive or negative, that the participant may have had with the agency used to recruit participants to become mentors
Program Structure	any comments, positive or negative, that the participant made regarding the requirements of the mentoring program as determined by the agency
Family Experience	any mention of family and marital relationships or general familial interactions
Social Contribution	a participant's feelings about how members of society as a whole are expected to behave, as well as feelings of needing to give back to society and feelings of obligation to serve the community that they may have gathered from societal interactions
Personal Gratification	feelings of personal fulfillment and reward, as well as a participants' mention of personal characteristics they possess that they feel make them a qualified or good mentor
Peer and Social Experiences	a participant's commenting on how their peers, historically and currently, influence their decisions to mentor, as well as any mention of the participant having an influential other or mentor in their own life

Findings

Tables 2 and 3 indicate the gender, age, ethnicity, education, and volunteer experience of study participants.

Table 2. Participant Age/Gender/Mentor Status

Participants	Female Current Mentor (3)	Female Non-Mentor (2)	Male Current Mentor (3)	Male Non-Mentor (1)
Age	Range from 23-51 years	Range from 24-36 years	Range from 26-55 years	32 years

Table 3. Participant Ethnicity/Education/Volunteer Experience

Descriptors	Ethnicity	Education (Highest Level Completed)	Prior Volunteer Experience
Distribution of Participants	Caucasian (7)	High School (4)	Minimal Experience (6)
	African American (1)	Bachelors (2)	Currently Volunteers in another capacity (3)
	Arabic (1)	Graduate Work (1)	Prior Mentoring Experience (3)
		Graduate Degree (2)	

There were several similarities in the thematic category responses of the participants, including ideas regarding societal contributions, family experiences, experience with the agency and program structure, and previous volunteer background. In the following paragraphs, each of these similarities will be discussed as they relate to the thematic categories. Education level was captured as a demographic feature, but is not used in the analysis.

Experience with the Agency

None of the 9 participants noted negative interactions or experiences with the mentoring agency. One participant stated, "with [agency name] it's better because they are way more aware of just everything that's involved and all the importance of the background checks, fingerprinting, and they're just more professional about matching people."

Program Structure

Some negative comments surfaced regarding the mentoring application process and the time commitment required to become a mentor. All 9 participants characterized the structure of the program as "intense." Three participants noted the process of becoming a mentor was too lengthy. Five participants complained the mentoring program's requirement of a time commitment of one year was too great. A study participant stated that his reason for not becoming a mentor was directly due to the level of commitment required: "I wasn't going to have the

time they wanted." Another participant stated it was "a conflict with and a commitment to the time frame" that prevented her from pursuing the program. Consistent with prior research, the time commitment required to mentor had positive and negative repercussion for potential and current mentors.

Family Experience

All of the participants in this study spontaneously discussed their family interactions and experiences with influential others in their lives in response to questions about what factors most influenced their decision to mentor or not mentor and whether or not they had an influential other in their life. Two participants explained they considered a member of their family (such as a parent, sibling, an aunt or an uncle) to have been influential "others" or mentors to them. One participant noted, "my parents and my family members were the best mentors I had" and "the most influential." Four participants concluded peers or adults had been influential others or mentors to them. Only 1 participant felt as though she did not have an influential "other" in her lifetime. Three participants noted both family members and peers had been influential in their lives.

Several participants identified family experiences as reasons they chose to become mentors. Some participants saw the mentoring program as a vehicle to build upon positive family experiences from their past. Mentoring was especially salient when participants considered their parents to be influential in

their lives. One participant noted, "My parents and my family members were the best mentors I had." Another explained, "I always hung around a lot of older people growing up...older brothers, their friends, neighborhood folks, my dad was a wonderful role model." Participants were also attracted to the mentoring program to fill a family void. For example, one participant reported, "I was new to the city...I came from a big family and I like being around kids and I didn't have any family connections here so, that would be the primary one."

Personal Gratification

In the authors' analysis of participant responses, gender differences in factors that influenced individuals' reasons for mentoring became clear. One of the primary differences between male participants and female participants was the importance women placed on personal gratification as a reason for mentoring. For example, *all* women who were active mentors mentioned personal gratification as a factor in their decisions to become mentors at least 16 times during the interview. Conversely, female participants who declined to become mentors voiced at least seven concerns that the experience of mentoring would *not* provide them the personal gratification that they desired.

In contrast, male participants (both those who were mentors and those who were not) had far fewer responses during the interview in the personal gratification category than the peer and social experiences category.

Furthermore, women cited the ability to feel helpful, the desire to "do something meaningful" with their time, and fear of not meeting "expectations of myself" as most influential in their decision to mentor or not mentor. Male participants described their desire for personal gratification as "an evolution" during their time as a mentor or as something that they "might consider" in the future as a reason to mentor.

Women who were active mentors were the most likely participants to mention feelings of personal gratification as one of the reasons they choose to mentor. For example, one participant noted that she mentored not because she has to, but "because I want to." The same female participant explained she was motivated to remain in the mentoring program because "I like to feel valued as far as having life have meaning." When asked about her motivations for participating in a mentoring program, another female explained, "I would never think not to do something. I always feel like you should unless you're overwhelmed. I always want to do something. I always want to do more."

The female participants who were not mentoring also had feelings about personal gratification to convey. These women were more likely than women who were mentors to feel as though their personal gratification needs were fulfilled in other areas of their lives. Non-mentoring women expressed concern they would not be able to perform the duties of a mentor in a manner that was satisfying. The potential for an unsatisfying experience as a mentor may have been a reason why they chose not to volunteer in the mentoring program. One female who did not pursue the mentoring program noted she received personal gratification in other areas of her life: "My new job is the most recent example of an experience in which I feel rewarded. I feel like the staff is really accommodating and always gives me compliments." Another non-mentoring female noted she was concerned she would not be able to complete the requirements of the program in a way that would be rewarding to her, saying, "I didn't pursue the program because I was just scared of expectations of myself."

Peer and Social Experiences

Although the female participants clearly focused on personal gratification needs to indicate why they chose or declined to mentor, male participants focused on their peer and social experiences to indicate their reasons for mentoring or not mentoring. All the men who were mentors had more than two verbal responses each during the interview in the category of peer and social experiences for feelings related to their current experiences of mentoring. The male non-mentor study participant expressed concerns eight times during the interview that the experience of mentoring would not give him the peer and social feedback that he desired. Although female participants' response frequency in this category was higher on average than that of men, men were more likely to cite this category as their primary reason for making a decision about mentoring. For example, male participants more often cited the social pressure of adhering to a one-year commitment as instrumental in their decision to mentor or not mentor. One male participant believed the one-year time commitment was instrumental in his decision. This subject described social and peer pressures to commit to becoming a mentor for the full term due to a need to "follow through with it no matter what." Female participants exhibited less of a tendency to consider social pressures when deciding

whether or not to mentor. None of the female participants mentioned the social pressure to adhere to the time commitment as a factor in making their decision.

Male participants also were more likely than female participants to cite positive or negative experiences with childhood social groups as primary influences in their decision to become mentors. Male participants cited the fact that they had "a lot" of positive peer experiences that influenced their decision to become mentors. Relationships with older brothers, male friends, and "neighborhood folk" drove their desire to become mentors. Overall, data show males who mentored were most likely to offer reasons related to their peer and social experiences (both past and present) as to why they chose to be a part of the mentoring program.

Female participants were more likely to cite peer and social experiences as peripheral to their decision to mentor. A number of female participants said they "didn't really have a mentor figure" for themselves, or that they had "some" positive experiences with social groups but that these experiences did not largely influence their decision to mentor. Men who were part of the mentoring program most frequently cited a commitment to the agency and the mentee as reasons for fulfilling their obligations. One male mentor reported he remained in the program because of his commitment to the agency. "I signed on; I told them that this is my commitment and I'm going to stick with it no matter what." Another male participant stated he was recruited to become a mentor by a colleague at his place of employment. Perhaps part of his dedication to being a mentor was tied not only to the commitment he gave to the agency, but also to peer relationships within his profession.

Mentoring males also acknowledged a desire to fulfill a deficit in socialization and peer connections through their relationships with mentees. One current mentor explained, "I really prefer [a mentee] a little older that I can have a conversation with." Even the male participant who chose not to mentor described reasons related to peer and social experiences as to why he declined to become a mentor. This participant worried he would not have enough time for other significant peers in his life (such as his wife and friends) if he committed to the program.

Social Contribution

Despite the differences in the reasons for mentoring reported by men and women, all 9 participants noted feeling a desire to contribute to society as a principal reason to become a mentor. Furthermore, all of the participants in this study mentioned they felt mentoring was a useful and expected contribution to society. For some participants, societal contributions were linked to their religious beliefs. Two female participants noted that their spiritual beliefs include helping other individuals as an essential part of participation in life. Mentors also believed in the reciprocal benefit to society and one's self inherent in the mentoring experience. "We often don't know how much we are benefiting that person. Maybe it's years later…maybe it's never. Obviously you were a person in their life for a reason. All you do is your best, I think that is all we can ask for and hope for us." Other participants dedicated themselves to a belief in the importance of helping children as a way to improve society's future. "People really need to know whatever their cause is…it's [society's] future."

Clearly each participant had a meaningful experience – be it spiritual, familial, or social – that led to his or her desire to mentor.

Other Factors

A number of other factors contributing to the decision to mentor were mentioned by participants. Some felt the mentoring program offered a personal opportunity to rectify the challenges they faced while raising their own children. One participant identified the significance of a non-family member in her own life, saying, "I personally had problems with my son…and I remember [outside help] was extremely beneficial because parents can only do so much." Two participants discussed a desire to mentor after raising their own children. The desire to remain involved in the lives of other children remained strong. "I wanted to do something good… my own children were at the point where they were somewhat older [and they] didn't want to spend as much time as before and I still wanted to spend time with kids." Thus, like spiritual, familial, and social experiences, the experience of raising ones' own children was also an influential factor across groups.

Discussion

There are several limitations to this research study. Most importantly, the ability to generalize the findings to a larger population of current and potential mentors is limited by the small sample size and the fact that the sample was drawn only from one mentoring program. Additionally, the researchers' difficulty recruiting participants because of time constraints may be reflective of an unknown variable that also influences participants' choice of whether to mentor. Finally, the findings

may contain bias if active mentors were motivated to convey a positive picture of the mentoring program to the researchers.

There were several factors the researchers attempted to control that may have nonetheless impacted the research. Researcher biases is possible, as many of the participants were interviewed by different researchers who may have had different styles of asking the questions in spite of the researchers' attempts to make the interviews as uniform as possible. Furthermore, several of the interviews were conducted in loud and public environments, which may have contributed to misunderstandings in the dialogue when the interviews were transcribed.

Regardless of these limitations, tentative conclusions can be drawn from this research about the differences between women and men's reasons for mentoring, which has important implications for recruitment and retention of mentors. In particular, it appears that peer factors most strongly influence men's decisions to mentor while personal gratification is key for women. Social workers may be able to use this information when trying to recruit mentors or support ongoing mentoring relationships. Further research is needed on the length of time men and women participate in mentoring programs and factors that motivate mentors to remain involved with mentees.

Conclusion

Based on the analysis of the data gathered in this study, the most prominent differences between male and female mentors have to do with the reasons they choose to mentor. According to the findings of this study, female participants (both mentors and non-mentors) appeared to be more influenced than male participants by feelings of personal gratification when deciding whether to become mentors, while male participants appeared to be more influenced by their peer and social experiences in their decisions about whether to become mentors. Hence, gender played a role in the decision to mentor.

At the same time, clear similarities emerged from participants. All spoke of a desire to contribute to society. Most discussed the significance of prior family experiences as a factor influencing their decisions to mentor. There were few differences between mentors and non-mentors in response to questions related to participants' level of education, volunteer background, ethnicity, age or experience with the mentoring agency program structure.

Thus, men and women became mentors for reasons that are both similar and different. While societal contributions and family experiences were important to participants regardless of gender, personal gratification and peer/social experiences were more divided along gender lines. This data supports a tentative conclusion that individuals choose to mentor for a variety of reasons, which should be taken into account when developing recruitment strategies and program structures for mentoring programs.

References

Blackman, S. (1998). Recruiting male volunteers: A guide based on exploratory research. Retrieved March 29, 2005, from http://www. energizeinc.com/download/blackman.pdf.

Boraas, S. (2003). Volunteerism in the United States. *Monthly Labor Review, 126*(8), 3–11.

Ellis, S. (1984). Research on volunteerism: What needs to be done. *Journal of Voluntary Action Research, 14*(2-3), 11–14.

Ellis, S. (1997). What's gender got to do with it? *Energize Inc....Especially for Leaders of Volunteers.* Retrieved March 29, 2005, from http://www.energizeinc.com/hot/sept97.html

Grossman, B. & Sipe, C. (Eds.). (1999). Contemporary issues in mentoring. In *Mentoring Matters: A National Survey of Adults Mentoring Young People* (pp.68–83). Retrieved March 29, 2005, from http://www.ppv.org/ ppv/publications/assets/37_ publication.pdf

Gur, M. & Miller, L. (2004). Mentoring improves acceptance of a community intervention for court: Referred male Persons in Need of Supervision (PINS). *Child and Adolescent Social Work Journal, 21*(6), 573–592.

Holland, S. (1996). PROJECT 2000: An educational mentoring and academic support model for inner-city African American boys. *Journal of Negro Education, 65*(3), 315–321.

Huber, J. (1998). The role of education for mentoring volunteerism: An alternative answer to life long community service. *Palaestra,14*(3), 59.

Mackay, D., Glasrud, B., Leipper, D., & Elliston, S. (1997). Responses to: What's gender got to do with it? *Energize Inc....Especially for Leaders of Volunteers.* Retrieved March 29, 2005, from http://www.energizeinc.com/hot/ressep97.html

Nefstead, S. & Nefstead, S. (2005). Recruitment tips for a mentoring program. *University of Minnesota Extension Service.* Retrieved March 29, 2005, from http://www.extension.umn.edu/ distribution/citizenship/DH6497.html

Ragins, B., Cotton, J. & Miller, J. (2000). Marginal mentoring: The effects of type of mentor, quality of relationship, and program design on work and career attitudes. *Academy of Management Journal, 43*(6), 1177–1194.

Ruark, J. (2003). Mentors and the importance of commitment [Electronic version]. *Chronicle of Higher Education, 49*(20): A-12.

Sipe, C. (1996). *Mentoring: A synthesis of P/PV's research: 1988-1995*. Retrieved March 29, 2005, from http://www.ppv.org/ppv/publications/assets/40_ publication.pdf

Tierney, J., Grossman, J. & Resch, N. (2000). *Making a difference: An impact study of Big Brothers Big Sisters*. Retrieved March 29, 2005, from http://www.ppv.org/ppv/publications/assets/111_publication.pdf

Appendix A

List of Interview Questions

Set A: Active mentors

1) Please provide the following demograhic information: gender, age, race, ethnicity, level of education, job title, number of siblings (by birth, adopted, step, or half), rank order among the siblings, marital status, how you learned about the program, and duration in the program.

2) What factors most influenced your decision to become a mentor in this program?

3) Do you volunteer in any other capacity, including formal and informal organizations?

4) Did you have an influential other in your life as a young person? Please consider both formal and informal relationships, as well as peer and adult relationships.

5) Please describe your experience, in as much detail as possible, of the recruitment / application process for this program. Please consider both positive and negative aspects of the experience.

6) Please describe your experience interacting with the volunteer coordinator of this program.

7) Please describe your experience of the volunteer information session you attended.

8) Please describe your experiences with your mentee, both when you were first matched and currently.

9) If you had to do it over again, would you choose to become a mentor again?

10) What motivates you to remain in the program?

Set B: Non-mentors

1) Please provide the following demograhic information: gender, age, race, ethnicity, level of education, job title, number of siblings (by birth, adopted, step, or half), rank order among the siblings, marital status, how you learned about the program, and duration in the program.

2) What factors influenced your decision not to pursue mentoring for this program?

3) Do you volunteer in any other capacity, including formal and informal organizations?

4) Did you have an influential other in your life as a young person? Please consider both formal and informal relationships, as well as peer and adult relationships.

5) Please describe your experience interacting with the volunteer coordinator of this program.

6) Please describe your experience of the volunteer information session you attended.

7) Please describe your expectations of the program before attending the information session, and any influence attending an information session had on those expectations.

8) Would you recommend this program to another individual? Why or why not?

9) Tell me about a situation in your life in which you felt rewarded.

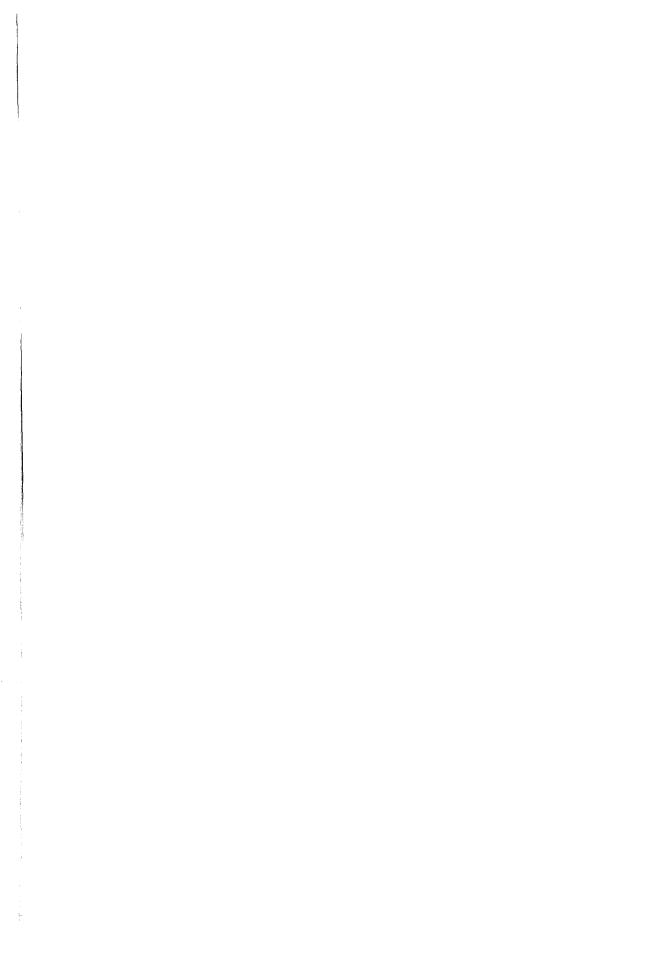10) If you were the coordinator for a program such as this one, what would you do to recruit mentors?

Gina Gehrke, an alumna of Knox College, graduated in 2004 with a bachelor's degree in elementary education. Gina further pursued her education by attending the School of Social Work, graduating in the Spring 2006 with an MSW and a concentration in school social work.

Quincy D.H. Jenkins received her MSW from the School of Social Work in May 2006, as well. She earned her B.S. in psychology from the University of Illinois at Urbana-Champaign in 2003. While at Loyola, her internships were with John H. Stroger Jr. Hospital of Cook County in the pediatrics department and Arlington Heights School District 25 in the elementary and early childhood settings. Quincy will be working as a school social worker this fall at Home School in Lyons School District 103.

Pauline F. Wray also received her MSW from the School of Social Work in May 2006. She earned her B.A. in theater from Knox College in 2001. While at Loyola, Pauline focused her energies on social work in health care and social work with adolescents. Pauline currently works as an MSR for the Friends First program at Mercy Home for Boys and Girls. She is interested in working in the medical social work field or working with adolescents and families.

Adolescent Borderline Personality Disorder and Dialectical Behavior Therapy

by Deanna M. D'Amico Guthrie

Abstract

Previous research supports the reliability and validity of using Borderline Personality Disorder (BPD) as a diagnosis with adolescents. There are numerous treatment options for the disorder, but outcome studies indicate the best results are achieved with Dialectical Behavior Therapy (DBT). In this article, the literature surrounding adolescent BPD will be reviewed, followed by a summary of the model of DBT that is used with adolescents and their families. The author will also explore the fit between DBT and social work values.

Introduction

The Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision; American Psychiatric Association, 2000) allows a child or adolescent to be diagnosed with a personality disorder if the pattern of pathology is present for at least a year and is pervasive, persistent, and unlikely to be limited to a developmental stage or an Axis I disorder. Clinicians, however, have been reluctant to make Axis II diagnoses in clients under the age of 18 (Paris, 2005). This article will therefore discuss the reliability and validity of diagnosing Borderline Personality Disorder (BPD) in adolescents. Further, it will examine how children and adolescents who are diagnosed with BPD can benefit from Dialectical Behavior Therapy (DBT), the premier empirically based treatment for BPD. In conclusion, an application of DBT principles to the social work practice with children and adolescents will be presented.

Biosocial Theory of Borderline Personality Disorder

In order to consider diagnosing BPD in adolescents, it is first important to look at the biosocial theory of BPD. The foundation of this theory, developed by Marsha Linehan, is that:

> BPD is primarily a dysfunction of the emotional regulation system; it results from biological irregularities combined with certain environments, as well as from their interaction and transaction over time. The characteristics associated with BPD are sequelae of, and thus secondary to, this fundamental emotional dysregulation. Moreover,

these same patterns cause further deregulation. Invalidating environments during childhood contribute to the development of emotional dysregulation; they also fail to teach the child how to label and regulate arousal, how to tolerate emotional distress, and when to trust her own emotional responses as reflections of valid interpretations of events. (Linehan, 1993, p. 42)

Per Linehan (1993), emotional dysregulation is due to emotional vulnerability and an inability to regulate emotions. Emotional vulnerability includes: a "high sensitivity" to emotional stimuli (reacts quickly and has a low threshold for emotional reactions), "emotional intensity" (extreme emotional reactions), and a "slow return to emotional baseline" (long-lasting emotional reactions) (p. 43–44). An invalidating environment is one in which there is a poor fit between the environment and the child's temperament, and can also include physically or sexually abusive environments (Katz, Gunasekara, & Miller, 2002). In such environments, the parent and/or caretaker does not validate the child's personal experiences (the child is instead punished or trivialized), and the parent and/or caretaker does not acknowledge the child's behaviors, the intent, or the motivation behind the behaviors. Such invalidation tells the child that she or he is wrong in his or her view of what is causing emotions, thoughts, and behaviors. In addition, the child attributes experiences to having socially unacceptable characteristics. The child in turn takes on the characteristics of the invalidating environment and learns to invalidate his or her own emotional experiences (Linehan, 1993).

Areas of Impairment in Individuals with Borderline Personality Disorder

Linehan, describes five areas of impairment in individuals with BPD. As noted earlier, the central problem is one of emotional dysregulation, which in turn is thought to contribute to the other areas of impairment: interpersonal, self, cognitive, and behavioral dysregulation. Interpersonal dysregulation can manifest itself in the form of fears of abandonment and chaotic relationships. Instability in one's emotions and relationships can lead to self-dysregulation, which can include an unstable self-image and a chronic feeling of emptiness. Cognitive

dysregulation can also be present in individuals diagnosed with BPD in the form of rigid thinking, irrational beliefs, paranoid ideation, and dissociation. Behavioral dysregulation is also common, which develops as a consequence of emotional dysregulation or as an attempt to regulate emotions. This type of dysregulation manifests as impulsivity and parasuicidal behaviors (Katz, Gunasekara, & Miller, 2002; Linehan, 1993). Individuals diagnosed with BPD are predisposed to difficulty in regulating emotions and may therefore develop maladaptive coping strategies, such as parasuicide, to regulate their emotions. Parasuicide is defined as "any acute, intentional self-injurious behavior resulting in physical harm, with or without the intent to die" (Katz, Cox, Gunasekara, & Miller, 2004, p. 276).

Diagnosing Adolescent Borderline Personality Disorder

As previously stated, clinicians have traditionally been reluctant to make Axis II diagnoses, such as BPD, in clients under the age of 18 (Paris, 2005). The rationale behind this reluctance is that "adolescence has been seen as a time of transition that can be marked by turmoil. Since personality disorders are chronic, by definition, clinicians understandably prefer to wait and see before coming to conclusions. Nonetheless, there is no reason why the same pathology should be called one thing before a defined age and another afterward" (Paris, 2005, p. 237–238).

There is empirical support for the validity of diagnosing adolescents with BPD. For example, Durrett & Westen (2005) identify that "personality pathology is not limited to adulthood. To the extent that DSM-IV provides criteria useful for assessing adults, these criteria yield diagnoses with similar operating characteristics in adolescents" (pp. 457–458). Paris (2005) further supports the belief that many symptoms in adolescents are identical to those seen in adults with personality disorders. Moreover, longitudinal studies have shown that an adolescent's presentation of symptoms consistent with a personality disorder is a potential correlate of serious pathology in young adulthood.

Researchers have supported the frequency and reliability of diagnosing adolescents with BPD (Becker, & Grilo, 2005). "Research findings suggest that clinicians should seriously consider diagnosing BPD when patients present with the classical features of the disorder, that is, affective instability, chronic suicidality, self-mutilation, a wide range of impulsivity, and micropsychotic phenomena" (Paris, 2005, p. 241). The most important predictors of continuation of personality disorder symptoms into adulthood are severity and age of onset, with a greater severity and younger age of onset predicting a greater continuation of symptoms. BPD typically begins in adolescence; most clients who present with symptoms of BPD state an onset of symptoms around puberty. Psychosocial risk factors seen in adolescent and adult cases are also effectively the same (Paris, 2005). Additionally, using structured interviews, adolescents (ages 12–17) meet the criteria for personality disorders at the same rates as young adults (age 18–37) (Durrett & Westen, 2005).

Certain features present in adolescents diagnosed with BPD diverge from those features in adolescents without the diagnosis of BPD, which can assist the clinician in making an appropriate BPD diagnosis in an adolescent. Adolescents with BPD are more likely to have diagnoses of posttraumatic stress disorder, affective disorders, and substance abuse disorders than adolescents without BPD. Adolescents with BPD symptoms and/or a BPD diagnosis also more commonly report histories of neglect, abandonment, physical and sexual abuse, delinquent activity, and parasuicidal behaviors (Pinto, Grapentine, Francis, & Picariello, 1996). A study by Pinto and colleagues (1996) compared depressed adolescents with a BPD diagnosis to depressed adolescents without a BPD diagnosis on measures of affective and cognitive features of BPD. They found that both groups displayed significant feelings of anxiety, anger, and hopelessness. They displayed external loci of control, self-deprecatory attributes, and poor self-concepts. Even though both groups displayed these symptoms, the adolescents with BPD displayed a greater level of symptomatology in these areas. The only area in which a *significant* difference was found was in self-concept. The adolescents diagnosed with BPD reported significantly poorer self-concept, particularly on measures of popularity, physical appearance, and happiness/satisfaction. The Pinto et al. study found that the difference in self-concept was not due to depression severity; thus, negative self-concept appears to distinguish adolescents with a BPD diagnosis from adolescents who were depressed without a diagnosis of BPD. These results are important when attempting to distinguish between depression and BPD among adolescents, a distinction that may not always be clear in this population. This finding can be used to assist clinicians in making the appropriate diagnosis.

Another way to understand the nature of BPD diagnosed among adolescents is by studying the diagnostic efficacy of BPD criteria. Becker, Grilo, Edell, and McGlashan (2002) compared the diagnostic efficacy of BPD criteria in hospitalized adolescents and adults. Diagnostic efficacy was defined as "the extent to which diagnostic criteria (or symptoms) are able to discriminate individuals with a given disorder from those without that disorder" (p. 2043). In this study, the adolescents and adults had similar base rates for the BPD diagnosis and for the BPD criteria, suggesting general similarities between the age groups with respect to BPD. They found that five of the BPD symptoms—impulsiveness, affective instability, uncontrolled anger, suicidal thoughts or gestures, and emptiness or boredom—were present in at least two-thirds of the adolescents. In the adult group, no one symptom had a clear advantage as an inclusion criterion, which is consistent with the DSM-IV perspective that all symptoms are viewed as having equivalent predictive power. However, in the adolescent group some criteria did have significantly higher positive predictive power than others. In this study, abandonment fears had the greatest utility as an inclusion criterion. The absence of impulsiveness was found to be the best exclusion criterion for adults (impulsiveness also had the greatest predictive value for the adults), but the absence of uncontrolled anger was the best exclusion criterion for adolescents. When both positive and negative predictive capacity were taken into account (the symptom's power as an inclusion or exclusion criterion) the researchers found that affective instability, uncontrolled anger, and identity disturbance had the most overall utility in diagnosing BPD among adolescents, with affective instability being the greatest predictor. Overall, the adolescent symptoms had significantly higher positive predictive power than the adult symptoms. The implication of this finding is that adolescents with a single BPD symptom are more likely to receive a BPD diagnosis than are adults with a single BPD symptom. These findings are also consistent with the results of Pinto and colleagues (1996), in that identity disturbance is more useful than most BPD symptoms in leading to a correct diagnosis. The only symptoms with equal or better predictive value in adolescents are affective instability and uncontrolled anger. These findings suggest that symptoms of poor affect regulation may be the most characteristic of adolescents with a BPD diagnosis (Becker et al., 2002), which is also consistent with Linehan's biosocial theory, in that the main problem in individuals with BPD is emotional dysregulation.

Even though BPD can be reliably and frequently diagnosed in adolescents (Becker & Grilo, 2005), clinicians should still use care when making this diagnosis due to the overlap between BPD and Axis I disorder symptoms, as well as with "normal" adolescent behaviors. Becker and Grilo (2005) examined the validity of BPD among adolescents. They looked at the factor structure of BPD among adolescents and whether the factors were related to specific Axis I disorders. Four factors emerged from their analysis. Factor one consisted of "suicidal threats or gestures" (behavioral dysregulation) and "emptiness and boredom" (self dysregulation) and was significantly associated with major depression and dysthymia. Factor two contained "affective instability", "uncontrolled anger" (emotional dysregulation), and "identity disturbance" (self dysregulation), and corresponded to oppositional defiant disorder and anxiety disorders. Factor three, which consisted of "unstable relationships" and "abandonment fears" (interpersonal dysregulation), also corresponded to anxiety disorders. Factor four consisted of "impulsiveness" (behavioral dysregulation), and conduct disorder was associated with this factor. When a BPD diagnosis is not made, adolescents are likely to receive a diagnosis of major depressive disorder if they present with internalizing symptoms, or a diagnosis of conduct disorder if they present with externalizing symptoms (Paris, 2005).

The BPD symptoms of affective instability, uncontrolled anger, impulsivity, and identity disturbance are common in adolescents, which begs the question: How are these BPD symptoms differentiated from "normal" adolescent behaviors? In answering this question, Paris (2005) states, "One sometimes hears that all adolescents may be 'a little borderline.' No one denies that moodiness and some degree of impulsive behavior are common in this age group. But most adolescents are not seriously troubled or rebellious" (p. 240). This suggests that the severity of the adolescent's behavior and the impact those behaviors are having on his or her functioning can assist clinicians in differentiating non-pathological adolescent behaviors from those indicating that a BPD diagnosis may be appropriate.

Treatment Options for Adolescents Diagnosed with Borderline Personality Disorder

There are numerous treatment options for adolescents diagnosed with BPD, including standard cognitive-behavioral therapy, individual psychotherapy, and substance abuse treatment

(Swenson, Torrey, & Koerner, 2002). Because BPD has numerous symptoms that overlap with other disorders and because of the intractable nature of personality disorders, clinicians should understand that BPD is likely to be chronic (Paris, 2005). As a result, it is important for a therapist to have realistic expectations for clients and also to develop treatment goals that take into account the nature of the client's psychopathology and numerous symptoms. Therapists are guided by the empirical literature to modify personality traits and understand that a more conservative use of psychopharmacology and more active efforts at psychotherapy may be helpful (Paris, 2005). The best evidence-based outcomes for people with BPD are from Dialectical Behavior Therapy (Katz, Gunasekara, & Miller, 2002).

General Structure of DBT

DBT is based on dialectics, which is the continual synthesis of opposing ideas. The most fundamental dialectic of DBT is "the necessity of accepting patients just as they are within a context of trying to teach them to change" (Linehan, 1993, p. 19). Linehan developed this therapy for the treatment of chronically parasuicidal women diagnosed with BPD, and it is the first empirically supported treatment for this population (Katz, Gunasekara, & Miller, 2002). It blends standard cognitive-behavioral therapy with Eastern philosophy and meditation, and includes elements from psychodynamic, client-centered, gestalt, paradoxical, and strategic approaches. DBT supports a non-critical stance towards individuals diagnosed with BPD, which helps to correct the common tendency to blame them for their maladaptive behaviors (Swenson, Torrey, & Koerner, 2002). There are six core elements of DBT: a biosocial theory regarding BPD (discussed above), a conceptual framework of the stages of treatment, a hierarchy of treatment targets within each stage, an explanation of the functions of treatment, different treatment modalities that fulfill those functions, and sets of treatment strategies (Robins & Chapman, 2004).

Treatment Stages and Hierarchy of Targets

DBT is composed of a total of four stages of treatment, beginning with a "pretreatment" stage. During pretreatment (Orientation and Commitment), the targets of therapy are an orientation to treatment and the agreement on goals, during which the client makes a commitment to therapy. In the first stage of treatment (Attaining Basic Capacities), the targets are addressed in a hierarchical order of importance. The most important target is decreasing suicidal behaviors, which include suicide crisis behaviors, parasuicidal behaviors, intrusive suicidal urges, images, and communications, and suicidal ideation. After these behaviors have been addressed, the next target is decreasing behaviors that interfere with treatment. This includes problems that threaten the continuation of therapy and those that interfere with the process of treatment. Another target is decreasing quality of life-interfering behaviors. Behaviors causing immediate crises are targeted and easy-to-change behaviors are targeted over difficult-to-change behaviors. The final target is increasing behavioral skills. The skills, in order of importance, are: core mindfulness skills, interpersonal effectiveness, emotional regulation, and distress tolerance. The therapist addresses the highest priority target that is relevant at that time. The goal of stage 2 (Reducing Posttraumatic Stress) is the direct treatment of posttraumatic stress. This is only done after the client has the necessary skills and supports to resolve the trauma. Increasing self-respect and achieving individual goals are the targets of stage 3 (Increasing Self-Respect and Achieving Individual Goals).

Behavioral Skills Modules

DBT addresses the five problem areas of BPD that were discussed earlier (emotional, interpersonal, self, cognitive, and behavioral dysregulation) with four corresponding behavioral skills modules: mindfulness, distress tolerance, emotional regulation, and interpersonal effectiveness. These skills modules are taught in a psychoeducational skills training group (Linehan, 1993). The support for skills training in the treatment for people diagnosed with BPD comes from the idea that:

> Many of the difficulties in BPD may be linked with deficits or disruptions in emotional regulation skills, which contribute to deficits and disruptions in interpersonal relations and skills, distress tolerance skills, and mindfulness skills. Teaching and rehearsing these skills would be expected to, among other things, help the patient develop greater capabilities to interact assertively, to regulate his or her emotions, to tolerate distress and inhibit behaviors that provide short-term relief from it but create long-term problems, to be more aware of his or her current internal states and external environment, and to be less judgmental. Developing such skills and having them reinforced by the environment would be expected to lead to a variety of positive mental health outcomes (Robins & Chapman, 2004, p. 85).

Mindfulness, the core skills module, addresses dysregulation. The skills utilized are psychological

and behavioral versions of meditation skills (Linehan, 1993). Six skills are taught to help clients observe their experiences in nonjudgmental ways and to put observations into words in order to change from making emotional choices to making balanced decisions (using both emotional and rational input), which are called "wise-mind decisions" (Katz, Gunasekara, & Miller, 2002). The six mindfulness skills are: observing, describing, participating, taking a non-judgmental stance, focusing on one thing in the moment, and being effective. The distress tolerance skills module targets behavioral and cognitive dysregulation. The goal of these skills is to help the client accept reality and survive crises. The emotion regulation skills module addresses emotional dysregulation by giving the client a non-judgmental place to experience emotions, therefore reducing emotional distress. The interpersonal effectiveness skills module addresses interpersonal dysregulation and teaches the client how to ask for what one needs, say no, and cope with interpersonal conflict (Linehan, 1993).

Functions and Modes of Treatment

Linehan describes five functions of comprehensive treatment of patients diagnosed with BPD, which serve to guide the structure of DBT. Each function is assigned to a different mode of treatment (Miller, 1999). The first function is to enhance the individual's capabilities, which is done through a weekly psychoeducational skills training group, utilizing the four skills modules discussed above. The second function is to improve the individual's motivation to change. To address this, the client has weekly sessions with an individual therapist to identify and reduce factors that interfere with the ability to use skills. The third function is to ensure the generalization of new capabilities from therapy to everyday life, which is facilitated through telephone contacts with the therapist on an as-needed basis. The client can call the therapist when crises arise, to give good news, or to repair the therapeutic relationship, if needed. The fourth function is to enhance the therapist's capabilities and motivation to treat effectively through a weekly case consultation group that offers technical help and emotional support. The fifth function is to structure the environment to support the client's and therapist's capabilities. This is done by ensuring that the client does not have to get worse in order to attain additional help and that the therapist has reasonable time demands to prevent burnout (Katz, Gunasekara, & Miller, 2002).

Core Treatment Strategies-Validation and Problem Solving

There are four categories of basic treatment strategies in DBT: dialectical strategies, core strategies, stylistic strategies, and case management strategies. Since a complete discussion of these strategies is beyond the scope of this article, only the core strategies will be presented here (see Linehan, 1993 for a complete discussion). The core treatment strategies in DBT are validation (acceptance) and problem solving (change), as DBT emphasizes accepting the client while also promoting change. Some ways in which the therapist can show validation towards the client are to accept the client's feelings; communicate that feelings are valid; encourage, praise, and reassure the client; actively express hope to the client; and focus on the client's capabilities (Linehan, 1993). In validating the client, the therapist actively communicates acceptance of the client. The act of validation allows the client and therapist to understand the client's responses. The therapist does not make valid what is not, but instead searches for some validity within the client's behaviors (Katz, Gunasekara, & Miller, 2002). The therapist balances this validation with strategies for change. Problem-solving strategies help the client understand and accept the problem and generate, evaluate, and carry out solutions (Linehan, 1993).

The main problem to be treated in individuals diagnosed with BPD is emotional dysregulation. Extreme behaviors are viewed as either a result of emotional dysregulation or an unsuccessful attempt to regulate emotion, so the therapist analyzes the nature and etiology of the emotional dysregulation to understand the function of the maladaptive behavior. Additionally, the therapist and client together identify triggers and consequences that maintain behavior by looking at the events leading to a certain behavior, the client's response, and the environment's response to the behavior. The therapist also asks whether the client has the skills to respond effectively, and if not, capability enhancement strategies are used. If the client has the necessary skills but is not using them, the impediments to adaptive responses are addressed (Katz, Gunasekara, & Miller, 2002).

Dialectical Behavior Therapy Modified for Adolescents

DBT has been modified for use with different psychopathologies (substance abuse, eating disorders) and age groups (adolescent inpatients and outpatients) (Robins & Chapman, 2004). Several changes to the general structure of DBT have been made for its use with adolescents. One change is that DBT can be used at the same time as, or as part of, family treatment.

When being used with an individual adolescent, the first stage of treatment is shortened from one year to 12 weeks. The main focus of treatment is initially on the pretreatment targets of commitment to treatment and agreement on goals, and then on the first-stage targets of stability, connection, and safety. Goals in this stage include decreasing life-threatening behaviors, decreasing behaviors that interfere with therapy and quality of life, and increasing behavioral skills (Miller, 1999). The second-stage target of addressing posttraumatic stress and the third-stage targets of increasing self-respect and achieving individual goals are not formally addressed in working with adolescents (Katz, Gunasekara, & Miller, 2002).

For a family intervention, some modifications in the implementation of the five functions of treatment have been made. Parents are included in the skills-training group to increase the generalization and maintenance of skills. The goals are to teach the family to use the skills and improve the adolescent's home environment. Also, the number of skills addressed in the group is reduced to accommodate for the shorter time period, and the language on the skills handouts has been simplified to be developmentally and culturally appropriate (Katz, Gunasekara, & Miller, 2002). A new skills-training module has also been added to the group called "Walking the Middle Path." This skills module was added in order to address conflicts and dilemmas often found in parent-adolescent relationships (Miller et al., 2002). An additional modification is that parents and other family members are included in the individual sessions as needed (Katz, Gunasekara, & Miller, 2002). In the individual sessions, the same hierarchy is used as in standard DBT. Nothing else is discussed until self-harm is addressed. If there have not been any parasuicidal behaviors since the previous session, the session focuses on anything that may be interfering with treatment or quality of life (Miller, 1999).

DBT with adolescents addresses the same five goals as standard DBT. The adolescent and his or her parents address capability enhancement in a weekly 2-hour skills training group, which provides opportunities for learning skills through instruction and modeling, and for skill-strengthening through the rehearsal of skills and the reinforcement of new skills. The adolescent's motivation is enhanced in weekly individual sessions where the client reviews a weekly diary card and does a behavioral analysis of maladaptive events; works on skill strengthening and generalization; and focuses on emotional dysregulation, cognitive errors, and contingencies that can compromise motivation. As in standard DBT, the therapist is available for telephone consultation for the purpose of preventing parasuicidal behaviors, facilitating generalization of skills, sharing good news, or repairing the therapist-client relationship. The therapist also attends a weekly DBT consultation group to enhance the capacity and motivation to treat clients effectively. Lastly, the therapist structures the environment by including family, other treatment providers, and the school in treatment to ensure the client does not have to get worse in order to get help (Miller, 1999; Katz, Gunasekara, & Miller, 2002).

Dialectical Behavior Family Treatment

Since most adolescents live with their families and a core contributing factor to the development of BPD is thought to be an invalidating family environment, the transaction between the adolescent and family becomes an important focus in treatment (Woodberry, Miller, Glinski, Indik, & Mitchell, 2002). Family therapists believe the power of family therapy is its ability to change interactions between family members; combining family treatment and DBT, then, may reduce invalidation within the family—a major contributing factor to emotional dysregulation. Additionally, it may be easier to decrease risk and increase protective factors in an adolescent's environment than to change individual characteristics within the adolescent (Miller et al., 2002).

A therapist who combines DBT with family therapy will be required to evaluate and understand a situation from multiple, and often opposing, perspectives. The therapist helps the adolescent and the family to integrate opposing viewpoints (Miller et al., 2002). There are certain family therapy targets that need to be addressed, which may be related to behaviors by the adolescent that DBT will attempt to change. The first is decreasing family risk factors, including abuse, neglect, high levels of conflict and stress, and parental psychopathology. Family therapy attempts to reduce skills deficits and increase skills among family members. Another target is to enhance familial protective factors, such as warmth, closeness, emotional involvement, family stability, cohesion, motivation, adaptability, and dialectical thinking and behaviors. A final target is improving interpersonal interactions by enhancing mindfulness of interaction patterns, encouraging reciprocal validation between the adolescent and the family, and increasing affective reciprocity, in which the parents decrease reactivity and the adolescent

decreases negativity (Woodberry et al., 2002). Combining these two modalities allows the therapist to gain an integrated and empathic view of the family. If an adolescent is only being seen in individual therapy, the therapist is more likely to view the adolescent as a victim of rather than as a participant in the invalidating environment (Miller et al., 2002). Genograms can also help to give the family and the therapist insight into the intergenerational transmission of invalidation, thus allowing the therapist, adolescent and family to be more validating of the family's behavioral patterns and interactions. "Validation acknowledges an understanding of how the person came to act, think, and feel a certain way. The DBT therapist utilizes this understanding to help the adolescent and family members recognize that while thinking, feeling or acting in a certain way makes sense in terms of past history, it may no longer be effective in the present context" (Woodberry et al., 2002, pp. 574–575). All of the targets of standard DBT can be modified for use in family sessions by emphasizing interactions between family members rather than individual behavior, with the first priority always being the adolescent's suicidal or parasuicidal behavior. Family relationships can also be used as a source of strength that can help adolescents cope with emotional dysregulation (Miller et al., 2002).

Advantages to Using Dialectical Behavior Therapy with Adolescents

There are advantages to using DBT with adolescents. DBT structures treatment and guides the therapist's focus according to the treatment hierarchy by making the adolescent's behaviors (especially life-threatening and parasuicidal behaviors) the primary treatment target (Katz, Gunasekara, & Miller, 2002). DBT is client-centered in that it instructs the therapist to assess where the client is on a particular day and use that information to guide the current session. If a therapist is unsure of how to address an adolescent's behavior, DBT provides guidance, thereby reducing the therapist's anxiety and thus diminishing the chance that the therapist will respond in a way that is unhelpful to the client. Though a treatment modality should not be chosen based on the therapist's needs, the fact that DBT can reduce therapist anxiety is an advantage as long as the client's needs remain primary. DBT also directly targets treatment noncompliance and focuses on keeping adolescents engaged in treatment (Katz, Gunasekara, & Miller, 2002) through the pretreatment targets of collaboratively agreeing on goals and

committing to change. This is important because engagement in treatment and compliance can be difficult to achieve when working with this population. Adolescents may be more likely to engage in treatment if they feel a sense of control over the treatment goals. Additionally, the areas addressed by DBT (e.g., emotional instability, impulsivity, interpersonal problems, and confusion about oneself) are consistent with the developmental tasks of adolescence (Katz, Gunasekara, & Miller, 2002).

Limitations with the Use of Dialectical Behavior Therapy

There are several limitations to using DBT with adolescents. A chief limitation of DBT is that it is resource intensive (Paris, 2005). DBT involves twice-weekly therapy (one individual session and one psychoeducational skills group), family treatment if indicated, 24-hour access to the therapist, and a therapist case consultation group. Due to the intensive nature of this treatment and the additional training required for clinicians, it may not be available in all communities, which can also lead to difficulty in accessing treatment. An additional issue that must be addressed is using short-term treatment with adolescents believed to be presenting with a personality disorder. In adults, DBT is a longer-term treatment, with the first phase typically lasting one year. In adolescents, however, this first phase has been shortened to 12 weeks. One of the main goals of this phase is stabilization of the adolescent, which includes control of suicidal or parasuicidal behaviors (Katz, Gunasekara, & Miller, 2002). The goal of this phase is also to teach the adolescent and his or her family skills needed to increase functioning. While these sessions may be helpful in controlling behavior that could be harmful to the adolescent and in improving the interactions between the adolescent and the family, it may not be as effective as longer-term treatment.

Applications to Social Work Practice

DBT is based on the premise that emotional dysregulation results from the interaction between the biology and characteristics of an individual within the social environment (Linehan, 1993). This premise is consistent with the "person-in-environment" perspective held by social workers. In adolescents diagnosed with BPD, it is not enough to look at the characteristics within the individual and use them as treatment targets, but the individual's environment must also be a target. The client's environment is always important, but this is especially true with adolescents since they typically are living in their parents' or caregiver's home, attending school, and

may be involved with other service providers. Because an invalidating environment is thought to be a contributing factor in the maintenance of emotional dysregulation, the DBT therapist works collaboratively with the family, school, and other service providers to best help the adolescent.

DBT also focuses on accepting clients as they are and providing them with empathy. Even if a certain behavior is inappropriate or even harmful, the therapist finds validity in it based on the client's context and life experiences. Each individual session is structured based on where the client is and the hierarchy of treatment targets. Regardless of what the therapist may want to address during a session, the highest priority target for the client is addressed, especially with suicidal or parasuicidal behavior. The stance of non-judgment in DBT also helps the therapist to maintain empathy towards the client. If the therapist becomes frustrated with the client's destructive behaviors, she or he might begin to blame the client for causing his or her own suffering and see the client as resisting therapy. The biosocial theoretical principles that form the foundation for understanding BPD may alleviate this blame by illustrating how maladaptive behaviors can develop from "normal responses to dysfunctional biological, psychological, and environmental events" (Linehan, 1993, p. 26).

DBT also fits with social work practice in its use of a strengths-based perspective. Linehan (1993) mentions several assumptions about borderline individuals, which include that they are doing the best they can and that they want to improve. The DBT therapist focuses on positive qualities within the individual and validates the client's current capabilities and behaviors. The therapist believes in the client's inherent ability to build a more satisfying life, focuses on the client's strengths, and believes in the client (Linehan, 1993). The skills groups also focus on increasing strengths as opposed to decreasing pathology. The goal is to increase the client's capabilities. This also serves to empower the client by teaching the client to be his or her own case manager. The therapist helps the client gain the skills needed to solve problems. This strategy is used because the therapist believes in the client (Linehan, 1993).

Conclusion

The use of the BPD diagnosis for adolescents has been substantiated by a growing body of research. However, regardless of whether a clinician is comfortable formally diagnosing a personality disorder in an adolescent, the BPD construct can be used to evaluate DBT as a potential treatment for adolescents

displaying symptoms of the disorder. This is especially so given that certain aspects of DBT are consistent with the way social workers practice. DBT incorporates a person-in-environment viewpoint, a strengths perspective, a belief in empowerment, and a priority on the involvement of the family in treatment. As such, to the extent that adolescents display sufficiently severe characteristics of BPD (beyond those typically associated with adolescence), social workers can responsibly use DBT to teach adolescents skills for regulating emotions, impulsivity, problems in interpersonal relationships, and confusion about themselves.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, D.C.: Author.

Becker, D.F., & Grilo, C.M. (2005). Validation studies of the borderline personality disorder construct in adolescents: Implications for theory and practice. *Adolescent Psychiatry, 29*, 217–235.

Becker, D.F., Grilo, C.M., Edell, W.S., & McGlashan, T.H. (2002). Diagnostic efficacy of borderline personality criteria in hospitalized adolescents: Comparison with hospitalized adults. *American Journal of Psychiatry, 159*(12), 2042–2047.

Durrett, C. & Westen, D. (2005). The structure of axis II disorders in adolescents: A cluster- and factor-analytic investigation of DSM-IV categories and criteria. *Journal of Personality Disorders, 19*(4), 440–461.

Katz, L.Y., Gunasekara, S., & Miller, A.L. (2002). Dialectical behavior therapy for inpatient and outpatient parasuicidal adolescents. *Adolescent Psychiatry, 26*, 161–178.

Katz, L.Y., Cox, B.J., Gunasekara, S, & Miller, A.L. (2004). Feasibility of dialectical behavior therapy for suicidal adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*(3), 276–282.

Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Miller, A.L. (1999). Dialectical behavior therapy: A new treatment approach for suicidal adolescents. *American Journal of Psychotherapy, 53*(3), 413–417.

Miller, A.L., Glinski, J., Woodberry, K.A., Mitchell, A.G., & Indik, J. (2002). Family therapy and dialectical behavior therapy with adolescents: Part I: Proposing a clinical synthesis. *American Journal of Psychotherapy, 56*(4), 568–584.

Paris, J. (2005). Diagnosing borderline personality disorder in adolescence. *Adolescent Psychiatry, 29,* 237–247.

Pinto, A., Grapentine, W.L., Francis, G., & Picariello, C.M. (1996). Borderline personality disorder in adolescents: Affective and cognitive features. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*(10), 1338–1343.

Robins, C.J., & Chapman, A.L. (2004). Dialectical behavior therapy: Current status, recent developments, and future directions. *Journal of Personality Disorders, 18,* 73–89.

Swenson, C.R., Torrey, W.C., & Koerner, K. (2002). Implementing dialectical behavior therapy. *Psychiatric Services, 53,* 171–178.

Woodberry, K.A., Miller, A.L., Glinski, J., Indik, J., & Mitchell, A.G. (2002). Family therapy and dialectical behavior therapy with adolescents: Part II: A theoretical review. *American Journal of Psychotherapy, 56*(4), 585–602.

Deanna M. D'Amico Guthrie received her MSW from the School of Social Work in May 2006. Her first-year internship was at Northwestern University Legal Clinic, where she served as a legal advocate for children and adolescents facing juvenile delinquency cases. In her second-year internship she provided long-term individual therapy to children, adolescents, and adults at Niles Family Services, where she now works as a social worker.

Function versus Cause: Moving Beyond Debate

by Carol Jarvis

Abstract

Two narratives – that of function, associated with Charity Organization Societies, and cause, associated with the settlement house movement – have strongly influenced the social work profession since its inception. For much of the profession's history, there has been an emphasis on the function tradition, with cause remaining at the periphery. This essay traces the factors that led to the development of these two divergent philosophical approaches and the various forms in which the tension between the two approaches has been expressed. Today's social worker has a myriad of practice approaches from which to choose. These approaches, having their foundations in both function and cause traditions, suggest the social work profession may be ready to dispense with debate in order to face the challenges of the 21st century.

Introduction

The function versus cause debate, which has consumed the social work profession since its inception in the late 19th century, has taken various forms. Going back to the beginning of the debate, a commitment to "cause," or a focus on social reform, is associated with the social reform efforts of Jane Addams and the settlement house movement, while a commitment to "function," or a focus on changing individual behavior, has its roots in the Charity Organization Societies and the casework techniques developed by Mary Richmond. Over time, this dualism within the profession has been expressed in numerous ways, including the debate between the functional and diagnostic schools and, more recently, social work clinicians divided between a problem-solving approach to practice on one hand and a strengths-based or empowerment approach on the other. Dualisms like these create ongoing internal conflict for social workers and divert attention from external pressures that need to be dealt with by the profession. From severely reduced funding for social service programs to demands for evidence-based practice, social workers are challenged to "do more with less." Our clients, too, face enormous challenges brought on by globalization and free trade, resulting in reduced opportunities for a living wage, the lack of affordable health care, and an absence of government protections in many arenas of society. It is imperative for social workers to find a way to move from debate to dialogue on the fundamental question for the profession, framed here in terms of the original debate between function and cause. Acceptance of practice approaches that draws from the function *as well as* the cause traditions in the profession could provide a means for moving past these divisive debates and position the profession to meet the challenges of the 21st century.

Origins of the Debate

Beginning in the Progressive Era, a debate began to take form concerning where social workers should focus their efforts to assist those in need. The Charity Organization Societies (COS), emphasizing the individual as the focus for initiating change, or an emphasis on "function", came first, preceding the Settlement House Movement (SHM) in the United States, with its emphasis on social reform, or "cause," by almost a decade (Leiby, 1978). The COS movement emerged as a response to perceived abuses of the poor laws in England and a fear of pauperization (Leiby, 1978). These concerns led philanthropists to devise ways of distributing aid in a more orderly and systematic way. Hence, from its beginnings the COS movement, grounded in the fear that the poor would become dependent on almsgiving, established a means for "rational charity" with a focus on eventual change within the individual (Leiby, 1978, p. 114). Proponents of the COS movement believed it necessary to move beyond what they saw as indiscriminate aid provision to an examination of the causes of poverty, which were believed by the COS to lie within the individual (Suppes & Wells, 2003).

The methods used by the COS were chosen to express and implement the organization's emphasis on the individual as the focus for intervention as well as the underlying cause of the problem of poverty. Specifically, COS applied the scientific method, then especially in vogue, to the distribution of aid. This method, which became known as "'scientific charity,'" placed great emphasis on the investigation of each individual requesting aid (Popple, 1995, p. 2283). This was based on a belief that COS workers (at that time primarily volunteers) conducting

a thorough investigation would be able to determine the underlying problem that resulted in a given individual's need for aid. This move toward a "logical, evidence-based method for helping" also led to a focus on practice technique (Weick, Rapp, Sullivan, & Kisthardt, 1989, p. 350).

The Settlement House Movement (SHM), by contrast, focused on meeting the needs of the individual while simultaneously addressing the underlying societal causes of poverty. Established primarily in urban settings, the SHM implemented a wide range of services in response to the problems caused by industrialization and urban slums (Koerin, 2003). Whereas the COS focused primarily on technique-based investigation (function) of the individual, the SHM "reflected a dual responsibility for social service and social reform" (Koerin, 2003, p. 54). The primary belief underlying this approach was that by addressing the societal factors leading to poverty the need for aid would be eliminated. Consequently, the SHM became associated more with social reform (cause), although the settlement houses did provide numerous services at the individual and community levels.

The debate on function versus cause in the social work profession was not held in a vacuum. The prevailing worldview of the time, influenced by Catholic and Protestant themes of redemption and compassion, emphasized the provision of moral guidance in conjunction with material aid (Leiby, 1978). The Protestant work ethic reinforced the idea that individuals could improve their situations through hard work as well as good use of moral guidance. In this worldview, poverty was seen as an individual failing originating from a "lack of moral will" (Weick et al., 1989, p. 350). However, this tradition did call upon Christians to be charitable toward those in need: "a Christian was obliged to recognize and love the Christ in the sinner, but also to hate and correct the sin" (Leiby, 1978, p. 21). The religious tradition, then, provided meaning for those suffering from poverty as well as those who sought to alleviate this suffering (Leiby, 1978).

From the Age of Enlightenment, a scientific tradition emerged which emphasized logic, rationalism, and empiricism (Weick et al., 1989). This tradition led to the development of scientific philanthropy and the COS method of scientific charity (Leiby, 1978). As Weick (1992) characterizes this approach, the scientific tradition provides "a secular version of this same drama. Instead of sin and moral insufficiency, the scientific method devoted itself to problem-solving" (p. 20). The use of a scientific approach to resolving individual problems led to the development of techniques to provide for an orderly distribution of aid.

Flexner and Lee Sharpen the Debate

Two influential statements in the first third of the 20th century—Abraham Flexner's report ("Is Social Work a Profession?") to the National Conference of Charities and Correction in 1915, and Porter Lee's speech to the National Conference of Social Work in 1929 ("Social Work as Cause and Function")—contributed to sharpening the division between the two approaches of the profession: an individual focus for change associated with the COS, and a societal focus for change associated with the SHM (Wenocur & Reisch, 1989). Flexner, an educator who had authored a report in 1910 evaluating the nation's medical schools, took a similar evaluative aim at other professions such as social work, business, and law (Iwabuchi, 2004). The importance of the Flexner report in increasing social work's preoccupation with function and its companion, technique, cannot be overstated. Comparing social work to other developing professions such as medicine and law, Flexner "denied that social work could ever become a genuine profession, claiming that it lacked a specific skill applied to a specific function" [1] (Lubove, 1969, p. 106). Even though the profession was already on its way to developing training schools, the results of the Flexner report were a "redoubling" of efforts to develop additional social work methods and techniques grounded in the scientific method (Costin, 1983, p. 101), and "status anxiety," leading to increasing efforts toward professionalization (Weick, 1992, p. 20). These efforts to correct the problems Flexner identified eventually led to a diminution of social reform efforts in favor of casework techniques (Popple, 1995). Schoen (as cited in Saleeby, 1992) remarks that the Flexner report took the profession toward a position of "Technical/Rationality," "a conception of professional thinking and doing smitten with the notion of professional as applied technologist" (Saleeby, 1992, p. 4). Richmond's *Social Diagnosis* best exemplifies the profession's determination to correct for the deficiencies Flexner identified (Blundo, 2001).

As social casework proliferated, there arose a pressing need to develop consensus among the various casework specializations in order to keep the profession unified (Wenocur and Reisch, 1989). The vehicle for fulfilling this commitment was a series of meetings of prominent social workers, held annually from the early to mid 1920s (Wenocur & Reisch,

[1] Other disciplines Flexner denied professional status include business, journalism, home economics, and library science (Iwabuchi, 2004).

1989). Called the Milford Conference, these meetings in particular helped the profession to organize around a unifying conceptualization of "generic social casework" (Wenocur & Reisch, 1989, p.137). A key participant in this conference (and the chair of the committee responsible for the final conference report) was Porter Lee, director of The New York School (a training school known for family and psychiatric casework specializations) (Wenocur & Reisch, 1989, p. 136). Lee's speech to the National Conference of Social Workers in 1929 cemented the separation of cause and function, or social reform and individual intervention in the form of casework:

> Since cause and function are both carried on by human agents, they make use of the same human characteristics. Nevertheless, their emphases are different and their demands in the long run require different combinations of human qualities. Zeal is perhaps the most conspicuous trait in adherents to the cause, while intelligence is perhaps most essential in those who administer a function. The emblazoned banner and the shibboleth for the cause, the program and the manual for the function; devoted sacrifice and the flaming spirit for the cause, fidelity, standards, and methods for the function; embattled host for the cause, an efficient personnel for the function. (as cited in Leiby, 1978, p. 180)

Lee's assertions made apparent the increasing polarity of the two traditions within the profession. They also expressed a belief held by many on the function side of the debate that the professionalization of social work required a narrower definition of social work that excluded many of the SHM techniques (Popple, 1995). The decline of the SHM coincided with social work's "...transition from an avocation to a paid vocation. As the idea of professionalization took hold, the social reform segment *could not sustain this definition* of social work"[emphasis added] (Wenocur & Reisch, 1989, p. 139).

To a large extent, function (casework) was elevated to the exclusion of cause (social reform) in order to advance the modernization and development of the profession, although there is evidence that this advancement of function/casework had been hastened by the changing "structuration," which emphasized casework tasks (Abbott, 1995, p. 556). In addition, economic instability and crisis caused COS agencies to become overwhelmed with requests for material assistance; the ensuing rush to provide sufficient agency staffing continued the focus on function (Simon, 1994).

The emphasis on function over cause was intensified by social work's application of psychoanalytic theory to casework methods; this trend would continue until the implementation of anti-poverty programs in the 1960s (Popple, 1995). The profession eventually began to relegate social reform efforts to separate activities altogether, such as community organization (Abramovitz, 1998). Saleeby (1992) notes, "the tension between reformist impulses and the development of a professionally respectable body of theory and technique...[had] been resolved in favor of the latter" (p. 14).

The Debate Shifts:
The Functionalist-Diagnostic Divide

As social casework evolved, many in the profession became aligned with psychiatry and Freudian doctrine (Lubove, 1969). The move toward understanding clients based on their inner experiences (psychology) was quite radical in a time when morality still played a large role in understanding people's behavior (Simon, 1994). However, not everyone in the profession was pleased with social work's adherence to Freudian principles. As Lubove (1969) notes:

> The absorption of Freudian doctrine and a general interest in psychotherapy contributed to a shift in the caseworker's orientation from social environment to mental process. They identified themselves with the psychiatric clinic team rather than the social meliorist, who seemed a bit old-fashioned. (p. 86)

Beginning in the 1930s and continuing into the 1950s, the profession was polarized between two schools of thought for social casework: the diagnostics, affiliated with The New York School of Social Work and the Smith School for Social Work (now known as Smith College), and the functionalists, affiliated with the Pennsylvania School of Social Work (Tyson, 1995). While each approach was based on principles drawn from psychology, each was also unique. The functional approach, with its "emphasis on phenomena as processes, the concept of wholeness, relationship, and human potential," retained the narrative of the cause tradition of "advocating for social change, social justice, and the search for meaning and purpose in human endeavors" (Early & GlenMaye, 2000, p. 122). In contrast, the diagnostic approach, drawing upon Richmond's theories about casework, focused on social study, diagnosis, and treatment, thereby continuing the function tradition (Woods & Robinson, 1996).

The dispute between the functionalists and diagnostics was bitter and intense (Woods & Robinson, 1996; Tyson, 1995). Proponents of each school, strongly believing their approach was right, not only for clients but for social work as well, fought hard for dominance within the profession. At one point the division within the profession became so great that, as Tyson (1995) notes, "adherents of one approach found it difficult to obtain employment at an agency that supported the other approach" (p. 56).

An Old Debate Finds New Expression

The 1957 publication of Helen Harris Perlman's *Social Casework: A Problem-solving Process*, while possibly resolving the polarization between the diagnostic and functional schools, also served to solidify the profession's emphasis on function by its continued focus on problem identification (diagnosis) and treatment (McMillen, Morris, & Sherraden, 2004). Recently, though, the strengths-based approach has given new expression to the inclusion of cause in the profession. The introduction of this approach has created conflict within the profession between advocates of the strengths-based approach and proponents of the problem-solving approach. So, the dualisms and debate continue.

The problem-solving approach, with its roots in the diagnostic school, continues the profession's reliance on function and technique in its step-by-step approach to working with clients. "Problem-solving offers a logical process for assessing a social problem, reviewing options for addressing it, and working out a plan designed for its amelioration" (Turner & Jaco, 1996, p. 504). This approach is also consistent with social work's long alliance with psychiatry; adherents of the problem-solving approach generally use assessment and diagnosis, leading to a structured treatment plan. The scientific tradition and a positivist viewpoint also strongly influence the problem-solving approach, as indicated by the reliance of those who use this approach on logic, empiricism, and rationality (Payne, 2005). The problem-solving approach has been so thoroughly incorporated in social work curricula that "it has essentially become the basic method that underlies much of practice" (Turner & Jaco, 1996, p. 519). Indeed, given responses to a recent query on the Baccalaureate Program Director's listserv, the problem-solving method still appears to be the preferred method for teaching the generalist approach to social work practice (R. Birkey, personal communication, November 28, 2005).

In contrast, the strengths-based approach has largely remained outside the mainstream of social work education and practice (Blundo, 2001). Emerging in the 1980s from a constructivist standpoint and an empowerment perspective and having its roots in the functional school, the strengths-based approach was first utilized for case management in community mental health centers (Early & GlenMaye, 2000; Brun & Rapp, 2001). It has been included in the problem-solving approach in a way that strengths-based proponents consider to be superficial and unsatisfactory (Blundo, 2001). In the view of strengths-based proponents, problem-solving practitioners who include a strengths-based perspective in their work do so in a way that makes it a supplement, and subordinate, to an approach that still gives pre-eminence to the worker's expertise. Inclusions of this kind leave the strengths-based approach at the periphery of social work education and practice in the view of strengths-based practitioners. Interestingly, there is some anecdotal evidence indicating a preference among undergraduate social work students for the inclusion of a strengths/empowerment perspective in practice courses (Cox, 2001). This suggests that social work students are willing to accept a variety of practice approaches as generalist practitioners and points to the need for social work educators to consider including both approaches in practice theory/methods courses, especially at the undergraduate level.

A strengths-based approach places less emphasis on technique and more on a set of underlying concepts. "The strengths approach, with its emphasis on growth and change, collaborative relationship, and the center of change located in the client, has as its foundation a subjectivist understanding of human behavior and purpose" (Early & GlenMaye, 2000, p. 123). Assessment emphasizes discovery rather than diagnosis. Clients are seen as experts in their own right; mutuality in the client-worker relationship is stressed. This approach is consistent with the philosophy expressed through the functional school that emphasized "human purposive action, self-actualization [and] human potential..." and is seen as continuing the narrative of the cause tradition (Early & GlenMaye, 2000, p. 122).

The fact that the empowerment perspective is incorporated in the strengths-based approach suggests a renewal of interest in cause and social reform. By stressing the expertise of both worker and client, "a relationship is formed between a professional and an individual, a family, a group, an organization, or a community for the purposes of empowerment and promotion of social and economic justice" (Poulin, 2005, p. 3). This collaborative relationship, in which

the standpoints of worker and client are given equal credence, has strong potential for addressing inequities. Moreover, according to Poulin (2005), social reform becomes possible once both the client and the worker recognize that *every* environment has resources (emphasis added). This view is reminiscent of the work of such settlement house workers as Mary Parker Follett, Mary Simkhovitch, and Edith Abbott (Simon, 1994).

The debate among social workers regarding which approach—problem-solving or strengths-based— represents the best practice approach for the profession has at times taken a rancorous tone (McMillen et al., 2004; Saleeby, 2004). Attempts to advance one approach over the other have resulted in disparaging, hyperbolic language, and unfair characterizations. For example, some social workers have described the debate as a "grudge match" with one side wearing "black spandex" and "in the other corner, [the social worker] with her white flowing robes…" (McMillen et al., 2004, p. 317). The passion and tenacity with which proponents of each approach hold their viewpoints is strikingly similar to the early debates between social work pioneers such as Jane Addams (cause) and Mary Richmond (function), and those between the functionalists and diagnostics.

Moving Beyond Debate

Given the complex political and economic realities of the 21st century, it is incumbent upon the profession to move past these divisive debates. We live in a global economy in which job outsourcing has the potential to displace vast numbers of unskilled workers, most of them without the protection of union support. At the same time, there has been an overall retrenchment by the government as a provider of social services. Social services are increasingly controlled by private markets, such as the insurance industry, which exert powerful control over people's lives (Saleeby, 2004). These factors point to the profession's need to pay more attention to cause in order to keep its commitment to social justice and help clients cope with the many uncertainties of daily life.

Previous attempts by the profession to unify around one theory or approach never seemed to satisfy the profession because these efforts usually favored one tradition (function) over the other (cause) (McMillen et al., 2004). Perhaps instead of trying to agree on any single unifying theory, the profession can be unified by its core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and

competence (National Association of Social Workers, 1999). The current trend toward eclecticism and integration of practice approaches, emanating from both the cause and the function traditions, suggests that social workers are already moving beyond debate to an acceptance of both traditions. Instead of having only a few practice approaches from which to choose, as was the case for much of social work's history, there is now a plethora of practice approaches available to social workers. Many of these have strong ties to the cause tradition (i.e., feminist, empowerment, narrative, client-centered) signaling a willingness on the profession to accept both traditions rather than being stuck in a forced choice between them (Turner, 1996). The "growing tolerance of differences among theories and theorists" is certainly a positive indication that the profession is ready to take a pluralistic approach to social work practice (Turner, 1996, p. 699).

While the profession will not likely be unified by any one theory or practice approach, the profession can choose to organize around the "external threats to our values and foundations in [the] changed world outside the profession" (Rossiter, 2005, pp. 195, 201). Ironically, the realities confronting clients of this century are not unlike those that clients faced at the end of the 19th century: social upheaval brought on by external and unpredictable economic, political, and social forces. If social workers are able to move beyond internal disputes and debates, it may be that an integration of practice approaches, drawing upon *both* the function and the cause traditions, will enable us to meet the challenges of the 21st century.

References

Abbott, A. (1995). Boundaries of social work or social work of boundaries? [Electronic version] *Social Service Review, 69,* 545–562.

Abramovitz, M. (1998). Social work and social reform: An arena of struggle [Electronic version]. *Social Work, 43,* 512–526.

Blundo, R. (2001). Learning strengths-based practice: Challenging our personal and professional frames. *Families in Society: The Journal of Contemporary Human Services, 82,* 296–304.

Brun, C., and Rapp, R. (2001). Strengths-based case management: Individuals' perspectives on strengths and the case manager relationship. *Social Work, 46,* 278–288.

Costin, L. (1983). Edith Abbott and the Chicago influence on social work education. *Social Service Review, 57,* 94–111.

Cox, A. L. (2001). BSW students favor strengths/empowerment-based generalist practice. *Families in Society: The Journal of Contemporary Human Services, 82,* 305–313.

Early, T.J. and GlenMaye, L. F. (2000). Valuing families: Social work practice with families from a strengths perspective. *Social Work, 45,* 118–130.

Iwabuchi, S. (2004). The pursuit of excellence: Abraham Flexner and his views on learning in higher education [Electronic version]. *The Japanese Journal of American Studies, 15,* 139–161.

Koerin, B. (2003). The settlement house tradition: Current trends and future concerns [Electronic version]. *Journal of Sociology and Social Welfare, 30,* 53–68.

Leiby, J. (1978). *A history of social welfare and social work in the United States.* New York: Columbia University Press.

Lubove, R. (1969). *The professional altruist: The emergence of social work as a career, 1880 – 1930.* New York: Atheneum.

McMillen, J. C., Morris, L., and Sherriden, M. (2004). Ending social work's grudge match: Problems versus strengths. *Families in Society: The Journal of Contemporary Social Services, 85,* 317–325.

National Association of Social Workers. (1999). Code of ethics of the National Association of Social Workers. [Brochure]. Washington, DC: Author.

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

Popple, P. R. (1995). Social work profession: History. In *Encyclopedia of social work* (pp. 2282–2292). Washington, DC: NASW Press.

Poulin, J. (2005). *Strengths-based generalist practice: A collaborative approach.* Belmont, CA: Brooks/Cole.

Rossiter, A. (2005). Where in the world are we? Notes on the need for a social work response to global power. In S. Hick, J. Fook, and R. Pozzuto (Eds.), *Social work: A critical turn* (pp. 189–202). Toronto, Canada: Thompson Educational Publishing, Inc.

Saleeby, D. (Ed.). (1992). *The strengths perspective in social work practice.* White Plains, NY: Longman Publishing Group.

Saleeby, D. (2004). Response to "Ending Social Work's Grudge Match." *Families in Society: The Journal of Contemporary Social Services, 85,* 588–590.

Simon, B. L. (1994). *The empowerment tradition in American social work: A history.* New York: Columbia University Press.

Suppes, M. A. and Wells, C.C. (2003). *The social work experience* (4th ed.). Boston: McGraw-Hill Publishers.

Turner, F. J. (1996). *Social work treatment: Interlocking theoretical approaches* (4th ed.). New York: The Free Press.

Turner, J., and Jaco, R. M. (1996). Problem-solving theory and social work treatment. In F. J. Turner (Ed.), *Social work treatment: Interlocking theoretical approaches* (4th ed., pp. 503–522). New York: The Free Press.

Tyson, K. (1995). *New foundations for scientific social and behavioral research: The heuristic paradigm.* Needham Heights, MA: Allyn and Bacon.

Weick, A., Rapp, C., Sullivan, W.P., and Kisthardt, W. (1989). A strengths perspective for social work practice. *Social Work, 34,* 350–354.

Weick, A. (1992). Building a strengths perspective for social work. In D. Saleeby (Ed.), *The strengths perspective in social work practice* (pp. 18–38). White Plains, NY: Longman Publishing Group.

Wenocur, S. and Reisch, M. (1989). *From charity to enterprise: The development of American social work in a market economy.* Urbana, IL: University of Illinois Press.

Woods, M. E., and Robinson, H. (1996). Psychosocial theory and social work treatment. In F. J. Turner, (Ed.), *Social work treatment: Interlocking theoretical approaches* (4th ed., pp. 555–580).

After a twenty-year career in the field, Carol Jarvis, LCSW, entered the doctoral program of the School of Social Work to pursue a Ph.D. Her research interests include peer-run grief centers and non-traditional women students. She is an adjunct faculty member in the Social Work and Women's Studies programs at Goshen College in Goshen, Indiana.

Person-In-Situation: History, Theory, and New Directions for Social Work Practice

by Kathryn L. Cornell

Abstract

This article explores the history of the person-in-situation concept in social work practice, identifies difficulties in integrating the concept in practice theories, and explores how philosophical innovations have informed a more integrated approach to social work theory. The potential impact of the convergence of integrating subjective and objective phenomena in philosophy with integrating the person and environment perspective in clinical theory is discussed.

Introduction

The concept of "person-in-situation" or "person-in-environment" stemmed from the beginning of social work and its dual focus on both individual assistance and social reform. The historical development of the concept reflects political, social, and economic concerns as well as debates within the profession of social work. It has been central to direct practice[1] in particular, though there have been difficulties in applying the concept within some of the major theoretical frameworks adopted by social workers. This article will trace the person-in-situation concept throughout the history of social work, examine how practice theories have often failed to fully integrate the concept, and explore the convergence of contemporary philosophy with advances in integrating the concept in clinical theory.

History

The early years of social work practice are defined by the contributions of Jane Addams in the settlement house movement and Mary Richmond in social casework. The two influences represent the beginnings of the dual focus of social work on social reform (by the settlement house movement) and on individuals and families (in social casework). Mary Richmond (1922) attempted to bridge these divisions by emphasizing the importance in work with individuals and families of the interaction between the person and the environment. She defined social casework as "those processes which develop personality through adjustments consciously effected, individual by individual, between men [sic] and their social environment" (pp. 98–99). Here we encounter the first formal conceptualization of direct social work as focusing on both the person and his or her environment. Richmond proclaimed that the social worker should be "no more occupied with abnormalities in individual than in the environment...no more able to neglect one than the other" (p. 98). Richmond's casework occurred within the context of the relationship between social worker and client, but she promoted both direct action through that relationship and indirect action through use of environmental resources (p. 101). Furthermore, Richmond stated that in the "absence of services... social workers should develop substitutes and push hard to secure community agencies still lacking" by making use of "arguments and illustrations from casework" (p. 115). In this way, she understood that casework, group work, community work, social reform, and social research were all interdependent aspects of social work that should come together on the behalf of clients. Hence, Richmond was able to contextualize individual, direct action within the framework of the environment and the multiple functions of the social worker.

While Richmond's work synthesized concerns about the person and environment in both the assessment of cases and in the activities of the social worker, the rise of psychoanalytic theory soon shifted this focus for social workers in direct practice. Freud's work and his focus on individual pathology became widely read and popular among social workers in the U.S. (Simon, 1994). The intrapsychic focus of Freud's theories as well as the analytic stance of abstinence of the practioner in treatment led to a reduction of attention to, and intervention in, environmental causes of distress. By the 1940s, some direct practitioners were beginning to label themselves as psychiatric social workers and explicitly aligning with psychoanalytic theory and practice.

It was then that Gordon Hamilton (1940) wrote the influential *Theory and Practice of Social Casework*. Hamilton clearly incorporated aspects of psychoanalytic theory including transference, defense and resistance, and interpretation into casework practice. In the preface to the 1951 edition of *Theory and Practice of Social Casework*, Hamilton identified herself as part of the diagnostic school and expressed her allegiance to Freudian theory, though she also stated that by the time the second

[1] Direct practice here is used to distinguish work with individuals and families from macro level administrative, community, and policy social work.

edition was published she believed social work practice fit more with ego psychology and psychodynamic theory than with the specialty of psychoanalysis (pp. v–vii). Hamilton reaffirmed social work's traditional concern with the environment and "committed not only to understand the structure and dynamics of personality but also to rediscover the use of environmental or social therapy" (p. v). Hamilton was the first to make use of the phrase "person and situation" as a way to define the distinguishing characteristics of social work as a "humanistic" or clinical profession (p. 3). She used the construct to highlight the interaction between the intrapsychic and objective, with the interaction being the primary domain of the social worker. Hamilton perceived the role of the direct practice social worker as understanding intrapsychic conflict while making use of the healthy aspects of the client to help the individual adapt to his or her environment, though she fails to equally emphasize intervening to cause the environment to adapt to the individual. She did recognize that counseling frequently needed to be accompanied by practical assistance that required the social worker to develop an understanding of the community, the client's social needs, and the resources to meet those needs (p. 84). She also included the use of social resources as one of the four characteristic processes of direct practice (p. 26). Thus, while psychodynamic theory strongly influenced Hamilton's approach to practice, she returned to the emphasis on person and situation in assessment and treatment, and in defining the unique perspective of the profession.

Hamilton's desire to define the profession was not unique in her time. There was a prevailing fear that social work would become absorbed in other professions such as psychology, psychiatry, medicine and sociology (Turner, 1978). By the 1950s, mental health work had strong popular support and therapists held high status, leading to higher status for psychiatric social workers (Turner, p. 2). Psychiatric social workers advocated for casework to be recognized as a form of psychotherapy and appeared to be more aligned with psychiatry than social work. In clinical settings, direct practice social workers were seen as experts on the external factors of a case, while psychiatrists were experts on the internal factors, though in fact the roles of the social worker and psychiatrist were not so clearly defined in actual practice (Turner, p. 9). Despite ambiguity in actual roles, psychiatrists were held in higher status and frequently supervised social workers, paralleling the higher status given to "internal" or intrapsychic

issues as opposed to environmental issues on a case.

In the 1960s, awareness of social problems began to expand greatly, impacting the focus of the social work profession. The publication of *The Other America*, the implementation of President Kennedy's social programs, and the growth of the civil rights movement all contributed to renewed interest in social reform (Simon, 1994). The social programs of the Great Society and the War on Poverty heightened this interest. Social workers began to question direct practice and condemned psychotherapy as a "band-aid" approach that did not address underlying social issues (Turner, 1978, p. 3).

In the midst of this change in the social climate, Florence Hollis (1964) published *Casework: A Psychosocial Therapy*. As in the prior works of Hamilton and Richmond, Hollis directed attention back to the interaction between the individual and environmental factors in social work, stating that, "Central to casework is the notion of 'the-person-in-his-situation' as a threefold configuration consisting of the person, the situation, and the interaction between them" (p. 10). However, Hollis limited her understanding of "situation" to an interpersonal dynamic between the client and significant others such as friends and family rather than broader socio-political concerns. She also stated that the difference between social casework and psychiatry was "mainly a matter of methods" and that emphasizing differences in culture would risk understating universal Freudian personality dynamics (pp. 11–12). In defining the distinctive characteristics of casework, Hollis noted that casework "gives weight to both person and situation in diagnosis, works primarily with the individual but also enters into the environment when it is in the client's best interest" (p. 267). The influence of the focus on intrapsychic dynamics in the previous decade is evident in Hollis's emphasis on individual treatment and her alignment with psychodynamic theory. However, she did note ways in which the social worker could intervene in environmental factors, including referring to other professional experts, suggesting resources, preparing the client to make use of resources, enlisting social supports, influencing others on behalf of the client, and "direct marshalling of resources and services on the client's behalf" (p. 112). Hollis also noted:

> Not since Mary Richmond's time have we given the same quality of attention to indirect as to direct work. This neglect has tended to downgrade environmental treatment in the worker's mind...[as] something unworthy of serious

analysis…. This is an absolutely false assumption. Environmental work also takes place with people and through psychological means." (p. 77).

So even in the midst of her adherence to Freudian and psychodynamic theory, Hollis called for a renewal of social work's traditional focus on the environment and identified it as serious, psychological work for the social caseworker.

Even as Hollis advocated the recognition of the interaction between the person and the environment, the profession began in the 1960s to turn its attention away from direct practice and toward community organization, policy design, and social action (Goldstein, 1996). Direct practice caseworkers lost their status, schools of social work reduced curriculum space allotted to direct practice intervention and theory, social work undergraduate programs proliferated, and social work doctoral programs increasingly emphasized administration, social policy, and research (Goldstein, 1996, p. 90). Supporters of direct practice were accused of "blaming the victim" of oppression and pathologizing marginalized groups such as women, gays, and people of color (Goldstein, 1996). Direct practitioners, in turn, felt that the poor were being deprived of individualized services, social work was becoming deprofessionalized, the quality of treatment available was suffering, and direct service was being abandoned by the NASW (Goldstein, 1996).

Direct practitioners turned to psychosocial theories that emphasized the person-in-situation to defend direct practice as relevant to the mission of social work. In 1978, Turner's *Psychosocial Therapy* detailed the debate within social work and emphasized skills in relating to individuals, families, groups and communities, as well as skills in mobilizing available resources. Turner highlighted the knowledge and skill direct practitioners need to make use of community resources and noted the "liberating effect" on clients when such resources are made available (p. 60). He also added the role of facilitator to social work practice as a means to integrate the complex web of resources and services involved in care for clients. Turner noted that the need for a multi-skilled direct service social worker was becoming evident as psychosocial therapy gained attention and highlighted a variety of needs and interventions.

Many social workers at that time equated clinical social work with psychodynamically-oriented casework and psychotherapy, an effort to promote private practice, and an attempt to achieve higher status by psychotherapists within the profession (Goldstein, 1996, p. 91). Some social workers questioned whether clinical practitioners respected the traditions of social work, especially those of social justice and concern for the poor and oppressed (Goldstein, 1996). Critics of clinical social work contended that it still relied too heavily on psychodynamic theory and only "paid lip service" to the person-in-situation perspective. However, by 1980 a broad definition of clinical social work had arisen that "reaffirmed its person-situation perspective, its concern with the social as well as personal context, its biopyschosocial assessment lens…[and] broad knowledge base" and reaffirmed both agency-based and private practice (Goldstein, 1996, p. 93).

In clinical social work in the 1980s, theories such as self-psychology, the ecological perspective, object relations, couples and family theories, cognitive/behavioral, crisis intervention, task-centered, and empowerment theory increased in popularity (Goldstein, 1996). Psychodynamically oriented clinicians began to make use of new theories and models for the treatment of women, people of color, gays, and lesbians (Goldstein, 1996). Criticism and debate regarding clinical social work practice (particularly private practice) remained, as some perceived it as failing to address the needs of the poor and oppressed (Specht, & Courtney, 1994). Yet evidence suggests most private practitioners also worked at least part time in agency settings (Goldstein, 1996), and case related advocacy was still being practiced by clinical social workers both as a part of work in agency settings and on their own time as volunteers (Ezell, 1994).

Continuing challenges for the profession by the 1990s included an increasingly diverse knowledge base, specialization, and professional fragmentation (Goldstein, 1996). In the face of these challenges, clinical social work again made use of the person-in-environment/situation concept to unite the profession (Goldstein, 1996; Lieberman, 1987). In 1987, the Board of Directors of the NASW, the Federation of Societies of Clinical Social Work, and the American Board of Examiners accepted a common definition of clinical social work that included a basis in knowledge and theory with "particular attention to person-in-environment" and services that consist of "assessment, diagnosis, treatment, client-centered advocacy, and evaluation" (Northen, 1995, p. 8). Most current clinical social work texts now make use of the term "person-in-environment" and spend at least some space on the environmental/social aspects of assessment and treatment (Berzoff, Flanagan, & Hertz, 1996; Brandell, 1997;

Cooper & Lesser, 2002; Northern, 1995; Webb, 2003). However, the concept is still not fully integrated into discussions of theory and treatment. It may be relegated to a special chapter (Berzoff, Flanagan, & Hertz, 1996), posed as an opening statement (Northen, 1995, Cooper & Lesser, 2002; Webb, 2003), discussed only in the context of assessment (Northern, 1995; Cooper & Lesser, 2002; Webb, 2003), or not discussed at all (Turner, 1996). This is due, in part, to the continuing difficulty of integrating the person, the environment, and the interaction between the two in the theories that guide clinical social work practice, as theories have traditionally focused on intrapsychic issues with minimal attention to the environment or socio-cultural issues with little emphasize on the individual.

Practice Theories

This section explores four established social work practice theories that have differing approaches to and emphases on the person, the environment, and the interaction between the two. These theories, which include psychoanalytic theory, ego psychology, constructivist theory, and radical theories, represent a broad range of theoretical traditions that all have some difficulty integrating a balanced person-in-environment perspective.

The psychodynamic theories that have influenced clinical social work have had difficulty including both the environment and the interaction between person and environment in approaches to practice. One of Freud's basic tenets of psychoanalytic theory was that an infant begins from a pleasure principle but must later adjust to the demands of the reality principle. Freud assumed that individual needs and drives precede the infant's perception of reality, a view that newer postmodern theorists have questioned (Saari, 2002). The potential effects of the sociopolitical environment on intrapsychic processes were not considered in psychoanalytic theory. In regard to the environment, Freudian theory assumed that society was monolithic and universal, and that it was built on social consensus (Thompson, 1992). Freud did not account for competing needs within society or variations in how individuals experience culture and society. This then negated the need for attention to social justice issues, attention to cultural diversity, and the impact of real experiences of oppression and discrimination in the lives of many social work clients. Thus, both the interactive effect of the environment on personality development and the need to confront environmental issues were excluded from Freudian theory. The theory had at its

base the person, but not the environment or the interaction between it and the person. Social workers attempted to modify this theory in order to account for the person-in-situation perspective, but it was only "tacked on" and not truly integrated into theory (Berzoff, Flanagan, & Hertz, 1996; Hamilton, 1951; and Hollis, 1964). A consequence of this is that environmental interventions have also never been truly integrated into psychodynamic social work practice. So, following Richmond's writings (which were completed prior to Freud's overwhelming influence on the profession) significant works addressing social work direct practice struggled to modify Freudian theory and practice to integrate the person-in-situation concept.

Hamilton recognized this issue and turned to ego psychology in an attempt to combine intrapsychic theory with the person-in-situation focus of social work (Hamilton, 1951, preface). However, while Hartmann, a leading theorist of ego psychology, focused on the ego's adaptation to the "average expectable environment", he failed to account for the cultural complexity and diversity that is encountered in modern society (Saari, 2002, p. 3). Furthermore, ego psychology has not accounted for socio-cultural phenomena such as oppression, sexism, racism, heterosexism, and competing class interests. Since the societal issues that have a very real impact on clients' functioning and sense of well-being remained unacknowledged, they could not be addressed through the psychodynamic framework. In fact, some have argued that psychodynamic theories focus the social worker's attention on the individual's adaptation to society, which could cause him or her to "blame the victim" for a failure to adapt to an oppressive society.

More recent postmodern philosophies have influenced psychodynamic theory, leading to the adoption of constructivist theories (Saari, 2002). Constructivism is based on the idea that knowledge is context bound and that "social life is not uniform nor determined by essential processes" (Houston, 2002, p. 151). Under this theory, there is no one reality outside of the subjective experience and no universal claims can be made as to truth or knowledge (Carpenter, 1996). This relativism has appealed to social workers as it negates the claims of universalism and the valuing of dominant worldviews over those of oppressed or devalued cultures (Houston, 2002). However, without any reference to the objective world, there is the question of how constructivists can account for the role of the environment in shaping the individual. In fact, Carpenter (1996)

notes that a principle concept of constructivism is structure determinism, that is that human experience is predominated by internal processes that determine perceptions and preclude the direct influence of the environment. This form of constructivism is unable to explain the very real effect of environmental influences such as oppression, poverty, trauma, and violence. With the exclusive focus on the subjective, the environmental component involved in the person-in-environment perspective is eradicated. In fact, Carpenter states that through this lens, "'psychosocial problems' do not exist in the ontological sense but only in language and thought" (Carpenter, 1996, p.157). Using that premise, one could propose that clients' problems are a result of faulty thinking, so that changes in their subjective experiences or thought patterns will eradicate their perceived problems. This then places the responsibility for the problem back with the client rather than with very real inequities and environmental constraints. If social relativism is the basis for social work practice, there is no role for advocacy to change social structures that perpetuate social inequality and empowering clients to act collectively.

Radical social work diametrically opposes the relativism of constructivist theory. Radical theory draws heavily from Marxist concepts and emphasizes politics, class conflict, ideological hegemony, and socialism (Thompson, 1992). It highlights structural inequities inherent in a capitalist society and the role of culture and belief systems in perpetuating inequality. It refocuses the attention of the social worker on the environment. Radical theory creates a problem for clinical social workers in that it attributes individual difficulties to structural inequities. It would accordingly prescribe structural interventions rather than individual, family, or group work. Radical theory would thus require social workers to focus any direct practice on educating clients and empowering them to change the structures that contribute to their oppression rather than helping them to adapt to the status quo (Thompson, 1992). The risk of this approach is that the social worker may impose his or her values and worldview regarding the sociopolitical nature of problems upon clients who are seeking help. Client self-determination is negated as the social worker educates the client on the "real" causes of his or her problems and insists on political awareness and political action. Furthermore, radical theory can at times dehumanize the individual by solely focusing on sociopolitical determinants without acknowledging the role of individual choice and action.

Radical social work's incorporation of a sociopolitical viewpoint of the environment comes at the expense of an enriched theoretical understanding of individual and subjective experiences. Thompson (1992) notes, "the oppressive social order manifests itself in a variety of significant ways-social, psychological and emotional" (p. 105). Thus the social worker should not neglect the individual's experience in attempting to address social issues.

All of the above perspectives of psychoanalytic, psychodynamic, constructivist, and radical theory have been unable to adequately capture and balance both aspects of the person-in-environment construct. This has contributed to the difficulties within the profession, including bitter divides between community organizers and direct practice workers. Furthermore, despite the value placed on understanding both the person and the environment, the lack of a cohesive theory for clinical work can lead to a lack of integration of interventions at both the individual and environmental levels. The relatively recent decline in the primacy of psychodynamic theory has led to more theories from which clinical social workers can choose but can also result in fragmentation. An eclectic approach, which makes use of a variety of theories, is not guaranteed to integrate these differing perspectives, leading to difficulties with achieving balance between approaches and a lack of guiding principles to clarify difficult clinical decisions.

New Developments in Practice Theory

Some social work theorists have attempted to address the difficulty of integrating environmental and intrapsychic considerations by making use of contemporary philosophies that attempt to unite subjective experience (person) and objective sociopolitical realities (environment). This section will explore how authors have begun to apply principles from Sartrean existentialism, Michel Foucault's postmodern theory, and Bourdieu's critical realist philosophy to re-examine and more fully integrate the person-in-environment concept.

Thompson (1992) uses Sartrean existentialism to develop an existentialist framework for social work practice. Thompson identifies the core existentialist principles of freedom and responsibility. Existential freedom is self-creation through choices and actions as opposed to deterministic accounts of human nature (Thompson, 1992). This includes responsibility for one's own actions, which contributes to the range of options available to oneself and others (Thompson, 1992, p. 175). Sartre was particularly
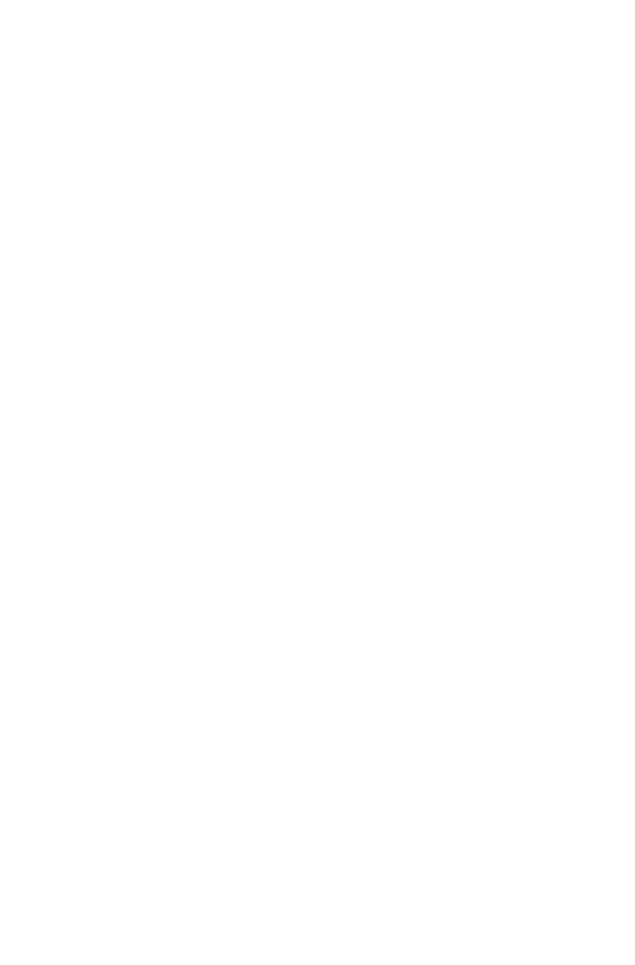
interested in the moral dimensions of how individual praxis becomes sociopolitical in its context and consequences (Thompson, 1992, p. 176). Through this framework, Thompson is able to integrate the person-in-environment concept as a dialectic between existential freedom and political liberty. Existential freedom equates with ontological freedom, or the capacity for the individual to make choices, while political liberty is the range of choices available to the individual (Thompson, 1992). The framework allows for the subjective individual experience, objective environmental constraints, and a constant exchange between the two that leads to a totalisation of experience. Thompson uses this framework to develop principles for existential social work, give examples of the principles in direct practice, and use the principles to critique other prominent social work theories. Some of the principles for practice that he draws from existentialism include the concept of a shared subjective journey, authenticity in confronting difficult choices, responsibility and solidarity, self-creation as a prerequisite for political liberty, recognizing contingency and choice as opposed to stability, and recognizing and managing the dynamic tension between authority and non-directive practice in social work.

Saari (2002) approaches the problem of the intersection between person and environment by identifying the difficulties in psychoanalytic and developmental theory, particularly the criticisms of postmodernist Michel Foucault, and by using postmodern theory to reformulate ideas about the therapeutic relationship and the nature of change. Saari concludes that there has been little consideration of the environment in psychodynamic theory—even in postmodern constructivist theory—but that postmodern philosophy can be used to interrelate the intrapsychic and environmental (p. 156). She notes Foucault's main criticism is that psychotherapy can be used as an instrument of domination of individuals' subjective experience in support of societal oppression (p. 54). Foucault argues that psychotherapy can act as a form of social control through hierarchical surveillance of the clients' thoughts and impulses by the analyst, normalizing judgment or classification of the client into good or bad categories which may seem arbitrary to the client (e.g. DSM-IV), and the examination which combines the prior two categories to produce judgments that can have significant consequences for the individual's status in society (pp. 93–94). Saari accepts that psychotherapy can be used to dominate others as described by Foucault, but she notes

psychotherapy can also be liberating by helping clients create new meanings and participate in their cultural environment. She constructs a new vision of psychotherapy that accounts for the environment in concepts of liberation, meaning, culture, and symbolization. By attending to issues of power, acknowledging client's social and environmental realities, and assisting the client in constructing new, meaningful narrated identities in the context of client self-determination and adherence to the client's, rather than the therapist's, goals, Saari demonstrates how psychotherapy can be liberating rather than dominating. Furthermore, she notes that "understanding the interrelated nature of inner and external worlds ought to lead" to both better conditions for human functioning as well as the improvement of psychotherapy for our clients (p. 164).

Houston (2002) also comments on constructivist theory in social work and uses Bourdieu's critical realist philosophy to develop a model for culturally sensitive and politically radical social work. Houston notes that Bourdieu's philosophy integrates an understanding of Marxist ideas about how culture and class shape society with a respect for individual human agency. The philosophy contends that societal inequality is reproduced by culture in modern capitalism, but also acknowledges that individuals can effect change in their daily lives through choice and action (p. 155). Similarly to Thompson, Houston highlights this dialectic between personal agency and structural inequality in understanding the interaction between subjective experiences and objective social realities. Houston believes that a model based on the principles of critical realism "enables practitioners to gain an in-depth understanding of the nexus constituting the person in society" (p. 163). Houston uses this philosophy to develop a four-stage model for culturally sensitive social work that includes understanding the relationship between culture, power, and reproduction; enhancing professional reflexivity; developing cultural sensitivity; and raising awareness and empowering clients. He argues that social work practitioners cannot solely attend to the subjective experience of their clients without also understanding how issues of power and culture affect both the client and the client/worker relationship. In his work applying critical realism to child welfare interventions, Houston also highlights the interaction between the objective and subjective that accounts for intrapsychic, familial, social, political, and economic factors in a model for assessment and intervention (Houston, 2001). Again he argues for understanding how all of these

factors interact to create the client's reality and need to be understood by the social worker for ethical and effective practice.

Future Directions for Social Work

The theoretical contributions of Houston, Saari, and Thompson, among others, represent the future of the development of the person-in-environment concept in social work practice. The convergence of philosophical understandings of the interrelatedness of subjective and objective phenomena with social work's historical attempts to develop a comprehensive approach to both humans and their environments can lead to exciting and innovative, in-depth theories that truly integrate both the person and the environment. While these concepts are not simple or easily distilled into concrete techniques, their complexity and depth offer a rich framework for guiding flexible and responsive practice. The concepts offered, once integrated into clinical practice, have the potential for providing a firm foundation for the complex and difficult decisions that clinical social workers face daily. These theories could improve social work practice by allowing clinicians to develop a full understanding of how the realities of social justice and oppression affect the subjective experiences of our clients. With this improved understanding, clinicians would be better able to relieve individual suffering, ensure culturally competent practice, avoid contributing to oppression, empower clients, and integrate social action and clinical advocacy into their practice. Clients would no longer need to be either adapted to society or abandoned in the pursuit of structural social change, but a clearer understanding of how social structures inform individual development and how individual's choices impact social structures could emerge.

This emerging understanding could also help unite the traditionally divisive poles of the profession. The divides between micro and macro issues, or personal and social issues, could become less distinct as the interaction between the individual and the environment is more fully integrated into theory. Social workers could consequently see all levels of practice as interdependent rather than competitive or unique. We may still develop specialized skills in psychotherapy, clinical advocacy, clinical research, community organizing, social research, administration, or policy, but all levels of practice would inform each other and distinctions would be more fluid and less rigid. The clinical social worker would understand and combat the effects of sociopolitical inequalities with individuals while the community organizer would understand how subjective experiences and individual agency can be used and valued in activism, organizing, and social change. In this way the profession could combat fragmentation and fully realize Mary Richmond's vision of interdependence between casework, group work, community work, social reform, and social research in service of our clients.

References

Berzoff, J., Flanagan, L. M., & Hertz, P. (2004). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts.* Lanham, MD: Rowan & Littlefield.

Carpenter, D. (1996). Constructivism and social work treatment. In F. Turner (Ed.), *Social work treatment: Interlocking theoretical approaches* (4th ed., pp. 146–167). New York: Free Press.

Cooper, M. & Lesser, J. G. (2002). *Clinical social work practice: An integrated approach.* Needham Heights, MA: Allyn & Bacon.

Ezell, M. (1994). Advocacy practice of social workers. *Families in Society: The Journal of Contemporary Human Services, 75*(1), 36–46.

Goldstein, E. G. (1996). What is clinical social work? Looking back to move ahead. *Clinical Social Work Journal, 24*(1), 89–104.

Hamilton, G. (1951). *Theory and practice of social case work* (2nd ed.). New York: Columbia University Press.

Hollis, F. (1964). *Casework: A psychosocial therapy.* New York: Random House.

Houston, S. (2002). Reflecting on habitus, field and capital: Towards a culturally sensitive social work. *Journal of Social Work, 2*(2), 149–167.

Houston, S. (2001). Transcending the fissure in risk theory: Critical realism and child welfare. *Child & Family Social Work, 6*(3), 219–228.

Lieberman, F. (1987). Psychotherapy and the clinical social worker. *American Journal of Psychotherapy, 41*(3), 369–383.

Northen, H. (1995). *Clinical social work: Knowledge and skills* (2nd ed.). New York: Columbia University Press.

Richmond, M. E. (1922). *What is social case work? An introductory description.* New York: Russell Sage Foundation.

Saari, C. (2002). *The environment: Its role in psychosocial functioning and psychotherapy.* New York: Columbia University Press.

Simon, B. L. (1994). *The empowerment tradition in American social work: A history.* New York: Columbia University Press.

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

Thompson, N. (1992). *Existentialism and social work.* Aldershot, England: Averbury.

Turner, F. J. (1996). *Social work treatment: Interlocking theoretical approaches* (4th ed.). New York: Free Press.

Turner, F. J. (1978). *Psychosocial therapy.* New York: Free Press.

Webb, N. B. (2003). *Social work practice with children* (2nd ed.). New York: Guilford Press.

Kathryn L. Cornell, LCSW, is a doctoral student and alumna of the MSW program. She has been working for the past five years as a clinician in the Jewish Children's Bureau's System of Care Program, providing individual therapy, family therapy, and advocacy for children and families in the child welfare system.

Cultural Notions of Psychopathology: An Examination of Understandings of Spiritual Healing and Affliction across Cultures

by Elana L. Benatar

Abstract

Culture has a vital impact on how individuals and professionals view psychopathology. What some cultures view as a gift of spiritual mediumship and healing, others condemn as psychosis. In many cultures, this idea of spiritual healing, or shamanism, may exist side by side with a belief in more negative altered states, such as demon possession or spiritual affliction, which are often viewed as punishment for wrongdoing. This article will examine varying views of the meaning associated with phenomena that, in the Western world, would be referred to as delusions, hallucinations, or dissociations. The beliefs, practices, and experiences that characterize shamanism will be outlined and will be juxtaposed with a Western psychological understanding of the same phenomenon based on the symptoms presented. In addition, the article will examine what some cultures view as "spiritual affliction," a condition often treated by shamans. Similarities between shamans and therapists will be explored and conclusions will be drawn about what Western psychology may learn from traditional healing models.

Cultural Notions of Psychopathology

Several years ago, during a semester abroad in Ghana, West Africa, I had the opportunity to meet a traditional Akan priestess and observe a possession ceremony. I observed her being physically taken over by a spirit. Her eyes became wide, and her entire demeanor took on a different quality. She danced, grunted, and yelled, and then without hesitation returned to her earlier state. The priestess explained to us that as a child she was chosen by the spirits. At that time, the spirits took her into the woods for 2 years and taught her how to use her powers. She made clear to us that one who gets the calling but not the education is just a "plain old crazy person." Immersed in the culture at the time, I believed completely in this woman's powers. But as I sat in a psychology class in the United States months later, I began to wonder: Was this woman in fact having a dissociative episode? Was this period of two years in the woods actually a euphemism for some kind of traumatic experience? What was it that she learned there that made her different from just a "plain old crazy person?"

Mental health professionals should be aware that mental illness exists in a cultural context. Some might have immediately diagnosed the Akan possession ceremony as a psychotic or dissociative episode. Others, such as a Ghanaian acquaintance of mine who was studying traditional religion at the time, would disagree. When I inquired about this issue in a letter to this friend, he responded:

> On the superficial level, one might want to agree to some extent because different spirits and personalities are revealed at different times. But possession to me is an entirely different ball game. Possession is highly religious and very spiritual and of course a physical manifestation of spiritual bodies. Although it can come by itself, it is also invoked and the individual is only used as a medium of communication to the people when the need arises. (Y. Gwamfi, personal communication, July 29, 1999)

For Mr. Gwamfi, there is no question that this phenomenon is religious rather than psychological.

Culture, therefore, has a vital impact on how psychopathology is viewed. While some cultures esteem these experiences as a gift of healing, others condemn them as psychosis. This article will examine varying views of the meaning and pathology associated with phenomena that, in the Western world, would be referred to as delusions, hallucinations, or dissociations. In some cases altered states are used in a therapeutic way. Yet in many cultures this idea of spiritual healing, or shamanism, may exist side by side with a belief in negative altered states, such as demon possession or "spiritual affliction," which are often viewed as punishment for wrongdoing. The beliefs, practices, and experiences that characterize shamanism will be outlined here. They will be juxtaposed with a Western psychological understanding of shamanic experiences, which is based on viewing them as symptoms. Spiritual afflictions will also be discussed, including a comparison of the ways a shaman and a Western psychotherapist might treat them. It will be argued that Western psychotherapy may learn from these traditional, shamanic healing models and that viewing mental illness through the lenses of both cultures may yield greater understanding of the impact of cultural norms and beliefs on definitions and diagnoses of mental illness.

Shamanism from the Perspective of Shamanic Cultures

Walsh (1997) defines shamanism as "a family of traditions whose practitioners focus on voluntarily entering altered states of consciousness in which they experience themselves, or their spirit(s), traveling to other realms at will and interacting with other entities in order to serve their community" (p. 103). In some cultures, shamanism is esteemed as a valuable healing tool for treating medical and psychological crises of community members. The term "shamanism" thus encompasses varied cultures that share a belief in spiritual possession and in the power of healing through mediumship. This article will include examples of shamans from two such cultures: the Akan priestess from Ghana, and a Kashaya healer from Alaska.

Walsh (1996) found that while shamanism thus exists in a multitude of cultures, it often consists of three main qualities: an initiation crisis, mediumship or spirit possession, and the shamanic journey. The initiation crisis takes place when an individual is first "called" by the spirit world, much as the Akan priestess was when she described being "chosen by the spirits" as a child. In this state, the individual does not yet know that this experience represents being chosen by the spirits, and he or she may be frightened and disoriented. As Walsh describes,

> At this time shamans-to-be may experience themselves as tormented and controlled by spirits. They may exhibit considerable confusion, emotional turmoil, withdrawal from society, and a range of unusual and bizarre behavior such as going naked, refusing food, and biting themselves. (p. 111)

This experience is understandably one that would be interpreted by many Western psychologists as being problematic. We might understand this as a significant impairment of consciousness and cohesiveness of self. Many have interpreted this behavior as reflecting a dissociative state or as a sign of schizophrenia or psychosis. Silverman (as cited in Krippner, 2002), for example, viewed shamanism as a state of acute schizophrenia, characterized by non-reality oriented ideation, abnormal perceptual experiences, emotional upheaval, and bizarre mannerisms.

Though, as with schizophrenia, the "calling" to become a shaman is often not voluntary on the part of the individual, the ability of the shaman to *recover* from this crisis distinguishes this experience from one that would lead to mental illness (Walsh, 1996).

In the case of the Akan Priestess, perhaps this "recovery" occurred through her 2-year education in how to harness her spiritual powers. Whatever it was that the Akan priestess learned during those 2 years in the woods, her experience somehow allowed her to return to the society, not as a "crazy person," but as an esteemed healer with a special gift. Unlike in the case of severe mental illness such as schizophrenia, in which an individual may become more limited cognitively and affectively after a psychotic break (Gabbard, 2000), shamans seem to return from an initiation crisis with an enhanced ability to experience the world in new ways that are valued by their culture and seen as useful to their society. It could be said that people with schizophrenia may also experience their world in new ways, but Western culture does not view these hallucinatory experiences as valuable to society. This concept of gaining strength through suffering psychological disease is one that is foreign to Western society. Seldom do we conceive of mental illness as an enriching and revelatory experience that, if endured, could lead to greater enlightenment. One exception to this might be the view that psychological crisis is often the root of great art.

Thus, in shamanism it is through the ability to respond to and live through this crisis that a shaman gains power. According to one academic studying this population, those who "refuse the call" may "sicken, go mad, or die" (Walsh, 1996, p. 116). Walsh therefore suggests viewing these disturbances during the initiation crisis as "developmental crises" that can be precipitated by stress and that can lead to "individuation, self-actualization, self-transcendence, and eros" (Walsh, 1996, p. 115).

A shaman who has experienced this initiation crisis and who "heeds the call" often experiences "mediumship," in which spirits or ancestors will speak or act through the shaman while the shaman is in an altered state of consciousness. Similar to mediumship is the "shamanic journey," in which the shaman enters into a trance-state, "becomes less aware of the environment, and experiences journeying to other worlds to contact a rich range of spirit beings and visionary experiences" (Walsh, 1996, p. 109). A Kashaya healer from Alaska described this experience:

> You hear voices that tell you what to do, and hear songs. When you look at your patient – it's like the voices are tellin' you things, and your eyes become like x-ray. It's really something! You don't feel your body. You just feel like you're all brain. Your whole body feels like it turns into a brain – a spirit brain. (Mertz, 1994, pp. 3–4)

Other shamans may describe this experience as one in which spirits speak through them or work through them, using special powers in order to heal the afflicted. When this occurs, the spirit may displace the shaman's personality, and body posture, movements, and voice can change dramatically (Walsh, 1996).

Shamanism from the Perspective of Western Psychology

In western psychology, these experiences are often seen as a form of dissociation, and spirits are conceived of as split off factions of the psyche (Walsh, p. 108). Some have described this state as "dissociative trance disorder," which, in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., Text Revision; American Psychiatric Association, 2000), falls under the category of Dissociative Disorders Not Otherwise Specified and is described as:

> Single or episodic disturbances in the state of consciousness, identity, or memory that are indigenous to particular locations and cultures. Dissociative trance involves narrowing of awareness of immediate surroundings or stereotyped behaviors or movements that are experienced as being beyond one's control. Possession trance involves replacement of the customary sense of personal identity by new identity, attributed to the influence of a spirit, power, deity, or other person, and associated with stereotyped "involuntary" movements or amnesia. (pp. 532–533)

Though the DSM-IV-TR understands this to be a culture-bound syndrome, some may still find its inclusion in the manual pathologizing. If a "mental illness" is not considered to be an illness and in other cultures and may even be seen as valuable, should it truly be understood as an illness in Western culture? What makes it pathological in one culture and worthy of great esteem in another? As Grof (1985) points out, "What should be seen as sane, normal, or rationally justified depends critically on circumstances and on the cultural or historical context" (p. 298). While shamans might be diagnosed with a psychotic disorder in a Western cultural context, Grof notes that common Western characteristics of "insatiable ambitions...obsession with technology...[and] the modern arms race...would be seen as symptoms of utter insanity by an East Indian sage" (p. 298). What is socially desirable even in Western culture can be easily viewed as pathological in another culture.

Some researchers have defined shamanism as a non-pathological form of dissociation ("What is dissociative trance disorder?," 1995), though few have recognized it as a possibly culturally *beneficial* form of dissociation. Yet, it is worth questioning whether this trance-like state even fits the definition of a dissociative episode—pathological or non-pathological, beneficial or non-beneficial. According to ego psychology, dissociation is a defense mechanism. It is used to faction off experiences or parts of the self that are too painful for the individual; it is used adaptively to avoid some form of psychological pain (Gabbard, 2000). According to Gabbard, dissociation is often linked with a history of trauma and serves the adaptive function of splitting of the traumatized self in order for the full self to retain an illusion of psychological control. Dissociation thus occurs as a "vertical split," in which "disparate self schemas...must be maintained in separate mental compartments because they are in conflict with each other" (pp. 270–271).

The Western conception of the underlying nature of dissociation and dissociative disorders is thus very different from how shamanic experience may be conceived of by non-Western cultures. In the existing literature (Walsh, 1996; Walsh, 1997; Mertz, 1994; Krippner, 2002), few authors note shamans as having experienced a trauma, beyond perhaps the initial trauma of the initiation crisis. Furthermore, though one might argue that what shamans experience as spirits constitute multiple self schemas, these schemas are generally not in conflict with one another. Dissociative disorders are associated with a sort of internal strife and denial of various parts of the self, but these aspects are not seen in shamanic trances. Walsh (1996) distinguishes mediumship from dissociation, stating that these spirits are not experienced as aspects of the *self* but as distinct entities that possess knowledge or power outside of the person being possessed. Thus, the "alters" are not factions of the individual's self but are outside of him or her entirely (Walsh, 1996). Similarly, the shaman is not *victim* to these spirits but has complete control over the process. The mediumship experience is not conceived of as an unconscious defense in order to avoid the recognition of pain. Instead, as Walsh points out, "shamans deliberately open themselves to either their own pain and suffering, that of their people, or even that of the 'spirits' in other worlds, and thereby attempt to find a resolution to that pain" (Walsh, 1997, p. 110).

Thus, the shamanic experience differs from dissociative disorder in important respects. Further, researchers have found that these individuals often

show few other signs of psychological impairment. As Ripinsky-Naxon states, "the world of a mentally dysfunctional individual is disintegrated. On the other hand, just the opposite may be said about a shaman" (as cited in Krippner, 2002, p. 966). One group of researchers administered Rorshach inkblots to a group of non-shamans, shamans and "pseudo-shamans" (individuals who considered themselves shamans, but were not viewed as such in their communities). Researchers found that the shamans had a high degree of reality testing potential, and their mental approach was found to be less "hysterical" than other groups. Similar studies described shamans as having a mental state that was simply "freer, and more creative" (Krippner, 2002, p. 966).

The most important distinction between shamanism and mental illness is the curative nature of this power. Though some of these experiences may resemble psychosis or dissociation, shamans are able to use these symptoms for the good of the people around them. Shamans often take on the role of traditional healer, medicine man, folk doctor or even therapist. Frank and Frank (1991) have even traced the roots of psychotherapy back to shamanism. In addition, the "spiritual afflictions" described in the next section are often only effectively treated by shamans and other forms of traditional healers.

Spiritual Afflictions and Demon Possession

Many cultures view the concept of possession as twofold. While shamans receive the call and are able to use their gift for the public good, there are others who are thought to be chosen and tortured by malevolent spirits or to suffer from a variety of different forms of spiritual affliction. These people are often conceived of as haunted, possessed by demons, dispirited, or cursed. They may seek help from various forms of shamans or even Western doctors, psychologists, and social workers. In contrast to shamans, these individuals are often suffering and in search of relief, so likening their experiences to mental illness may be more legitimate.

People who conceive of themselves as possessed by demons of one sort or another are in great distress. In some cases, the complaints are somatic, leading to a form of physical pain for which they seek treatment. One patient of an African Ndembu healer describes being invaded by the tooth of a dead hunter:

> If ihamba comes to you, you can't even eat your daily mush. It just gives you pains. You will think it is just pains, but the way it hurts you is a sign. You will hear something biting. If it comes

> through the arm, leg, ear, or eye, you will see it moving through the veins of your body. (Mertz, 1994, p. 2)

In other cases, a spiritual affliction can manifest in more psychological symptoms that Westerners would see as a form of mental illness. Mertz (1994) provides an account from a traditional healer of a "dispirited" Alaskan man who had lost his mother early in life. According to this healer, Lorin Smith, the man had three spirits that were not integrated into a whole self; the spirit bodies had split off and wandered away from his material self. As Smith describes it,

> The same person's kind of like in three personages, but they're supposed to be all together. But, for him, they're all like, they're following each other…the main part of him was up front, another one was following, hoping somehow to get himself together so he could be a whole person again. (Mertz, 1994, pp. 7–8)

These individuals often seek help from healers or shamans, who use a variety of methods for treatment. In the case of the Alaskan man above, the healer's method resembles a sort of talk therapy, in which he talked to each of the spirits and attempted to figure out the cause of the fracture.

This sense of a fractured identity would likely be understood by Western psychologists as some sort of mental disorder (e.g., dissociation) resulting from an early trauma such as the death of the man's mother and the resultant blame he experienced from his father. What is interesting is that as he describes the man, Smith provides what could easily be a psychodynamic understanding of a patient. He states that the man's father "couldn't understand what his role was, or what as a parent, he should've done, showing love to that son of his, so the boy didn't have anything" (Mertz, 1994, p. 8). He describes in detail the feelings of aimlessness and loss of self that could be connected to such an early object loss. Smith seems to possess an understanding of this dispiriting as a coping mechanism for internal pain, and he recognizes the great suffering of this man, stating that "it's hard – it hurts" (Mertz, 1994, p. 9). He even seems to acknowledge a process of projective identification in saying, "when I was talking to him, I used to hurt" (Mertz, 1994, p. 9). In expressing this, Smith demonstrates a sophisticated understanding of the psychodynamic view of what it means to truly be with a client, so as to "learn in [his] bones" what the client is experiencing (Berzoff, Melano, Flanagan & Hertz, 2002, p. 169).

So what is it that makes this case different from a traditional Western treatment model? The first difference lies in the cultural understanding of the affliction. While Smith seems to touch on many of the same qualities that a Western therapist would, his understanding of the cause of the affliction and the way that the individual copes with this affliction are fundamentally different. Mertz (1994) describes this in terms of differing concepts of the self across cultures. In Western culture, the self is thought to be a distinct and cohesive entity. We possess an individualized view of the self, valuing autonomy and self-agency over communalism. Many other cultures, however, conceive of what Mertz refers to as the "sociocentric self," in which the boundaries between self and other are more diffuse. Mertz states that in these cultures, "the boundaries of the self are constantly under negotiation because the sociocentric self is experienced as permeable, subject to intrusion of malevolent intentions" (Mertz, p. 5). The illness is thus conceived of as having an external and intrusive component that may have little to do with the individual's direct experience. This, therefore, leads to a treatment that addresses these external sources of mental anguish through exorcism ceremonies or trance-like states.

In the case illustrated above, the patient sought services with a healer within his own culture. But what happens when someone from a similar culture seeks services in a Western mental health context? Al-Krewnawi & Graham (1997) describe a case in which a Bedouin patient experiencing symptoms was brought to a mental health agency and diagnosed with schizophrenia. This man described hallucinations of characters trying to hurt him. He made little sense at the time of referral and appeared disoriented and confused. The psychiatrist, seeing these as symptoms of psychosis, diagnosed the man with schizophrenia and commenced treatment with anti-psychotic medication. Though the medication helped the man somewhat, it did not eliminate the hallucinations, and he remained in serious distress.

Later in therapeutic treatment, the man stated that the hallucinations were demons, referred to as *Jinn*, who looked like the elders in the Bedouin tribe. Furthermore, he revealed that these voices were not always persecutory, and that "sometimes they are funny and make me happy, and at other times they pressure me to do things. They force me to do things that are embarrassing; but they also prevent me from committing suicide" (Al-Krenawi & Graham, 1997, p. 215). The man further attributed these visits with the Jinn to punishment for his sinful behav-

ior towards his mother. Thus, as the patient continued to reveal his cultural understanding of his experience, the diagnosis became questionable, and as a result the treatment changed. Eventually the clinician solicited the help of a *Dervish*, a traditional Bedouin healer, and it was through an exorcism-like ceremony that the Dervish was able to finally heal the man.

The case of this Bedouin patient demonstrates the importance of understanding illness within the context of one's own culture, for successful treatment is unlikely until this occurs. Al-Krenawi and Graham explain that in understanding these situations, a necessary distinction must be made between "form" of the symptom and "content," or meaning, of that symptom within a patient's cultural milieu. In the case above, the form would be the hearing of voices, while the content would be being visited by demons as a punishment for wrongdoing.

Practical Implications for the Western Therapist

In our ever more global society, Western mental health professionals are likely to treat an increasingly diverse population of clients. When clinicians work with clients from cultures different from their own, it is important for them to understand that mental illness can be a culturally bound phenomenon. In line with the social work value of "starting where the client is," clinicians should view the nature of a client's complaint through the lens of the client's own culture and be open to meanings beyond those Westerners may typically attribute to symptoms. Social workers need to explore a client's own cultural understanding of his or her symptoms. Whenever possible, social workers should consult with a healer of the client's culture to gain a greater understanding of the client's experience. These are key skills for culturally competent practice, and for effective treatment of symptomatic clients from non-Western cultures.

Conclusion

This examination of shamanism and spirit possession raises interesting questions about how Western society understands mental illness. Why is it that other cultures are able to see value and use in symptoms that would likely precipitate hospitalization in our own culture? Perhaps the ability to see these experiences as potentially beneficial rather than threatening is the very factor that allows these individuals to gain mastery over their own afflictions. The Akan priestess I met in Ghana told me

that she would take me on a spiritual journey, but that my mother would not approve. In saying this, I wonder if the Akan priestess understood something about how my cultural boundaries would prevent such a journey. Perhaps she understood something about the cultural relevance of mental illness from which we all can learn.
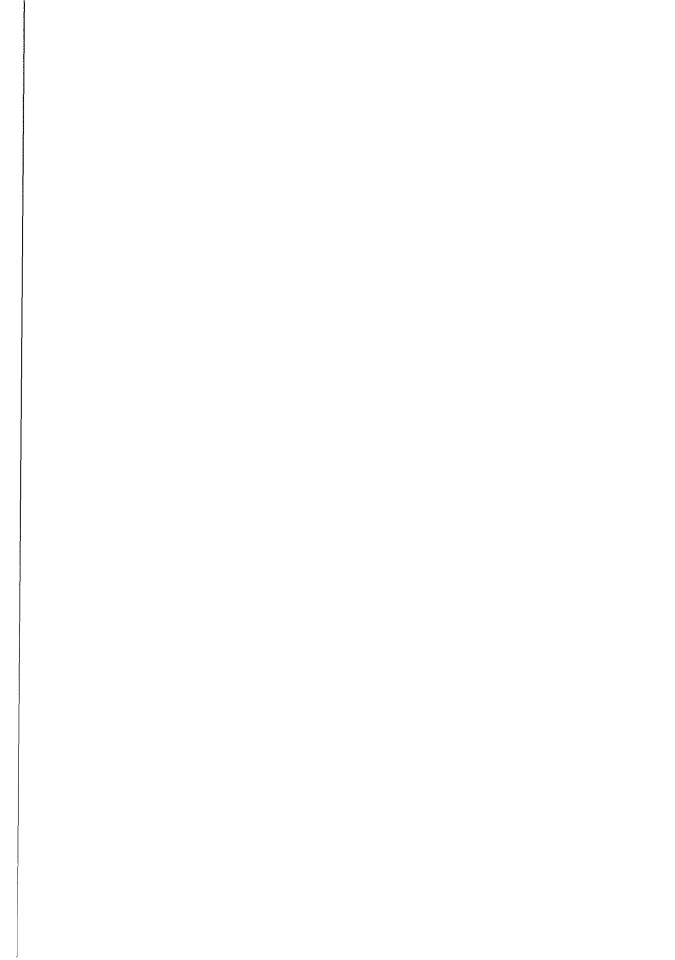
References

Al-Krewnawi, A., & Graham, J.R. (1997). Spirit possession and exorcism in the treatment of a Bedouin psychiatric patient. *Clinical Social Work Journal, 25*(2), 211–222.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Revision). Washington, D.C.: Author.

Berzoff, J., Flanagan, L.M., & Hertz, P. (2002). *Inside out and outside in.* Northvale, NJ: Jason Aronson Inc.

Gabbard, G.O. (2000). *Psychodynamic psychiatry in clinical practice* (4th ed.). Arlington, VA: American Psychiatric Press.

Grof, S. (1985). *Beyond the brain: Birth, death and transcendence in psychotherapy.* Albany, NY: State University of New York Press.

Frank, J.D., & Frank, J.B. (1991). *Persuasion & healing: A comparative study of psychotherapy* (3rd ed.). Baltimore: Johns Hopkins University Press.

Krippner, S.C. (2002). Conflicting perspectives on shamans and shamanism: Points and counterpoints. *American Psychologist, 57*(11), 962–973.

Mertz, L. (1994). The spirits say they aren't crazy: Trance and healing in cultural context. *ReVision, 17*(1), 29–35.

Walsh, R. (1997). The psychological health of shamans: A reevaluation. *Journal of the American Academy of Religion, 65*(1), 101–124.

What is dissociative trance disorder? (1995). *Harvard Mental Health Letter, 11*(9), 8–9.

Elena L. Benetar received an MS in Child Development from the Erikson Institute in June of 2005 and an MSW from Loyola in May 2006. She interned at Jewish Family and Community Service's Virginia Frank Child Development Center and at the Child Abuse Unit for Studies, Education, Research and Services. She is working as a social worker at the Virginia Frank Child Development Center.

Dissertation Abstracts

Congratulations and best wishes to Tom Charles, Cheryl Irmiter, and Yujin Kim. The dissertation topics continue to represent the diversity of interests and the commitment to clinical practice of our Ph.D. students. Dissertations are available on the 8th floor of Loyola's Lewis Library, 25 E. Pearson.

What are the Lived Experiences of Nonresidential Fathers Who Maintain Parenting Role Identities Postdivorce?

Tom Charles

This was an exploratory study of 33 nonresidential fathers divorced for the first time with at least one child twelve years of age or younger. This project combined quantitative and qualitative methods. Participants responded to survey questions, completed a card sort, and shared experiences about their lives. The purpose of the research was to find out how nonresidential fathers maintained parenting role identities postdivorce. The statistical analyses of the seventeen variables of the proposed fatherhood model revealed that there was an association between levels of education, hours worked, perception of former spouses' communication styles and nonresidential fathers' levels of engagement. Nonresidential fathers ranked the role of teacher/mentor/role model as the most salient fathering role and half of the sample balanced two or more of the seven roles during the card sort. Nine themes surfaced from thematic analyses of the narrative data gathered from interviews with four engaged and four disengaged nonresidential fathers. The topics included: personal strengths, community resources, parental concerns, coparental relationships, development of fathering roles, fatherhood norms, concerns about the legal system, and reasons for participation. It is important for practitioners to recognize the pain suffered by nonresidential fathers following separation and the importance of helping them build connections. A gender-neutral approach is recommended to assist nonresidential fathers renegotiate relationships. Policy changes are needed to insure greater equity in divorce outcomes, protection of ties between nonresidential fathers and their children, promotion of further education to improve nonresidential fathers' employment options, creation of laws to establish child support accountability, and development of legislation that is aimed at helping families help themselves. Further study is needed to assess nonresidential fathers' personal strengths, to understand the nature of community resources utilized, and the cultural influences on level of engagement. Those investigations should also incorporate designs that include other family members.

How Can We Slow Down the Revolving Door?: Developing Predictive Models to Improve Service Planning for Patients with Severe Mental Illness

Cheryl A. Irmiter

Objective: People rehospitalized with severe mental illness struggle to stay connected with outpatient treatment, family/significant others, and housing. These people contend with pervasive medical and psychological symptoms and pathology. As a result, their recovery process is compromised and they wander through various institutions. The goal of this study was to determine: 1) whether there are significant patterns of stay and rehospitalization (number, time between and length of hospitalizations) and 2) which categorical predictor variables (characteristics, admission and discharge disposition, and medical and psychiatric diagnoses) influence patterns of hospitalization.

Method: Psychiatric records (N = 5,902) for those admitted between 1982 through 1987 and rehospitalization records through 2003 were examined. A clustering procedure was used to assign cases to four possible categories based a priori grouping. Baseline categorical predictor variables were correlated to the four category-dependent variables via a series of logistic regression models. Zero-order and higher-order associations with predictor variables were estimated.

Results: Twenty-three percent of rehospitalized patients averaged the most hospitalizations (6) and the longest time hospitalized (49 days). Seventy-seven percent averaged half as many hospitalizations and one-third the time hospitalized. For time between hospitalizations, Clusters I and II averaged similar time between hospitalizations (1 year), whereas, Cluster III averaged six years (6 years). People with the most hospitalizations, Cluster I, were more likely to have Medicare (OR = 2.06), endocrine/immunity illnesses (OR = 1.7), and multiple psychiatric diagnoses, yet were least likely to have a substance-induced diagnosis. Cluster II patients (55%) were more likely to be male (OR = 1.2), older (OR = 1.11), and to have Medicaid (OR = 1.78), circulatory system illnesses (OR = 1.4), ill-defined illnesses (OR = 1.4), and/or endocrine/immunity illnesses (OR = 1.3). They were more likely to be diagnosed with multiple psychiatric diagnoses, including substance-induced diagnoses (OR = 1.49). Cluster III patients (22%) were more likely to have Medicaid and be diagnosed with a diagnosis of schizophrenia (OR = 2.39).

Conclusion: Ultimately, people with severe mental health problems have distinct patient characteristics that influence patterns of hospitalization, and they can be grouped based on their need for long-term housing and community care. From this study, a template for discharge care can be developed in an attempt to improve service delivery and to stop the institutional revolving door.

Understanding Korean American Family Caregivers' Experiences of Living with Alzheimer's Disease: A Phenomenological Inquiry

Yujin Kim

This transcendental phenomenological study was conducted in an effort to develop understanding of the experiences of caregiving from the perspective of primary caregivers in Korean American families residing in the Chicago area. Interviews with ten primary caregivers of elderly patients with Alzheimer's disease (AD) and vascular dementia were analyzed with the systematic procedure of Moustakas' (1994) modification of the Van Kaam method of phenomenological analysis. This analysis was designed to uncover both caregivers' explicit and implicit descriptions of their caregiving experiences.

The findings revealed that caregiving had different meanings for each caregiver and that the meaning of the experience changed with the progression of the disease in each patient. However, there were six core themes that characterized these caregivers' experiences: (1) understanding about elderly patients with AD by accepting AD as a disease, (2) self-definition and self-appraisal of caregiving, (3) contemplating existential thoughts, (4) polarity of ambivalent feelings, (5) questioning of the transgenerational continuity of filial piety, and (6) different experiences with the formal care system.

This study was based on a small, but relatively heterogeneous sample. It advanced the understanding of the experiences faced by Korean American caregivers. The findings unveiled how caregivers and families coped with the transition into caregiving for their elderly family members both before and after the onset of dementia as well as what caregivers experienced after their patients died, which is useful in developing a stage-specific systematic intervention for family caregivers.

The findings of this study will be helpful to professionals in their understanding of the underlying and dynamic context of Korean American family caregiving. Contrary to previous research on Korean American family caregiving, the accounts of caregiver participants suggest that the sense of filial piety alone does not seem to be sufficient motivation for caregiving of the elderly with dementia. Rather, it was the history of a close relationship and/or affection between the patient and the caregiver that led the caregiver to actively participate in the caregiving process. Another distinctive finding from this study was that these caregivers actively utilized formal elder care services.

Implications for both policy and social work practice with Korean American families with dementia are addressed. Followed by three illustrative questions that need future investigation, the researcher's epilogue on conducting research with family caregivers is presented.