

PRAXIS

Where Reflection & Practice Meet

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Our Ongoing Obligation for Competence**

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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 editorial board 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.

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EDITORIAL

Keeping Our Wits about Us: Our Ongoing Obligation for Competence

“That is what learning is. You suddenly understand something you’ve understood all your life, but in a new way.”

~Doris Lessing

A Smith student said it in a delightful drawl when she was asked why she did not study in the “browsing room” of the library where there were easy chairs. “I have found out,” she said, “that you can’t be too comfortable in this world and keep your wits about you at the same time.” (Reynolds, 1991, p. 298)

For the past year, I have been trying to conceptualize how to relay my final message as outgoing editor of *Praxis* as I have wanted to underscore the importance of ongoing training, research, and publication for the profession. So, I went to our profession’s roots and read through Bertha Reynold’s reflective book, *An Uncharted Journey*. In there, I found the above anecdote, which sums up my message: We must constantly challenge our beliefs about our practice and never be content with our existing level of knowledge.

Indeed, our graduate programs are designed to equip us with the tools to effectively work in the profession, but is that where our obligation for competence ends? Or, does it end with acquiring the mandated number of training hours each year to retain our license? I argue that achieving competence is an ongoing process that requires a mix of formalized training, staying current with the scholarship field, frequent dialogue and consultation with colleagues, personal reflection, and publication.

Just as our lives and personalities are ever evolving, our professional selves must also evolve. Each person comes into this field with a set of beliefs about the world and about helping others. Some are rigid; some are flexible. The rigid individuals hold onto their beliefs so tightly that they sustain personal injury if those beliefs are attacked, while the flexible individuals are able to embrace a critical view of their beliefs and maintain an open mind. It is only through this flexible level of personal reflection that one can move toward competence. Thus, recognizing the limitations of one’s belief system and actively seeking ideas that complement it or even oppose it are necessary for us to “keep our wits about us.” This, of course, can happen through the aforementioned formalized training, reading current literature, and ongoing consultation.

As one way to move toward competence is learning, another way is by contributing to the scholar-

ship in the field. Reynolds (1991) writes,

We need mental stimulation to live as much as we need food; we must digest experience and make it our own; we must give it out in some form of action. This may be in communication to others who can carry the action to a wider impact upon the life of our time, but communicate we must, or thought grows stale and interest in new ideas recedes. (p. 299)

Once again, our obligation for competence does not end with meeting our annual CEU requirement. We also have the obligation to share our knowledge. Teaching and writing for publication are two of the best forms of learning. It is in these acts that one must defend his/her point of view and face criticism of those beliefs head on. Besides that, we are a profession founded on the idea of giving to others, including our colleagues. Why do we not all have the same sense of obligation to give knowledge we gain as professionals to each other?

With that being said, I am proud to introduce seven fine manuscripts from authors, who had the courage and ambition to share with us their perspectives gained through personal experience, clinical practice, and original research. This volume starts off with two authors offering alternatives to the typical paradigms considered in social work practice. Jane McCourt shares a unique understanding of spirituality in marital therapy that will certainly challenge the reader’s definition of “spirituality” and will allow for the integration of spiritual concepts into everyday practice. Further, Chris Wisniewski introduces the reader to alternative interventions incorporating mindfulness meditation. In these articles, the authors challenge the readers to be creative and flexible in treatment, yet to stay in the parameters outlined by our Code of Ethics.

Next, two authors use their articles as a “call to action” on issues that have been underrepresented in our field. Deresha Gibson revisits the issues surrounding African American families affected by parental incarceration, challenging the dominant punishment paradigm in the criminal justice system. In reading her article, we see that this approach to crime not only punishes the individual committing the crime, but also his/her entire family system. Then, Megan Seliga discusses the

importance of improving the quality of life for nursing home residents. In our society, our elders somehow seem to lose importance and fall to the background; in this article, Megan brings them to the forefront by appealing to the nursing home administrators to look inward at the culture of their organization.

In addition, we have three original research articles on varying, yet important topics. One looks at the ever controversial topic of managed care and how it impacts clinical decision making. Next, the issues surrounding filial anxiety with regard to the anticipated care of elderly parents are studied; this article helps us rethink the impact that aging has on the entire family system. This volume ends with an intriguing study looking at the dynamics of adoption from the point of view of the biological child. The authors seek to give voice to the “forgotten” member of the adoption triangle. Overall, these authors tackle a wide range of topics with the intention to educate us, challenge our belief systems, and motivate us to act on these topics.

I started this editorial with my outgoing message to the readers to allow me to use my final lines to be a bit self-indulgent. Bittersweet. This is the only way to describe my feelings as I wind down on my tenure as editor of *Praxis* and as a doctoral student in general. My time as a student at Loyola has provided me with so many opportunities and memories. I will always carry the memories of meeting my first grad school friend at orientation, finding incredible mentors in my professors, having my beliefs about social work theory change at least 50 times, being published for the first time, creating my own program as part of my doctoral internship, and, of course, being a part of this jour-

nal. I credit my growth over the past six years to my friends from the masters program, my amazing doctoral cohort, my professors (special thanks to my doctoral committee!!), and all the others along the way that offered encouragement and challenged me. Now, as I prepare to move on to the next stage of my career, I am glad (and relieved) to pass the *Praxis* torch to the very competent hands of Deanna Guthrie, long-time board member and published author. With the steadfast, ongoing guidance from Dr. Rasheed, I have no doubt that she will maintain *Praxis*' high integrity as a journal. Finally, thank you to all who have contributed to the making of Volume 8: the authors, the Board, all the writers who submitted articles, Dr. Rasheed, and Dr. Wall for his ongoing support of this endeavor. This has turned out to be one of the most diverse editions of *Praxis* yet, and it is my hope that the readers are inspired by the passion of these authors to get out of their “easy chairs” and begin pursuing their own reflection, research, and writing.

Jeffrey J. Bulanda, LCSW
Doctoral Student
Editor-in-Chief

Reference

Reynolds, B.C. (1991). *An uncharted journey: Fifty years of growth in social work* (3rd ed.). Silver Spring, MD: NASW Press.

Presence of Spirituality in Marital Therapy Models

By Alexandra Jane McCourt

Abstract

With the divorce rate hovering around 50 percent, marital conflict is one of the leading reasons people seek services from clinical social workers in outpatient settings. Social workers have been trained in and practice from a variety of theoretical methods; however, a very important resource has been sorely missing in these marital therapy models: spirituality. Although hinted at in many of the models in the guise of fostering insight, spirituality is not specifically named as a therapeutic intervention in any of the models commonly in practice today. This article examines the presence of spirituality in three commonly practiced models of marital therapy and demonstrates its salient features of self awareness and transformative potential as powerful marital interventions.

Introduction

Spirituality and marital therapy may appear like strange bedfellows, but they actually make quite a good couple. At their inception, marriages are commonly presided over by a minister, priest or rabbi indicating the sacredness and seriousness of the endeavor. It seems logical then that marital therapy would also be imbued with the same sense of the sacred. The problem is that marital therapists often are reluctant to identify their work as spiritual or to intentionally incorporate spiritual ideas in their clinical work because it confounds conventional methods and eludes theoretical expression. Despite the fact that it is recognized by experts in the field as a valuable resource, its presence in the literature is underrepresented at best and at worst, often considered with skepticism.

Froma Walsh, professor emerita in the School of Social Service Administration and the Department of Psychiatry at the University of Chicago, also the former editor of the *Journal of Marital and Family Therapy*, states in the beginning of her book *Spirituality in Family Therapy*:

Spirituality is a powerful dimension of human experience, with growing importance and diversity in today's changing world. Yet it has long been regarded as off-limits in clinical training and practice, leaving most therapists and counselors blind to its significance and reluctant to approach it. (Walsh, 1999, p.ix)

This is the dilemma marital therapy faces today. Spirituality, this powerful resource, is not considered a viable method of clinical intervention. Prest and Keller (1993) said in the *Journal of Marital and Family Therapy* that in the clinical field, spirituality may be

more taboo than sex and death. Lately, however, evidence has arisen of a growing interest among marital and family therapists in spirituality as a potential asset in their work (Anderson, 1997).

Joining this growing interest, this author asserts that spirituality has much to offer couples' therapy and that it actually is present in the major models of marital therapy commonly practiced today, although not identified as such. In this paper, I will highlight the spiritual aspects embedded in three commonly practiced models of marital therapy: Emotionally Focused Therapy developed by Susan Johnson, Integrated Couples Therapy developed by Neil Jacobson and Andrew Christensen, and Imago Therapy developed by Harville Hendrix. These three models, while based on theoretical foundations and research-produced evidence, also include the spiritual dimension of cultivating transformative potential within the couple although they do not identify that dimension as such in their theoretical model.

Definition of Spirituality

In order to illustrate that spirituality is already present in the three models of marital therapy under examination in this paper, it is necessary to use a single definition and understanding of spirituality for application to all three models. For the purpose of this examination, spirituality will be defined as the belief in the potential for transformation within each human and the intentional seeking of those experiences, which promote it. Just as Walsh, Johnson, Jacobson and Christensen, and Hendrix are considered experts in the field of marital therapy, it is important to use an expert in the field of spirituality whose understanding of this phenomenon is widely accepted and considered credible. Anthony deMello, a Jesuit psychologist and spiritual director until his death in 1987, has written extensively on spirituality. His definition is exquisitely simple, "spirituality means waking up." His books, *Awareness* and *The Way to Love*, in particular address the interpersonal applications of "waking up."

This author understands "waking up" as a person's realization of their own potential uncontaminated by their family of origin issues, cultural biases, and unrealistic expectations of the people with whom they are in relationship. In some theoretical circles this "waking up" would be called insight. Insight is a result of spiritual awakening. The catalyst producing the insight is spirituality. Is spirituality Divinely inspired? This author believes so, but belief in the Divine inspiration of

spirituality, a Higher Power, is not necessary for it to be present and operating in any dimension of life, marital therapy or anywhere else. So atheists and people of any and all faiths whether they recognize, acknowledge, and cultivate it or not are spiritual beings having a human experience. An old Arab proverb tells us, “the nature of the rain is the same, but it makes thorns grow in the marshes and flowers in gardens” (deMello, 1990, p.6). The nature of spirituality is the same. It can be intentionally identified and channeled for transformative purposes in marital therapy or it can be disregarded and unidentified yet still be present and operating, as Froma Walsh (1999) states, as an untapped resource. It is not absent; it is unused.

In order for spirituality to be cultivated in marital therapy, there must be a spiritually attuned therapist—not necessarily spiritually attuned clients. Spirituality, the presence and expression of belief in the transformative potential within each person, influences how each therapist approaches the work of therapy. The therapist brings his or her awareness and experience of the transformative dimension to every session but may never mention a divine presence or purpose. It exists as the foundation from which every therapeutic intervention proceeds.

Irvin Yalom, the noted professor of psychiatry at Stanford University and scholar whose work on group psychotherapy and existential therapy is acclaimed worldwide, examined empirical research, philosophy, and literature and claimed that psychotherapy needs to regard people “not as subjects who can, under the proper circumstances, perceive external reality but as consciousness(es) who participate in the construction of reality” (1980, p. 23). Every human being, aware of it or not, is a meaning-making consciousness. Encouraging its cultivation for transformational purposes is the marital therapist’s endeavor in couples’ counseling. Waking up to the awareness that each individual consciousness potentially contains is what this author and Anthony deMello identify as spirituality.

deMello’s Main Concepts of Spirituality

deMello’s understanding of spirituality is based on New Testament tenets and Buddhist, mystical teachings from Eastern religions and traditions. Spirituality means waking up. Most people, even though they don’t know it, are asleep. You know, all mystics—Catholic, Christian, non-Christian, no matter what their theology, no matter what their religion—are unanimous on one thing: that all is well, all is well. Though everything is a mess, all is well. Strange paradox, to be sure. But tragically, most people never get to see that all is well because they are asleep. (1990, p. 5)

He admits the limitations of psychology in

truly helping people to awaken. He states that even the best psychologist or social worker will tell you that people don’t really want to be cured, they want relief because a cure is too painful.

Nothing is more practical than spirituality. What can the poor psychologist do? He can only relieve the pressure. I’m a psychologist myself, and I practice psychotherapy and I have this great conflict within me when I have to choose sometimes between psychology and spirituality. I suddenly discovered that people have to suffer *enough* in a relationship so that they get disillusioned with *all* relationships. (deMello, 1990, p. 12)

He claims that every human being already possesses the happiness relationships are supposed to offer. He states that attachment to the illusions about what people presume those relationships should be is the cause of interpersonal strife.

Further, he claims our emotional dependence upon one another prevents us from truly seeing and hearing each other—let alone truly loving each other. Conventional wisdom says that couples should depend upon each other for their happiness and are entitled to their hurt and angry feelings and behavior if their spouse fails somehow to produce. deMello throws water on that premise and tells people their hurt and anger is their own responsibility and that they need to address it themselves by awakening to their own conditioning and expectations. What deMello encourages is precisely what all the current experts in the marital counseling field are preaching, that is, spouses need to become aware of their own emotional pitfalls and how they interfere with their ability to be the partner their spouse needs them to be.

Negative feelings are in you, not in reality. Stop trying to change the other person. We spend all our time and energy trying to change external circumstances, trying to change our spouses, our bosses, our friends, our enemies, and everybody else. We don’t have to change anything. Negative feelings are in *you*. No person on earth has the power to make you unhappy. There is no event on earth that has the power to disturb you or hurt you. No event, condition, situation, or person. Nobody told you this; they told you the opposite. That’s why you’re in the mess that you’re in right now. That is why you’re asleep. They never told you this. But it’s self-evident. (deMello, 1992, p. 79)

Stated more simply, individuals need to examine, understand, and accept responsibility for their own emotional needs and then be supportive and instrumen-

tal in the same process for their spouse. This is his message in a nutshell. It seems reasonable enough, and easy even to grasp intellectually. However, emotionally it calls our basic beliefs about our roles, responsibilities, and expectations with regard to others into question. So, I'm not supposed to be bothered if my spouse is unfaithful? So, I'm supposed to wall myself off and live like an emotional hermit with connection to no one? These have been the most common responses to the start of the inquiry process using deMello's initial premise that we give others the power to make us feel the way we do. How then are we to make sense of the emotional yearning for connection, and the disappointment when that connection fails us?

In order to answer these questions, deMello explains four steps that cultivate awareness within the individual that would ease the pain of failed connection and encourage the individual to understand the attachments that cause the pain they are currently experiencing. He uses a four step program based on self-observation and understanding (deMello, 1990, p.89).

- Identify the negative feelings.
- Understand that the negative feelings are not in external reality, but inside you.
- Understand that the negative feelings are not an essential part of "I".
- Understand that when you change, everything changes.

Individual responses to particular situations, for instance, infidelity, change from person to person. In Western culture especially, the programming is such that this is taboo, and that the spouse who was "cheated on" is entitled to hurt, angry feelings, even revenge. However, in contrast, there are also those cases where a spouse may be relieved infidelity has occurred or even encourages extramarital sexual activity. So which is correct? The point is that it is the response generated within the individual by their own value system based on their attachment to cultural, moral, and traditional prescriptions that is creating the response. deMello exhorts his readers to take responsibility for their responses by becoming aware of their own programming that creates the attachment and hence the response. He suggests this can be done through rigorous self observation. He says we must cut, scrape, rub and melt the illusions about ourselves and others in order to become aware of the observing "I" within each of us. The "I" refers to the inner awareness all humans possess, the unrealized potential, and the "me" refers to those labels and roles we affix to ourselves and others.

There are no words for "I", but the "I" is never threatened. It's only the "me" that is threatened,

the conditioned-self. (deMello, 1990, p.59). "I" is neither great nor small. "I" is neither successful nor a failure. It is none of these labels. "Me" is generally selfish, foolish, childish. (deMello, 1990, p.77)

deMello uses stories and metaphors to illustrate his point about gaining awareness through self observation in our relationships. One adaptation of a story is about a couple who comes for counseling and the wife complains about her husband's infidelity and how it has made her feel ugly, undesirable, and betrayed. The counselor listens sympathetically and offers a prescription for the husband prompting the wife to thank the counselor very much and claim she feels much better now. Believing it was her husband, not her response to her husband's behavior, that caused her negative feelings, she leaves satisfied with the counselor's intervention.

We always want someone else to change so that we will feel good. But has it ever struck you that even if your wife changes or your husband changes, what does that do to you? You're just as vulnerable as before; you're just as idiotic as before, you're just as asleep as before. You are the one who needs to change, who needs to take medicine (deMello, 1990, p.83).

deMello uses this story to illustrate how under the illusion of the attachment to other people's approval, humans surrender their happiness and their potential for "enlightenment" to other's opinions of them. Translating to the context of infidelity, if my husband is unfaithful, something must be wrong with me. Experts in the field of marital therapy, Frank Pittman, for example, in his book, *Private Lies*, details the myriad of reasons for infidelity, all of which pertain to the person committing the infidelity. Infidelity is a symptom, a destructive one for sure, of a person's fear and inability to articulate and address intimacy needs. Those fears and inabilities distorted by cultural prescriptions of what "love" is and what being "in love" is the grist for the mill of much marital therapy done today. Couples are seldom awake to their individual contributions to the troubled condition of their marriage. The models outlined below are intended to address just that, and they offer ways to do so. The goal of the models, individual insight, however, bears an uncanny resemblance to deMello's spiritual message of awakening. It seems logical then to integrate the two in clinical practice, but spirituality elicits hesitation on the part of many therapists not only because of its ephemeral nature, but also because of its ties to formalized religion and the possibility it could be construed as proselytizing.

Marital Therapy Models and Spiritual Implications Helpful in Social Work Practice

Each of the following models employ different techniques from different theoretical backgrounds to heal marital wounds, such as infidelity. In each, a common spiritual theme, unidentified as such, can be found; they share an understanding that the individual alone possesses the power to form their own response to any such emotional traumatizing event. Each model suggests a different way to elicit this power individually and then use it for the benefit of the marriage.

Susan Johnson's Emotionally Focused Marital Therapy bases its understanding of marital conflict and intervention on attachment theory. Essentially, the marital therapist using this approach identifies the negative interaction cycle being maintained by the partners' intrapsychic experience, particularly their emotional responses, and interprets their behavior as long established emotional patterns; this moves them to an understanding of the damaging impact interpersonally (Johnson, 1996, p. 5). Optimally, they begin to see how their past, ruptured attachments have programmed their behavior and reactions in ways that prevent them from better understanding their own and their spouses' behavior and reactions. The therapist reflects the emotional injury each spouse has sustained and encourages them to see their responses to each other in that context. These are psychological concepts integrating psychodynamic and cognitive techniques commonly used in psychotherapy today, but what is not identified in the model is the spirit of developing potential presumed to be there. In deMello terms, the emotionally focused process would be disidentifying with the "me," the injured portion, and becoming aware of its attempt to heal through emotional demands made on the spouse. Repeating this process with both spouses is intended to result in mutually increased awareness of themselves and their spouse. Optimally, the couple then develops new emotional experiences with one other that create a sense of safety and security in the relationship, which fosters further self as well as other discovery, and the individual as well as the relationship thrives.

All I can do is challenge your beliefs and the belief system that makes you unhappy. All I can do for you is help you to unlearn. That's what learning is all about where spirituality is concerned: unlearning, unlearning almost everything you've been taught. A willingness to unlearn, to listen. (deMello, 1992, p. 17)

Becoming aware of the attachments, those genetically and culturally inherited ideas and behavior, through therapist reflection of client self observation is the com-

bination of psychology and spirituality that deMello describes, "Psychological insight is a great help. It's the 'Aha' experience that counts. When you become aware of your illusions, your addictions, your desires and fears the disappointment in your relationships disappears" (1990, p. 176).

Spirituality is not directly named as part of the process in Emotionally Focused Marital Therapy but it is clearly reflected in its intention. Clinical social workers using an insight-oriented model are encouraging spiritual awareness without the benefit of knowing it. Why would that make a difference? Clinicians could then connect with the couple around the cultivation of the "possible" in their marriage. Couples presenting for marital therapy have some hope their marriage can be saved or at the very least that their relationship has some meaning for one another. Employing an evidence-based model is useful, but it needs to also support and encourage that intangible dimension of hope for serving a purpose in each other's lives. Spirituality does that. It acknowledges and intentionally cultivates the currently untapped potential in the couple to be of service not only to themselves but also to their spouse.

In Integrative Couples' Therapy (ICT), Jacobson and Christensen (1996) offer ways to promote acceptance of the unacceptable emotional parts of spouses, which are the source of the marital discord. Unlike Emotionally Focused Marital Therapy, which is more focused on intrapsychic process, ICT is based on traditional behavioral therapy. It places greater emphasis on ordering and sequencing interpersonal interventions that promote acceptance and change in the couple's interactions. There is a series of intervention strategies each of which includes a number of behavioral techniques (Jacobson and Christensen, 1996). The acceptance interventions are based on turning problems into vehicles for intimacy and the change interventions are based on behavior modification and problem solving techniques (Jacobson and Christensen, p. 93). In their work with couples, they promote acceptance as the paradoxical consequence of letting go of the efforts to change. Partners feel they have permission to change.

To create acceptance through empathic joining...the negative behavior is seen as an example of common differences between people and the polarizations process as part of a natural, understandable, and perhaps even inevitable emotional reaction to those differences...Pain plus accusation equals marital discord; pain minus accusation equals acceptance. (Jacobson and Christensen, p.104)

The spiritual themes present in deMello's teachings are apparent in this form of therapy as well.

Again, the theme of self-awareness, but expanded to include the need for acceptance rather than fear or loathing of what is discovered from the examination process. deMello cautions against self-condemnation and abnegation which commonly result from, and often times prevents, a rigorous self-examination process. He says condemning ourselves for past mistakes is yet another indication we are still asleep. Much like Jacobson and Christensen, de Mello speaks of the virtue of letting go of the effort to change, self or other. Although Jacobson and Christensen offer concrete ways to the marital therapist for producing acceptance and ultimately change, deMello urges his readers to use understanding and observation without interference or judgment:

The harder you try to change, the worse it can get...the more you resist something, the greater power you give to it. How does one cope? In understanding, it disappears. When you turn on the light of awareness, it melts. What you judge you cannot understand. Because if you desire to change what is into what you think *should* be, you no longer understand. (1992, p.38)

The psychoanalytic approach to marital work as demonstrated by Harville Hendrix and Imago Relationship Therapy strongly leans on understanding the past and its impact on the unconscious choices of mate in an attempt to correct any undone or unfulfilled childhood wishes. Deciphering the role family of origin issues play in marital expectations and behavior is central to this form of marital therapy. It underscores the impact family of origin has on individual awareness of unconscious demands made as and by spouses. Many couples' problems are rooted in misunderstood, manipulated, or avoided communications. To correct this, Hendrix developed Imago Dialogue, the core skill of Imago Practice using a communication technique where the couple restructures the way they talk to each other so that what they say is mirrored back to each other, validated, and empathized (Hendrix, 1988). Couples are instructed to use the Imago Dialogue to tell each other about their childhoods, their frustrations, and exactly what they need from each other in order to heal. This is intended to help the couple learn more about the entrenched, inherited ways they and their spouse think and behave and hopefully will reduce "taking personally" their spouses' infractions. This Imago Dialogue process is intended to slow down the automatic response system learned in childhood and to make explicit the heretofore unacknowledged emotional habits creating deleterious effects in the marriage.

In different terms, deMello also considers the impact of early object relations in an individual's cur-

rent functioning.

I live now, not I, but my daddy lives in me." Who's living in you? You think you are free, but there probably isn't a gesture, a thought, an emotion, an attitude, a belief in you that isn't coming from someone else. It's going to take a lot of awareness for you to understand that perhaps this thing you call "I" is simply a conglomeration of your past experiences, of your conditioning and programming. (deMello, 1990, p.44-5)

Knowing why they are doing something is only half the battle. Marital therapists intervene with their interpretation of the effect "projective identification" is having on the marriage and work to correct it. deMello succinctly describes this process in one phrase: clarity of perception leads to accuracy of response.

Whatever a relationship may be, it certainly entails two things: clarity of perception and accuracy of response. You're more likely to respond accurately when you perceive clearly. How can you love someone whom you do not even see? Do you really see someone you're attached to? Do you really see someone you're afraid of and therefore dislike? ...You dislike that person insofar as you fear that person. And you don't *see* that person either, because your emotion gets in the way. Now, that's just as true when you are attracted to someone. At this human level, your likes and dislikes and preferences and attractions, etc., continue to get in the way. So you have to be aware of your prejudices, your likes, your dislikes, your attractions. They're all there, they come from your conditioning. (deMello, 1992, p. 117)

Identifying the projective identification as suggested in Imago therapy translates to clarity of perception resulting in accuracy of response in deMello's spiritual approach.

In summary, deMello's call for awakening crosses over from the psychological to the spiritual. Incorporating spiritual teaching into psychological understanding and interpretation provides a way to convey to the couple the universality of their dilemma and hence foster a positive therapeutic alliance by lessening the inherent "one up" position of the therapist. One of the challenges of psychotherapy is to create an atmosphere of safety where the clients feel comfortable, understood and not judged by the therapist. Integrating the spiritual dimension includes the therapist as a collaborator in grappling with the human condition of the awakening process. Strict adherence to a psychological model of intervention prevents this dimension from

emerging.

Incorporating Spirituality into Clinical Practice

What would spiritual concepts integrated with marital therapy look like in practice? First, consider the chart below that includes the aspects of spirituality described by deMello along with examples of reflections that could be used in a social work interview.

Aspect of Spirituality	Clinical Intervention
Identify the Negative Feeling	<i>Your husband's infidelity feels like abandonment to you. It feels like when your siblings didn't pay to attention to you.</i>
Understand the negative feeling is in you, not the external world.	<i>Your husband's infidelity is about him. He wasn't able to understand your depression so he retreated from the relationship with you.</i>
Understand the negative feelings are not part of the essential "I."	<i>You are not your depression. Depression is passing through you. "I" is the essential part of you that gives meaning to the feelings.</i>
Understand that when you change, everything changes.	<i>You can change your mind about what your husband's infidelity means to you. It can mean something about him, not you.</i>

Case Example

Now, I will provide a more detailed summation of several sessions with a couple; the clinical intervention is delineated in brackets. They presented with a request for help to improve intimacy after the husband had confessed an affair five years earlier. The wife struggled with depression and family of origin abandonment issues and the husband felt guilty and burdened by the sense he was responsible for making his wife happy.

Therapist: (to wife) Tell me a little bit about what it was like growing up in your family.

Wife ("B"): Well, I was basically invisible. I was the only child of my parents' marriage. Both of their first spouses died and my stepsiblings ignored me. I remem-

ber walking around to each of my brothers and sisters, there were 9 altogether, one Sunday morning trying to get them to read me the comic section, and they all acted as if I wasn't there. That's how I feel now with R (husband). He doesn't care that I'm hurt by what he's done. He stays away from me and works in the garden and generally avoids me. **[Identifying the negative feelings inside B.]**

Therapist: That must be difficult to revisit those older, hurtful feelings. How certain are you that R doesn't care you are hurt? Let's check with R about the possibility of another explanation. **[Exploring possibility that the negative feelings she is experiencing do not reside in the external world, that is, they don't emanate from her husband's infidelity or her family's abandonment.]**

Husband: Of course I care. I wouldn't be here if I didn't. I don't know how to fix this. B was so sad, always tired, not like the girl I met in college and married. C (affair) was the exact opposite. Always lively, happy to see me. I didn't have to do anything but show up at work to make her happy. But I felt sick inside being with her. I knew it wasn't right and I still missed B.

Therapist: (to husband) Not knowing how to fix this, how to make someone happy. Have you ever encountered this kind of dilemma before? **[Establishing that B's negative feelings did not come from R, but rather from his own inability to understand or address her sadness.]**

Husband: Oh, sure. I'm the oldest in my family and have four younger sisters who were always coming to me with their money and boy troubles especially after my parents died. That's why I liked B so much. She seemed so independent and able to take care of herself. **[Understanding the source of R's negative feelings, identifying them as internal and illustrating how those negative feelings influenced his original attraction to B.]**

Wife: I had to. Nobody in my family was going to.

Therapist: So both of you are carrying a burden from the families you grew up in.

How much does what you learned about who you were in your families growing up affect your ability to understand who you are as a husband and a wife?

[Integrating psychological concept of family of origin prescriptions as used in Imago Therapy and Emotionally Focused Marital Therapy with spiritual concept of clarity of perception leading to accuracy of response.]

Husband: I suppose it does, but I never thought of it like that.

Wife: I didn't know my being sad was hard for R. I thought he was more interested in work than in me.

Therapist: It is hard sometimes to understand our mate so we make assumptions about why they act a certain

way rather than find out from them why they are acting the way they are. What do you know about yourselves that your mate doesn't know. **[Detailing how perceptions need clarification so responses can become more accurate. Encouraging spouses to share more about themselves so their spouse can have a clearer perception, and hence a more accurate response.]**

Wife: I don't want to be sad. I don't want to need people to make me happy. I'm embarrassed to feel this way. **[Husband now has information about his wife which allows him to respond more accurately in the future.]**

Therapist: What if this sad was only a part of you? What if there were other undiscovered parts of yourself that the sad was leading you to?

[Making distinction between B's negative internal feelings and her essential "I".]

Wife: What do you mean?

Therapist: Within each person there is the possibility to choose how we want to respond to a situation and to understand a situation from many different angles. What if this experience with R instead of being another example of why you should remain sad, was an opportunity to discover that you could be still be happy despite unpleasant events occurring? You've told me how much you enjoy cooking and R says you're the best cook in town. He also says the way you redecorated his office was amazing. Where was this sadness when you were cooking and redecorating?

[Using concrete example of when she was different internally, the external circumstance changed in a positive way. Also, illustrating the potential for transformation within each circumstance.]

Wife: Well, I don't know. It wasn't there. R was being attentive so it wasn't there.

Husband: That's not it. You were humming in the kitchen so I knew I could come in. I could ask you for help with the office because I could tell you were in a good mood.

Therapist: I wonder if in the moments you were in the kitchen you forgot to remind yourself that you are sad so the pleasure you experience in cooking shone through and it led to R sharing in it. **[Reinforcing the spiritual concept of when change occurs internally the external world changes.]**

Husband: That sounds more like it. Like when someone is laughing it is contagious.

Therapist: Yeah. We tend to see things and people as we are, not as they are. It's like we have glasses on that distort our perception of things. If we understand that the glasses are distorting our perception, we can see things more clearly and respond differently. So if we are wearing sadness or the assumption that we have to fix things, those attitudes will be present in all our interactions.

[Generalizing to the human condition, including self in the human failure of misperception. Using spiritu-

al tenet to join with couple.]

Husband: I guess we'll have to keep our eyes on that. It really can get us into trouble if we're not careful.

Therapist: That is for sure. The more you are able to be aware of how your own perceptions may be in your way, the easier it will be to understand each other.

Wife: That seems like a lot of work.

Therapist: How about the alternative? It's pretty much work, too.

This case example is used to illustrate that spiritual tenets of encouraging self-observation and cultivating potential for growth are helpful in a psychotherapeutic environment. This clinical work definitely draws from the models of marital therapy reflecting traditional psychological methods but it includes integrating spiritual teaching in a psychoeducational format, which is geared toward the couple recognizing the greater potential they possess. Following the four basic tenets outlined in deMello's explanation of spirituality enhances the psychological models' effectiveness and provides concrete methods for developing new perceptions, which are the foundation for new behaviors.

Later in the work with these clients, I gave them audiotapes of deMello's book, *Awareness*, and they credited it with the healing of the wounds not only in their marriage but also from their childhoods. They have referred several other couples to me and the therapeutic course has been similar. Not having any empirical evidence on this approach, I cannot state for certain that incorporating deMello's spiritual teachings was the cause of these couples' improvement, but it definitely calls for further exploration. In fact, it was the experience of working with couples in this way that prompted my investigation into current marital therapy models and what they had in common with spiritual teachings. Upon examination of these models I was struck by the presence of spiritual themes running through each model and hence, furthered my investigation.

Conclusion

In conclusion, conducting marital therapy is an important part of a social worker's repertoire of clinical skills. Mastery alone of the models currently in practice is not sufficient because it lacks an emphasis on the importance of recognizing the potential for transformation within each individual. Spirituality, too often an untapped resource, enlivens these models and encourages insight based on self-awareness, not superficial or external changes based on will power. Spirituality, present although unidentified in therapeutic models, lives in the experienced connection between client potential and clinical purpose.

Presence of Spirituality in Marital Therapy Models

The growing interest in spiritual literature among mainstream American readers is indication enough that spirituality and its timeless appeal belongs in the therapy room. Being where the client is, a bedrock principle of social work practice, needs to include

exploring where a client is spiritually—that is, how they understand their purpose and potential in life. Expanding the field of inquiry to include this resource fosters the cultivation of insight and hence, healing in our client's lives.

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Applying Complementary and Alternative Medicine Practices in a Social Work Context: A Focus on Mindfulness Meditation

By Chris Wisniewski

Abstract

Complementary and Alternative Medicine (CAM) practices are becoming more widely used as an adjunct to traditional Western medicine. Mindfulness meditation is one type of CAM practice producing increasing evidence of positive outcomes including reduced stress, improved positive mood states, reduced ruminating and distracting thoughts, increased immune function, and reduced symptoms related to a number of physical ailments. This paper explores mindfulness meditation from a social work context focusing on effectiveness for physical and mental health problems, usefulness as a prevention strategy, neurobiological implications, common treatment modalities, assessment factors, and benefits for the social work clinician. Evidence is analyzed at the micro and macro levels and presented within a biopsychosocial framework, and resources are included for the social worker.

Introduction

Complementary and Alternative Medicine (CAM) consists of approaches to healing that are different from traditional Western medical practices. According to the National Center for Complementary and Alternative Medicine (NCCAM), CAM can be divided into five subcategories which include: biologically-based practices including herbs or vitamin supplements; mind-body approaches including hypnosis and meditation; manipulative and body-based practices including massage, chiropractic manipulation and reflexology; energy medicine practices which include Reiki, therapeutic touch, and tai chi; and whole medical systems which include naturopathic medicine, homeopathy, Chinese medicine, Ayurveda, and Japanese herbal medicine, also known as *Kampo* (Orzech, 2007). See Table A1 in the Appendix for a complete list of definitions of CAM categories.

A 1990 study estimated that one out of three Americans purchased CAM services and more visits were made to CAM providers than primary care physicians (Cook, Becvar, & Pontious, 2000). Additionally, a national survey conducted in 1998 found that 40% of all respondents reported using CAM therapy for various health problems including chronic pain, anxiety, musculoskeletal problems, substance abuse, arthritis and headaches (Cook et al.). Further, a 2004 study of 30,000 adults conducted by the Center for Disease Control National Center for Health Statistics (NCHS) found that 62% used some form of CAM in the past 12 months

when prayer for health reasons was included (Sawni, Ragothaman, Thomas, & Mahajan, 2007). While studies relating to CAM used in children are limited, they have been conducted and show a range of use from 11 to 80% in children with chronic illnesses, and 12 to 21% in pediatric primary care settings (Sawni et al.).

Given the increased usage of CAM therapies in Western culture, it is important for social workers to not only be aware of available therapies but also consider ways to incorporate these therapies into their individual practices. While many of the practices, such as yoga, acupuncture, or Reiki, require training or certification, some meditation practices such as breathing and guided imagery can be incorporated into the therapeutic environment more easily, with less training required. This paper will examine the practice of mindfulness meditation including evidence of effectiveness for physical and mental health problems, usefulness as a prevention strategy, neurobiological support for use with clients at various stages of development, most common treatment modalities, factors to consider during assessment, and benefits and tools for the social work clinician.

What is Mindfulness Meditation?

Mindfulness Meditation is “the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally, to the unfolding of experience moment by moment” (Kabat-Zinn, 2005, p. 145). There is no goal of trying to feel something; rather, the only goal is to see things as they truly are each moment. It involves paying attention to bodily sensations, thoughts, and feelings without evaluation. Instead of trying to move away from uncontrollable experiences, mindfulness encourages practitioners to move toward them and accept uncontrollable experiences as they are. Some of the exercises that are used to teach mindfulness include sitting meditation, walking meditation, hatha yoga, and the body scan. Sitting meditation can involve simply focusing on breathing for various lengths of time or can include focusing on the body, sounds, thoughts and feelings, or choiceless awareness, which is defined as being receptive to anything that arises (Kabat-Zinn, 1990). Walking meditation involves paying attention to the experience of walking, including sensations in the feet and legs or the whole body, and can incorporate the awareness of breath (Kabat-Zinn, 1990). The body scan is an exercise where practitioners lie on the floor and are guided through a process of bringing awareness and breath to each part of the body starting with the toes and finishing

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with the head, and hatha yoga consists of gentle stretching and strengthening done slowly and with awareness of breath and body sensations (Kabat-Zinn, 1990). The attitudes that are necessary for mindfulness practice include non-judging, patience, beginner's mind, trust in self, non-striving, acceptance, and letting go (Kabat-Zinn, 1990). Practitioners learn to pay attention to an object, such as the breath, and when the mind wanders, they come back to the breath again and again. They take on a sort of curious observer role to their own thoughts and sensations and learn to notice them without reacting. As a result, practitioners have reported benefits such as: reduced stress, improved positive mood states, reduced ruminating and distracting thoughts, increased immune function, and reduced symptoms related to a number of physical ailments such as chronic pain, hypertension, heart disease, and cancer (Jain, Shapiro, Swanick, Roesch, Mills, Bell, & Schwartz, 2007; Ott, Norris, & Bauer-Wu, 2006; Cook et al., 2000). Following is a more in-depth look at the evidence supporting the benefits of mindfulness meditation.

Mindfulness as an Evidence Based Practice

The research supporting the use of mindfulness meditation is growing in recent years and the benefits impact both the individual, at a biopsychosocial level, as well as the macro environment.

Biopsychosocial Evidence

Mindfulness meditation has been shown to be related to enduring changes to the brain and brain waves, because how we pay attention promotes neural plasticity (Siegel, 2007). Richard Davidson from the University of Wisconsin has studied the brains of Buddhist monks, and found that they have a left shift in frontal actions, which is related to positive emotional expression and affect (Siegel, 2007). Goleman (2008) discusses Davidson's study that found people exhibiting high levels of brain activation in this same left prefrontal area simultaneously report feelings such as happiness, joy, alertness, and high energy. Additionally, a work-site study looking at the effects of a Mindfulness Based Stress Reduction (MBSR) course on employees also found a significant shift to left side brain activation in those employees who participated in MBSR, and the shift persisted when the participants were tested 4 months later. Those employees who participated in MBSR also had a stronger immune response to a flu vaccine (Kabat-Zinn, 2005). While the shifts in brain activity in the employees at the work-site study were not as strong as those in the monks, the fact that an eight-week course in mindfulness produced the same type of

shift in brain activity as a long-time meditation practice, lends to the effectiveness of mindfulness meditation (Kabat-Zinn).

Goleman (2008) considers another study from Davidson, who found a dramatic shift to left prefrontal function when studying the brain activity of a monk meditating specifically on compassion, implying that generating thoughts of compassion can lead to positive internal states. Goleman notes that most psychological research is focused on alleviating negative states of mind, and the research on the benefits of generating positive states of mind, such as compassion, is almost non-existent. Therefore, this may indicate a new direction for future research on mindfulness meditation and one that is in line with a strengths perspective aimed at building positive states of mind rather than solely focusing on pathology.

In their work on stress reduction, Jon Kabat-Zinn and Andrew Weil (2001) explain how the shifts in awareness resulting from mindfulness meditation actually help to maintain a balance between the sympathetic and parasympathetic nervous systems, reducing the damaging effects of long-term, elevated levels of stress hormones on the body. Fehmi and Robbins (2007) also found that the neurobiological effects of accepting one's present circumstances resulted in the brain producing synchronous alpha waves which allow individuals to operate in an optimal state of balanced alertness and relaxation. Since mindfulness meditation involves the process of accepting the present moment, it appears there could be a link between mindfulness and an increase in the activation of alpha brain waves, implying that mindfulness contributes to this optimal state of relaxed alertness.

Aftanas and Golosheykin (2005) used EEG tests to study the brains of meditators and non-meditators at rest and during evoked negative emotions, and found that individuals who meditate have better capabilities to moderate intensity of emotional arousal. Also, a group of 83 medical, pre-medical, and nursing students participated in a study comparing the effects of mindfulness meditation versus relaxation training on distress, positive states of mind, and rumination and distraction. It was found that both mindfulness and relaxation training reduced distress and improved positive mood states, but mindfulness was more effective in reducing distracting and ruminating thoughts and behaviors (Jain et al., 2007). Jon Kabat-Zinn (2003) studied a group of patients with psoriasis where the study group underwent light box therapy while listening to a guided meditation tape and the control group only underwent light box therapy. Results showed that the psoriasis of the study group cleared up four times faster than that of the control group.

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In a critical review of nine research articles and five conference abstracts related to using mindfulness meditation with cancer patients, Ott et al. (2006) noted that the reported benefits of mindfulness, which included improved psychological functioning, a reduction of stress symptoms, and enhanced coping and well-being, were consistent. Another extensive review of the research found that mindfulness lead to statistically significant, enduring improvements in ratings of pain and general psychological symptoms in chronic pain patients, and a reduction in the levels of anxiety and panic in patients with anxiety disorders (Allen et al., 2006). This review also pointed to a study concluding that mindfulness used in a population of individuals with multiple sclerosis provided patients with a self-help method of symptom management that minimizes physical and psychological dysfunction (Allen et al.). The research also found a statistically significant reduction in binge episodes in a group of 18 women with a binge eating disorder (Allen et al.).

Another study examined the effects of an MBSR course on 10 patients who had sustained a mild to moderate traumatic brain injury. Subjects reported a statistically and clinically significant increased quality of life compared to the control group, and a reported decrease in depression symptoms, which approached statistical significance and would have reached significance if the study were larger (Be´Dard et al., 2003).

From an interpersonal perspective, mindfulness may also be related to secure attachment. Siegel (2007) notes that attuned communication with caregivers allows a child to develop regulatory circuits in the brain, which lead to resilience in the form of self-regulation and engagement in empathic relationships with others. Although not studied as of yet, Siegel has proposed that mindfulness is a sort of attunement with the self, similar to the attunement with a caregiver, and thus may result in similar brain development and resiliency characteristics. This indicates a sort of social impact of mindfulness in that it would lead to more secure social relationships among individuals.

These studies hold great potential for social workers interacting with clients in a variety of settings, and support an encouraging movement toward mindfulness as an evidence based practice. The reported benefits show that clients can be impacted biologically, psychologically, and socially, implying that mindfulness aligns with a social work perspective. However, while this research is very promising, each study inevitably has its limitations and it is advised that the reader reference particular studies cited for more information before utilizing a mindfulness approach with individual clients, or applying it to more macro concerns, which will be reviewed in the following section.

Evidence for Mindfulness at the Macro Level

Given the increasing research on the effectiveness of mindfulness meditation on the individual patient in both physical and mental health settings, it stands to reason that there may also be effects at the macro level. As noted in the studies cited above, mindfulness promotes physical and mental wellness and, once learned, can be used as a life-long tool for managing symptoms, stress, and overall lifestyle behaviors with no maintenance cost. The permanency of the technique, coupled with the increased wellness that results from its use, demonstrates the fact that it has the potential to lead to a reduction in healthcare costs at the macro level. Cook et al. (2000) cite a study that found that the use of the CAM technique, acupuncture, when used with standard protocols for the treatment of cerebral vascular accidents, reduced recovery time by 50% with a cost reduction of \$26,000 per patient. While there are no studies showing the same effect from mindfulness, the American Heart Association is now recommending meditation as a means to decrease stress and therefore lower the risk of heart disease (Cook et al.). Given the prevalence of cardiovascular disease in America, which affects nearly one out of three adults, even a small decrease in the percentage of heart disease patients would have an impact on the healthcare system (American Heart Association, 2008).

There are also indications that mindfulness meditation may contribute to a decrease in criminal behavior and therefore lessen the cost and burden on the criminal justice system. Be´Dard (2003) notes that brain injury can lead to behavioral problems, alcohol and drug use, and criminal behavior. Her study, which showed that patients with brain injury reported an increased quality of life and a decrease in depression symptoms, could imply fewer behavioral problems and potentially less impact on the criminal justice system. Whether applied at the micro or macro level, mindfulness appears to be a useful tool for social workers to consider when helping patients to manage existing symptoms and behaviors. However, there is also support for mindfulness as a prevention strategy and promoter of resilience, which further reinforces its use in and alignment with a social work context.

Mindfulness as a Prevention Strategy

Sadock and Sadock (2003) define anxiety as, “the feeling of apprehension caused by the anticipation of danger, which may be internal or external” (p. 281). Since the definition of anxiety is based on anticipation of an event, mindfulness, by its definition, may be considered an effective technique to prevent anxiety,

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because it trains the mind to focus on the here and now, rather than anticipating the future. Additionally, mindfulness teaches the practitioner to observe emotions without reacting to them and notice that they arise and dissipate on their own and are often based on thoughts that also arise and dissipate on their own. As the mediator learns to observe emotions without reacting, he or she becomes aware that emotions are fleeting mental events rather than accurate reflections of reality, and therefore may not experience the apprehension of anticipated events (Hamilton, Kitzman, & Guyotte, 2006).

Mindfulness has also been cited as an intervention that promotes resilience and leads to the prevention of psychopathology (Hamilton et al., 2006). Depressive schemas from past memories in response to sad moods may trigger depression, so individuals who have well developed negative schemas may be vulnerable to depression and not even aware of it (Hamilton et al.). However, mindfulness teaches people to view their emotions from a distance, recognize the effects of the emotions on their thinking, and challenge the accuracy of faulty appraisals, therefore, preventing the automatic activation of negative schemas (Hamilton et al.). Since negative schemas trigger depression, and mindfulness helps individuals to distance themselves from and then evaluate these schemas, mindfulness may be a strategy for preventing depression. Jon Kabat-Zinn (2000) also notes that building up physical and psychological well-being during lower stress times by using meditation, can act as a preventative measure against stress. So, individuals may be able to reduce the stress they experience by practicing mindfulness on a regular basis.

The research shows that mindfulness may contribute to both prevention and symptom alleviation of physical and mental afflictions. While most of the work cited above has applied to the general adult population, it is noteworthy to comment on the use of mindfulness in clients at various ages and stages of development. The following section discusses the use of mindfulness with these different groups, and explains how neurobiological characteristics at the various levels of development support this.

Using Mindfulness At Various Developmental Stages

Neurobiological changes are abundant in childhood and adolescence, and considering the concept of neuroplasticity, changes continue throughout adulthood into old age (Siegel, 2007). These changes support the use of mindfulness at various stages of development, and it is important for social workers who might be considering a mindfulness approach to understand this interaction.

Mindfulness with Children and Adolescents

In a number of studies conducted on pediatric oncology patients, researchers reported the use of mind-body therapies for the reduction of symptoms including nausea, vomiting, pain, and anxiety, and for the increase in immune function (Kelly, 2007). The therapies cited included hypnosis and imagery for nausea, vomiting and pain, and music therapy for anxiety and immune function (Kelly). The research did not produce many studies on mindfulness meditation in children, per se, perhaps because some of the techniques involve metacognition, and children under the age of about thirteen have typically not yet developed this ability (Urdang, 2002). However, there are neurobiological reasons that support why mindfulness might be a good tool to use more frequently with children. Since the majority of brain growth and development happens in childhood and adolescence, and circuitry that is created and reinforced is more likely to endure and be available in the future, instilling mindfulness practices in children could develop important, healthy "habits" which have lasting effects (Siegel, 2007). Teaching mindful breathing or simple yoga movements to young children reinforces body awareness, but it also may impart a sense of security and self-efficacy because the breath and body are tools that are always available and can be used for self-soothing at any time. In my own internship experience, I taught a 5-year-old client how to breathe in her belly rather than through her chest when she felt nervous so that she could tap into this tool whenever she needed it. Breathing is a great tool to use with children in hospital settings or children with disabilities, who may be limited in their ability to participate in a movement therapy, such as a mindful yoga practice. There are several programs available that adapt yoga and other mindfulness practices, such as karate for children with disabilities, so it is important for social workers to be aware of these programs to make appropriate referrals.

Practices, such as breath awareness, at a young age set the stage for reflective coherence as a child develops into adolescence, and Siegel (2007) proposes that this coherence may result in resilience during the adolescent stage, which is characterized by social and neural changes. Additionally, since adolescents develop the ability of metacognition, they may be able to learn to observe, distance themselves from, and challenge negative schemas, which as referenced earlier Hamilton et al. (2006) suggested might be helpful in preventing recurring depression. Siegel notes that a young adolescent patient who used mindful awareness practices and was able to significantly diminish depressive symptoms and avoid medications.

Therefore, using mindfulness with children

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and adolescents appears to hold great promise as an effective intervention resulting in immediate as well as long term benefits. As Siegel (2007) notes, “when children are reflective, they have the tools to not only experience mindful awareness in the moment, but they are being given the gift of the prefrontal reinforcement for challenging times in the future” (p. 274-275).

Mindfulness With Adults

While adults may not have the same benefit of catching neural pathways as they develop, the concept of neuroplasticity demonstrates that new pathways can be established, and mindfulness awareness seems to promote neuroplasticity (Siegel, 2007). As was demonstrated in the work site study referenced earlier, employees participating in an 8 week MBSR course had shifts in brain activity that endured after a 4 month follow up. Additionally, research supports that elderly patients with chronic pain can benefit from the use of CAM, and it is predicted that CAM use among older adults is growing rapidly (McBee, 2003; Orzech, 2007). McBee conducted MBSR groups at a multi-ethnic, multi-faith, urban nursing home with older adults and noted that patients reported feeling more connected to others and experienced solace, support, pain reduction and reduced agitation on the dementia units. Siegel also cited a case of a 67-year-old woman who feared going to the cardiologist because she believed something was wrong with her heart and she did not want to face it. In a subsequent therapy session with Siegel, the woman had a panic attack while doing a mindful body scan, when the focus was on her chest. At first glance it appeared logical that she would experience anxiety when the focus was on her chest, since that is where she believed her medical problems resided. However, it was later revealed that the anxiety she was experiencing around her heart was related to the unresolved loss of her father when she was a young child. She had never processed the loss, so it remained buried in her body. Using the mindful body scan allowed the client to integrate physical, bodily sensations into the mind so that processing and healing could take place.

Considering that mindfulness appears to hold some promise for enduring changes to the brain, and there are several uses and benefits of a mindfulness practice, it seems to be a logical enhancement to consider integrating into a traditional treatment plan. While MBSR seems to be the most widely used intervention, there are other treatment modalities that incorporate the concepts of mindfulness. The next section will discuss the most common mindfulness modalities.

Mindfulness Treatment Modalities

The mindfulness techniques that appear most frequently in the literature include Mindfulness Based Stress Reduction (MBSR), Mindfulness Based Cognitive Therapy (MBCT), Dialectical Behavior Therapy (DBT), and Acceptance and Commitment Therapy (ACT).

MBSR was developed in 1979 at the University of Massachusetts Medical Center by Jon Kabat-Zinn. It is typically an eight-week group intervention and involves teaching participants mind and body awareness by paying attention to the breath or body sensations. Through this awareness, participants learn to notice internal and external events without reacting in habitual ways, realizing that everything, including pain and pleasure and neutral experiences, are constantly changing and will come and go. The practice typically involves the formal techniques of sitting meditation, walking meditation, body scan, light yoga stretches, and group discussion where students share their experiences about the practice and learn how to develop an informal practice which is the ability to incorporate mindfulness into daily activities such as washing the dishes or driving to work. The idea is to consciously incorporate the concept of mindfulness into daily life, and in time, practitioners may find that it eventually becomes a way of life (Kabat-Zinn, 1990).

MBCT, DBT, and ACT are all based on cognitive-behavioral therapy techniques and focus on teaching patients awareness and the skill to discern problems that should be changed versus those that should be accepted. The idea is that sometimes excessive attempts at fixing a problem can become part of the problem, therefore a focus on acceptance is then encouraged (Henrichsen, 2005). MBCT is typically an eight week group intervention which was designed specifically for preventing depressive relapses by teaching clients to disengage from negative rumination (Allen et al., 2006). DBT typically consists of individual and group sessions held over a one year period, and is most commonly used with patients with borderline personality disorder (Baer & Lykins, 2007; Siegel, 2007). ACT can be utilized for individuals or groups and is centered on helping patients to minimize evaluation and learn to be aware of and accept the present moment and experience a sense of self that is transcendent (Baer & Lykins; Siegel). Clinicians wishing to learn more about these therapies may wish to view the video, “Mindful Therapy,” which is reviewed by Baer and Lykins.

For clinicians wishing to incorporate these mindfulness therapies into their practice, there are differing opinions on training requirements. Generally, it seems that DBT and ACT do not require that therapists

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personally practice mindfulness as long as they gain an understanding of the practice during a training course. However, MBSR requires accreditation which can be obtained through attending one 5-day or 10-day residential, silent retreat and 24 days of MBSR accredited courses which must also include some time in silent retreat (Allen et al. 2006). MBCT training requires a 7 day residential retreat and often involves video-taping therapeutic sessions as a means of ensuring that the newly taught therapist understands the principles correctly (Allen et al., 2006). See Table A2 in the Appendix for a summary of the mindfulness treatment modalities.

Of course, for clinicians who are considering integrating mindfulness techniques into their practice, it is important to consider the values, beliefs, socio-economic status, and overall mental health of each client. The following section discusses factors to consider when integrating mindfulness techniques into one's practice.

Factors to Consider when Integrating Mindfulness into a Therapeutic Practice

While mindfulness is considered a secular practice, it does have its roots in Buddhism, so clients who are of other faiths or of no faith may be apprehensive to try some of the techniques if they feel they would not be in line with their belief system. One way to work with this is to focus more on the actual techniques and cite the scientific evidence of the potential effectiveness of mindfulness. Another approach is to change the language used to incorporate the client's belief system into the practice. For example, rather than just asking the client to label their in-breath or out-breath as such, perhaps it can be suggested that someone of Christian faith could say, "I thank God for this in-breath; I thank God for this out-breath." While this is not cited in the literature, per se, from my experience in a MBSR course, it seems to be a logical way to teach the concepts of mindfulness while respecting and utilizing a value system that has meaning for the client. Adaptations should also be made to incorporate client values and beliefs relating to race and ethnicity.

Of course, mindfulness can be used with anyone, regardless of socio-economic status or education level, although some of the research states that CAM therapies, in general, are typically used more often by members with higher levels of education and socio-economic status and this could be related to the fact that third party payment is very limited or non-existent for CAM treatments (Cook et al., 2007). However, mindfulness may be the ideal CAM therapy to introduce to populations of lower socio-economic status and education because it is simple to learn and is virtually free if it is

already incorporated into the practice of the healthcare worker. There is no maintenance cost or equipment needed to practice. Clients need only to tune into their breath or body sensations and learn to accept the present moment to experience the benefits. However, the challenge might be resistance by clients who are uncomfortable with trying something unfamiliar, so the clinician must continually assess the client's comfort level and make adjustments as necessary.

Another important assessment factor is overall mental health. Although there is very limited research on the risks of mindfulness meditation, it was found that transcendental meditation has, in some instances, triggered unusual behavior, grandiosity, and depersonalization (Allen et al., 2006). It was also noted that some people with a history of psychosis or schizotypal personality disorder experienced psychosis after meditation (Allen et al., 2006). Allen and colleague note that more research is needed in this area and indicate that mindfulness might be useful with some patients exhibiting psychotic problems, but it is advised that this be considered carefully and with close supervision.

Mindfulness and the Social Work Clinician

While much of the earlier discussion has emphasized the importance of understanding how mindfulness can benefit the client, it is also noteworthy to discuss how it can benefit the social work clinician. Following is a discussion of how mindfulness can be used both personally and professionally to improve self-care and the effectiveness of one's therapy practice. A list of resources and readings is included in the appendix, which can be used by clinicians wishing to learn more about mindfulness for themselves or refer patients to mindfulness resources.

From a practice perspective, mindfulness may contribute to a more successful and effective practice because it teaches and strengthens skills that are vital for the social worker to master. Learning to be present each moment could enhance the social worker's empathy and ability to develop a solid therapeutic alliance since clients will most likely feel more "felt" by the social worker's ability to be with them right where they are, in the present moment. Additionally, developing the skill of non-judgmental, non-reactive acceptance of reality as it unfolds may help the therapist to remember to accept the client as the expert and respect her right to self-determination. Rather than react in habitual ways or in ways that the therapist thinks would be best for the client, reserving judgment and reaction may allow the client to feel more free and more in control of his or her treatment. Finally, as social workers learn to be more aware of their own thoughts, feelings, and sensations

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through the practice of mindfulness, they will likely be able to identify transference and counter-transference reactions more quickly and clearly, and use these to influence treatment. While there does not appear to be very much literature to support these positions, the nature of mindfulness seems to lend itself well to many of the social work practice competencies and warrants further research.

From a self-care perspective, social workers, like clients, could also benefit from the stress reduction experiences of a mindfulness practice. Many social work positions are physically, mentally, and emotionally challenging, and this could lead to health problems or burn out for the clinician. Social workers need to practice self-care to minimize the potential negative effects of the job on their health and well-being. Using mindfulness as a strategy to prevent and manage stress and anxiety can be considered one way to do this. Also, the benefits of such a practice might be transferable not only to clients, but also to anyone interacting with the clinician. For example, if the clinician develops a calm, non-reactive, receptive attitude, this will invariably impact the individuals who interact with her, and may even encourage those individuals to feel or act more calm, non-reactive, and receptive themselves. Perhaps this could be considered a sort of systems perspective of mindfulness since it involves the relationship between person and environment and the idea that change in an individual can impact the whole. Overall, social workers integrating mindfulness into their practice may not only be able to better support their clients, but, in the process, they may enhance their own abilities to manage stress and enjoy some of the wellness benefits of mindfulness meditation.

Conclusion

So much of our culture today is focused on future planning and quick fix solutions to problems. Technology devices take us on virtual tours away from the present moment, and products such as anti-aging creams reinforce the delusion that old age can be avoided. It is difficult to avoid these messages and prevent them from becoming ingrained into our psyches and part of our unconscious ways of relating to the world. However, ancient philosophies teach us that pain and suffering are inevitable parts of life and the energy spent trying to avoid these or desiring other circumstances actually cause more suffering. Mindfulness offers a way to accept life as it presents itself each moment, thereby eliminating the additional suffering caused by avoidance. As social workers working with entire systems, we have the ability to help a great number of people eliminate this unnecessary suffering through educating them about the mindfulness practices that are available to them. While more extensive research is required, the current research offers a solid starting point for demonstrating that mindfulness can be an effective approach for treating clients with existing physical and mental health problems, and preventing problems and promoting resilience, and possibly even compassion, in those who are healthy. There is a great opportunity, and perhaps even a responsibility, for us to reduce unnecessary suffering in the world, and quite ironically, it can be done with tools that we and our clients already and have always had – our minds, our bodies, and our breath.

Chris is completing her MSW at Loyola University, Chicago. She is currently enrolled in a summer block placement at La Rabida Children's Hospital and Willow House, which is an agency providing supportive services for children, teens, families and communities who are coping with death and dying. Her first year placement was at the Child and Adolescent Services Program of the Counseling Center of Lakeview where she provided counseling and case management for children and families. She has also worked at the Rehabilitation Institute of Chicago for the past 5 years in human resources, community service, and staff education. Chris' MSW specialty is centered on children and families, but she also has a strong interest in healthcare and wellness and is particularly interested in incorporating mindfulness meditation and Complementary and Alternative Medicine therapies into her future social work practice.

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Appendix

Table A1

Categorization of CAM therapies by the National Center for Complementary and Alternative Medicine

Type of CAM	Definition	Examples
Alternative Medical Systems	Complete systems of theory and practice	Homeopathy, naturopathy, traditional Chinese medicine, Ayurvedic medicine
Mind-Body Medicine	Variety of techniques designed to enhance the mind's capacity to affect bodily function and symptoms	Meditation, prayer, mental healing, art, music, or dance
Biologically Based Therapies	Substances found in nature	Dietary supplements, herbal products, and the use of other so-called "natural" but as yet scientifically unproven therapies
Manipulative and Body-Based Methods	Manipulation and/or movement of one or more parts of the body	Chiropractic or osteopathic manipulation, massage
Energy Therapies -Biofield Therapies	Intended to affect energy fields that purportedly surround and penetrate the human body	Qi gong, Reiki, therapeutic touch
-Bioelectromagnetic-Based Therapies	Involve the unconventional use of electromagnetic fields	Pulsed fields, magnetic fields, or alternating current or direct current fields

From: Kelly, K. (2007). Complementary and alternative medicines for use in supportive care in pediatric cancer. *Support Care Cancer*, 15, 457-460. DOI 10.1007/s00520-006-0162-2.

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Table A2
Summary of Mindfulness Treatment Modalities

Modality	Format	Population	Training Required For Social Work Clinician
Mindfulness Based Stress Reduction (MBSR)	8 week group format	Typically indicated for clients experiencing stress, anxiety, depression, chronic pain	One 5 or 10 day silent residential retreat and 24 days of accredited MBSR courses which must include time in silent retreat
Mindfulness Based Cognitive Therapy (MBCT)	8 week group format	Clients at risk for depression relapses	7 day residential retreat and video-taped therapeutic sessions
Dialectical Behavioral Therapy (DBT)	1 year - individual and group sessions	Clients diagnosed with borderline personality disorder	DBT training course – no requirement to practice mindfulness or attend a retreat currently
Acceptance and Commitment Therapy (ACT)	Individual or group format	Clients whose excessive rumination on problems and difficulty with acceptance causes impairments in normal functioning	ACT training course – no requirement to practice mindfulness or attend a retreat currently

Resources & Suggested Readings

(Adapted from resource booklet distributed at the MBSR Course run by Dr. Chris Chroniak at The Insight Center, Chicago, March 2008)

Local Meditation Groups

Chicago Vipassana Sitting Group
3166 N. Lincoln Ave, Ste 224, Chicago
773-903-7703

Shambhala Meditation Center of Chicago
7331 N. Sheridan Rd, Chicago
773-743-8147

Insight Chicago
www.insightchicago.org

Websites

Acceptance & Commitment Therapy: <http://www.contextualpsychology.org>

Dialectical Behavioral Therapy:
<http://bpd.about.com/od/treatmentoptions/a/DBTprofile.htm>

Mindfulness Based Cognitive Therapy:
<http://www.mbct.com/Index.htm>

Mindfulness Based Stress Reduction:
<http://www.theinsightcenter.com/page4.html>

Yoga classes in Chicago:
<http://www.yogachicago.com/>

Suggested Readings

Dalai Lama. (1998). *The art of happiness*. New York: Riverhead Books.

Goldstein, J. (1994). *Insight meditation: The practice of freedom*. Boston: Shambhala.

Kabat-Zinn, J. (1994). *Wherever you go, there you are*. New York: Hyperion.

Kornfield, J. (2000). *After the ecstasy, the laundry*. New York: Bantam.

Martin, P. (1997). *The healing mind: The vital links between brain and behavior, immunity and disease*. New York: St. Martin's Press

Nhat Hanh, T. (1991). *Peace is every step: The path of mindfulness in everyday life*. New York: Bantam.

Siegel, D. (2007). *The mindful brain*. New York: W.W. Norton & Company.

The Impact of Parental Incarceration on African American Families

By: Deresha D. Gibson

Abstract

African Americans make up 12% of the United States population and almost 35% of the prison population. African American men and women are disproportionately overrepresented in the criminal justice system. The incarceration of these men and women directly impacts the families and communities awaiting them upon their release. Some of the areas impacted are family relationships, finance, employment, and health. This article will investigate how parental incarceration impacts families and communities, discuss implications for social workers, and make recommendations for intervention and policy.

G is a 24 year old African American male, currently awaiting sentencing on a drug offense that carries a minimum of 10 years to life imprisonment. This situation adds to an already difficult life. His parents had substance abuse problems and involvement with the criminal justice system throughout his life. At the age of 12, G became the primary caregiver for his younger sister and was forced to drop out of school. At the time of his arrest he was her guardian. Additionally, he has a fiancé and two children, a son (6) and a daughter (5). G provided financial and emotional support, assisted with caregiving, and was a constant figure in his children's life. G's children, struggling with his absence, are having sleep difficulties and exhibiting withdrawal behaviors. They visit him every two weeks and count down the days until they see him. G's fiancé hopes when he is sentenced that he is not moved too far away so they will still be able to visit. If G receives the mandatory minimum of ten years, his children will be 16 and 17 when he is released. He will have missed their childhood and some of the most important times in their life. Although he can connect with his family through letters and visits if possible, his absence will have a dramatic impact on his children and the relationship with his fiancé.

Introduction

While tragic, unfortunately, G's case is not an anomaly. African Americans are only 12% of the U.S. population, but they make up over 35% of the prison population (Sabol, Couture, & Harrison, 2007). The Pew Center on the States recently released a study that found 1 in 100 adults are behind bars (Warren, Gelb, Horowitz, & Riordan, 2008). This study also found that

among African Americans the statistics are startling. Among African American males ages 20-34, 1 in 9 is behind bars. Among African American females in their mid- to late-30's, the average is 1 in 100. This rise in incarceration among African Americans has been attributed to the "war on drugs." Prior to this social policy, the drug arrest rate for African Americans was 684 per 100,000 or 77% greater than that for whites. With the inception of the "war on drugs," the arrest rate for African American drug arrest increased 225%. By 2003 African Americans were 3.4 times more likely to be arrested for a drug offense than whites (King, 2008). Incarceration creates collateral consequences that limit the ability of ex-offenders to secure employment, participate in the political process, get medical care and public assistance, and have proper housing (Williams, 2006). This will significantly impact the families of those incarcerated and the communities they are returning to.

This problem has long been recognized as having detrimental effects to the African American family and the community in general. In a paper titled, "The Impact of Incarceration on African American Families: Implications for Practice," King (1993) stated,

Unless social service agencies and professionals begin to address the problems incarceration creates for African American men and their families, imprisonment will become the most significant factor contributing to the dissolution and breakdown of African American families during the decade of the 1990s. (p. 145)

While this call for action occurred 15 years ago, there are severe deficits in the responses to this issue on the micro-, mezzo-, and macro levels of practice. Thus, I seek to bring this issue to the forefront of our agenda as a profession. This article investigates the impact parental incarceration has on the incarcerated parent, his/her children, and the children's caregivers, and it considers social work implications on all levels of intervention.

Impact of Parental Incarceration

Parents and their Children

About half of all parents in state prisons are African American and 7% of all African American children currently have a parent in prison (Mumola, 2000). The incarceration of a parent significantly alters the family structure. Although the family structure may

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have been unstable and fragmented before, the stress of incarceration threatens to destroy the family system. "Children retain bonds and love for parents regardless of the label attached to these parents by society. However, once a parent is incarcerated research has found that children experience feelings of shame, stigma, blame, guilt and anger" (Browning, Miller, & Spruance, 2001, p. 91). Children may feel as though they are carrying around a secret or trying to protect the image of their parent from people that speak about them in a negative manner. They may also feel abandoned and struggle with feelings of anger and love.

There is evidence to suggest that the impact of parental incarceration may be different depending on whether the mother or the father is incarcerated. Because mothers are often the primary caregivers for children before being incarcerated, their sudden exit out of their children's lives can be devastating. In a study that investigated the differences in risk factors for children and families of incarcerated mothers and fathers, Dellaire found that a little over half of children with incarcerated mothers were in the care of their grandparents. However, children with incarcerated mothers were more likely than minor children with incarcerated fathers to be in nonfamilial living situations such as foster care, another agency or institution, or living with a family friend. The majority of children with incarcerated fathers were in the care of their mothers. In a study that investigated the impact of maternal incarceration on families, Sharp & Marcus-Mendoza (2001) found that women reported the loss of their parental status and identity as a consequence of incarceration. Thus, children of incarcerated mothers and noninvolved fathers are particularly at risk for severe attachment difficulties.

Due to the attachment issues faced by the incarceration of mothers, children are at risk of developing psychopathology, entering the criminal justice system, and developing substance abuse issues later in life. Sharp Marcus-Mendoza (2001) found that mothers reported that their children experienced difficulties at school and problems with alcohol, drugs, and depression. Dellaire (2007) also found that incarcerated mothers of adult children reported that their adult children were 2.5 times more likely to be incarcerated than adult children of incarcerated fathers. This disruption in attachment may be further compounded by a host of contextual factors, such as parental neglect, erratic behavior, and abandonment.

While the impact of an incarcerated mother can be grave, it is important not to minimize the impact of an incarcerated father.

Due to the 'war on drugs' African American men are arrested, convicted and incarcerated at rates higher and longer than other racial and ethnic

groups. As a result, there has been an excessive removal of African American men from their communities, creating an emotional, social and financial void for their children and families. (Williams, 2006, p. 3)

A father's incarceration could mean financial instability and loss of childcare and social support for the family (Hairston, 2002). Mumola (2000) found that nearly half of all incarcerated fathers were living at home with their children before incarceration. African American males are often thought of as the forgotten parent in the prison population. Because of society's negative view of fathers and African American fathers, in particular, there is often only a focus on the mothers' role in their children's life, and fathers that are incarcerated do not seem particularly important (Browning et al., 2001). In a study that investigated the incarceration of fathers and intergenerational social exclusion, Foster and Hagan (2007) found that a father's incarceration contributed to educational retention in their children, which resulted in forms of social exclusion when they became adults. Problems children experience due to the absence of their father such as issues of socialization, financial struggles, and issues of neglect can contribute to the "disadvantage process that diminishes the educational success of children" (Foster & Hagan, p. 421). Foster and Hagan also found that a father's absence as a result of incarceration may contribute to the homelessness of daughters. The presence of biological fathers serves as a protective factor for daughters during puberty. "An unanticipated vulnerability is daughters leaving home and becoming homeless in early adulthood as a result of the replacement of biological fathers with abusive non-biological adult males entering the home following the father's incarceration" (Foster & Hagan, p. 422).

Contact between father and child is important to the well-being of both and to the maintenance of family ties, particularly given the rather lengthy sentences African American men tend to face. The telephone and mail become very important in these situations. Parents are often held over 100 miles away from their permanent home and family may be unable to visit (Mumola, 2000). Incarcerated fathers report that the decline in the quality of their relationship with their children is a major issue. Wondering if another man will take their place while incarcerated and being unable to have a relationship with their child(ren) has an impact on the mental health of incarcerated fathers (Tripp, 2001). Browning et al., (2001) write,

It is critical for the father to maintain contact with his children to prevent the socialization process from moving from the family and into the prison setting. The behavioral/socialization patterns

learned in the isolation realm of prison teaches one how to behave in prison, not as a family member and makes the reintegration process and responsible fatherhood more difficult. (p. 92)

Thus, impacts of incarceration are clear for both parent and child; however, attention also must be given to other key figures in the family system.

Caregivers

Relatives that provide care for the children of incarcerated parents are also significantly impacted. Often the grandmother of the children will become their primary caregiver if children are not sent to foster homes. Caregivers are often living on fixed incomes and have other responsibilities. They may experience economic difficulties, health problems, and stress due to the overwhelming new responsibilities. "Female incarcerations are particularly harmful to the family system. They place three generations at risk and destroy families, leaving lasting scars on children as well as putting enormous financial and health burdens on grandmother caregivers" (Ruiz, 2002, p. 190).

Caregivers may try to maintain a relationship with the incarcerated parent, which may be difficult, while trying to manage the daily responsibilities of raising grandchildren. When restrictions are placed on the child's ability to visit the parent (i.e. distance of correctional facility, restrictions due to nature of parents' crime, or child's age), it may be difficult for the caregiver to help the child cope with that loss. When communication is possible, it is crucial to maintain healthy exchanges between incarcerated parents, children, and caregivers. Hairston (2002) states,

Communication between prisoners and their families provide the most concrete and visible strategy that families and prisoners use to manage separation and maintain connections. Families visit their imprisoned relatives at the institutions where they are held, talk with them by phone and exchange cards and letters as a means of staying connected. These contacts allow caregivers, parents and children to share family experiences and participate in family rituals, (e.g. family celebrations, religious observances, etc.) and help them to remain emotionally attached. Incarcerated parents are assured that their children have not forgotten them and children that their parents love and care for them. This communication allows prisoners to see themselves, and to function in socially acceptable roles rather than as prison numbers and institutionalized dependents. (p. 9)

This communication helps the child understand the roles of his caregivers and his parents in his life.

Although communication is very important, it may be difficult to maintain. An impediment to healthy communication is the resentment that may be held against the incarcerated parent by the caregiver. This resentment could be due to a caregiver's anger about the parent being incarcerated, having to unexpectedly take on small children, and being stressed due to the additional life responsibilities and loss of freedom. This resentment could strain the parent-caregiver relationship and cause communication between the child and parent to be limited or on the caregiver's terms. Communication between the child and parent could also be strained due to anger the child may have because of the absence of his parent. This is especially true if the child does not know where his parent is or why he is absent. To alleviate some of these problems, caregivers and parents should try to come to a decision about how the parent's absence will be handled. Further, a focus of the dialogue must be in preparing for the eventual reentry of the parent into the family system and what this will mean for the parent, child and caregiver.

Reentry

Incarceration interferes with social networks by disrupting marriages, families and friendships. "Reentry can also impact support networks and reciprocity negatively. Issues such as caregivers maintaining families while parents are incarcerated, obtaining shelter, finding employment upon release, and repairing relationships can help to negatively impact networks and reciprocity" (Rose & Clear, 2002, p. 13). Families may have moved on while a parent was incarcerated and if communication was not maintained, the parent may feel like an outsider.

Mothers may find it challenging to be reunited with their children. Hagan & Coleman (2001) writes,

A 1997 law called the Adoption and Safe Families Act (ASFA) was initially created to protect the best interests of children in foster care. The ASFA requires that states make reasonable efforts to reunite children with their biological families. There was concern that children may have been returned to unsafe environments. As a result the ASFA was modified and mandated the termination of rights of legal parents when a child has been in foster care for 15 or more of the past 22 months. (p. 359)

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The average sentence of an incarcerated mother is 18 months, which almost assures custody will be terminated (Genty, 1998; Travis et al., 2005). This negatively impacts the parent-child relationship by making it difficult for the parents to regain custody of their child(ren).

Employment is another major area of concern. "Jobs available for ex-offenders tend to be low paying and highly unstable. Ex-offenders may have to maintain 2-3 jobs to make ends meet. Many are unable to find employment and opt for unemployment" (Rose & Clear, 2002, p. 10). Underemployment and unemployment may cause tension in families, which could lead to interpersonal violence and place the family at further risk of destruction. The ex-offender may then rely on family support, which could strain an already fragile relationship or return to a life of crime to support him/herself.

Rebuilding relationships also poses a problem for the incarcerated parent, children, and caregivers. Rose & Clear (2002) write,

Reentry poses ex-offenders and their families with a challenge: whether or not to rebuild the relationship. Rebuilding the relationship means relations can be restored, resulting in enhanced levels of trust and empowerment, both within the family and within the community at large. Choosing not to rebuild, however, impacts levels of trust, norms and values and an overall sense of belonging. (p. 13)

Relatives may have to regain trust with the ex-offender or may enable the person by not allowing him/her to find their own way. This is particularly true if the family was victimized by the ex-offender. The lack of trust could play a role in how the ex-offender is perceived and how he/she reconnects with the family and community.

Roles within the family are likely unclear. Rose and Clear (2002) found that while family and friends may be glad to be reunited with those who have been incarcerated, the social networks suffer another strain: trying to figure out how to reincorporate ex-offenders who are relearning how to be parents. This could be particularly hard for mothers who are no longer the decision makers for their children and may find it difficult to find their place in their children's lives. "Incarcerated parents' efforts to renew parenting roles as members of households where other adults have been children's primary caregivers seem to cause tension and create more stress when parents have not discussed and agreed on role changes" (Hairston, 2007, p. 27). The parent-child-caregiver relationship may experience undue stress due to triangulation. While the parent is trying to reclaim her parental territory, the caregiver

may not trust the parent's judgment or may believe she needs to protect the child. As a result the parent and caregiver may enlist the child's support against each other putting pressure on him (Worden, 2003, pg. 19).

Several other areas of adjustment might cause stress in the system. The stigma families' face about their relatives' incarceration also plays a role in how relationships will be reestablished. Family members that are left behind may face stigma about a relative's incarceration. They may feel awkward about having to explain the "reappearance" of a relative. The ex-offender, on the other hand, may struggle to unlearn the lessons useful in prison life which could be problematic in developing relationships and readjusting to family life.

Health issues are another factor in the reentry of ex-offenders. "Prisons often house inmates from communities disproportionately affected by health inequities and in turn return sick people to those same communities" (Moore & Elkavich, 2008, p. 784). Ex-offenders may have health issues such as chronic and infectious diseases and mental illnesses that may go unattended upon their return to the community.

A 1997 study found that almost one fourth of all people living with HIV infection or AIDS were released from a correctional facility in the same year, as were almost half of all the people with hepatitis C infection and more than one third of all people who had TB disease. (Hammet, Roberts, & Kennedy, 2001, p. 391)

Researchers are also investigating the link between the high number of HIV positive African American women and their male partners that have been incarcerated. Maintaining these health conditions could put a strain on family members and become rather stressful, particularly if the ex-offender is not complying with his or her medical regime.

Implications for Social Workers

Due to the large number of African American men and women that are incarcerated, it is important that social workers working with families be knowledgeable about how incarceration may impact the family system. Social workers can be instrumental in helping create interventions for this population on many levels.

Micro level interventions

On the micro level, it is critical that the individual impacts of incarceration on children in areas of maternal and paternal incarceration are recognized. Because these risk factors differ based on whether the mother or father is incarcerated, it is important that pro-

The Impact of Parental Incarceration on African American Families

grams are created to identify these children and work to provide support and protective factors in their lives. When children consistently see relatives cycling in and out of prison, it can become the norm in the community. "Prison is increasingly viewed as an almost inevitable aspect of the maturation process for many low-income children of color, in the same way that the expectation of going to college is the norm in many middle class communities" (Mauer, 2004, p. 612).

Programs that support familial caregivers are also important to help prevent burnout and help the caregiver understand what the child may be feeling emotionally. In the past, little financial and emotional support have been given to relatives that act as caregivers compared to the financial and social supports afforded foster parents. In addition to taking on small children, caregivers have to worry about financial matters, health concerns, and childcare. There is a need for programs that help caregivers navigate the system and get the assistance they need. It is also imperative that programs help caregivers and parents establish clearly defined roles to prevent occurrences of triangulation while the parent is incarcerated and upon release.

When creating clinical programs to assist offenders and their families, it is important that they are culturally appropriate. Family support groups for instance can help families address issues that undermine the family's level of functioning. Clinicians cannot underestimate the importance of support groups being established that are "based on the values, attitudes and beliefs of African American cultures. The goal is to help families become more effective African American families, not caricatures of successful European American families" (King, 1993, p. 150). Clinicians must also be cognizant of the issues faced in African American communities, such as racism, negative social and cultural identities, a sense of hopelessness created by constant struggle, and the notion that "black men are essentially born with the stigma of a felony conviction" (Mauer, p. 611).

It is also crucial that incarcerated individuals and those that are released have healthcare issues addressed, including substance abuse treatment and mental health counseling, if needed. More often than not, an individual's substance abuse or mental illness is a factor in his or her incarceration. It is imperative that these issues are addressed and a continuum of care is put into place upon release to decrease the likelihood of individuals re-offending.

Mezzo level interventions

On the mezzo level, programs need to be created in targeted communities where there is a large number of individuals being incarcerated and reentering the community. These programs can be established within

churches, social service agencies, and community based organizations. Because incarceration destabilizes the community, creating programs within the community not only works to stabilize communities, but also "meets the clients where they are," in a familiar environment with people from their community. Organizations can help ex-offenders with reintegrating into the community by providing help securing employment, linking clients to public programs and mental health services, and providing assistance with health care. These organizations can also help families with an incarcerated family member cope with that burden and work to stabilize the family. Ex-offender programs and family support services could help families cope with hardships and problems that threaten cohesion (King, 1993). Ex-offender programs must also be advocates for their clients. A huge problem is the stigma attached to being a "felon." Finding employers to hire ex-offenders and other programs that are willing to give them a second chance is crucial to their success.

It is important that schools of social work provide information about mass incarceration and its impact on families and communities, specifically families and communities of color. In addition, students must be provided with the knowledge to work with this population. It is crucial that researchers and instructors develop and teach models of evidence-based practice in working with this population.

Macro level interventions

When approaching this issue on the macro level, it is important to remember that the disproportionate amount of African Americans incarcerated is not a new phenomenon. However, policy makers do not seem to have acknowledged the full impact of mass incarceration. Life does not stand still while parents are incarcerated. Children still need their parents at critical times in their life and if their parents are not available and protective factors are not in place detours will be made. Are we really creating a safer society by imprisoning millions of parents? If we believe it is in the best interest to incarcerate an individual, are we obligated to make sure they are rehabilitated and not just punished for their crime? What is society's responsibility to the children of these parents? The reality is that we do have an obligation to the parents and their children. By incarcerating these parents, additional risk factors may be created, which means unless we provide protective factors the cycle of incarceration will continue.

Social workers have the opportunity to get in on the "ground floor" and make a difference in the lives of families that are being forever transformed. We can become advocates for incarcerated individuals and their families in a significant way by working to ensure poli-

cies are created that are sensitive to the needs of individuals and their families and help and not hinder them. President George W. Bush recently signed into the law the “Second Chance Act” (PL110-199), which is legislation designed to reduce recidivism, by expanding job training, providing mentoring, and assisting ex-offenders with securing housing and transitional services. This legislation has the expressed intent of ensuring individuals have the tools they need to be successful upon release. It is necessary to evaluate whether the “intent” is effectively implemented and to provide supplemental legislation, as needed.

Another significant legislation is the Kinship Caregiver Support Act (H.R. 2188), introduced in 2007 to help alleviate the financial, physical, and emotional difficulties caregivers may incur by creating programs that provide financial assistance and information about services available for families (i.e. housing assistance, childcare, health insurance, and educational assistance). At the time of publication, this bill is still in the first stage and has not been passed. It is necessary that policy is in place to support caregivers as they are crucial in supporting the loss experienced by a child with an incarcerated parent.

Social workers must advocate for more legislation and policies to be put into place and funded that work to assist incarcerated individuals and their families. Incarceration in the African American community is becoming a generational curse or what some have called a “rite of passage.” It is unacceptable that one of every three African American boys born today can expect to go to prison (Mauer, 2004). Social workers are in a position to help break the cycle and keep families together.

Conclusion

There are currently over two million men and women being held in prison and jails in the U.S.

Although parental incarceration and the collateral consequences that accompany it are not unique to African Americans, the fact that African American men are disproportionately over represented in prisons and African American women are entering prison at an increasing rate is a cause for alarm. The incarceration of this population directly impacts the African American family, which will impact communities.

As social workers, we must rally around these families and end the cycle of hurt and destructive behaviors that result from incarceration. In summary, we, as a profession, must:

- Develop and utilize evidence-based practices in working with these families
- Ensure that the children, incarcerated parent, and the temporary caregiver have access to social-emotional support
- Create more programs to ensure family ties are maintained if it is in the best interest of the children
- Reevaluate criminal justice policy and look at alternatives to incarceration for nonviolent offenders
- Modify laws, such as ASFA, to be more sensitive to the needs of the family system to maintain familial connections
- Focus on policy that prevents recidivism by ensuring that individuals have access to secure employment, housing, and medical assistance for chronic illnesses

The incarceration of African American men and women, while ever present in the media, has not been portrayed in a manner to look at the effects on all members of the system. Now, we have the opportunity to take action and realize that by ignoring the consequences of incarceration occurring on multiple levels, we have a hand in the destruction of families and communities.

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Changing the Culture of Nursing Homes

By Megan Seliga

Abstract

Long term care is an industry in crisis as evidenced by record high staff turnover and negative media coverage, fueled by a proliferation of abuse and neglect violations. The need for reform in the long term care industry is intensified by staggering predictions of industry growth given projections of dramatic expansion among the elderly as a demographic. Organizational culture, which has traditionally adhered to a medical model of care, emerges in the literature as the primary culprit for low staff morale and turnover. The benefits of resident-centered approaches to care are discussed, and strategies for adopting resident centered models, such as the direct empowerment of clients and front line staff, are presented. The role of leadership in effecting lasting culture change in long term care is discussed and acknowledged as critical to the success of culture change efforts.

Introduction

Caregiving organizations reflect the diversity and complexity of the needs presented by its consumers, who comprise some of the most vulnerable members of our society. The task of assessing the effectiveness of such organizations is of paramount importance given the potential for human suffering and loss that accompanies the delivery of services. Kahn (2005) defines a caregiving organization as “an institution whose members directly provide for people who seek healing, growth, ministry, learning or support of one kind or another” (p. 4). Elderly adults comprise a growing demographic and encompass many of the individuals who seek the healing and support of caregiving organizations. Bond (1999) lends a sense of urgency to this trend by sharing the following projection: It is estimated that by the year 2030 approximately 70 million people will be over the age of 65 in the United States and the number of individuals who will become residents of long term care facilities will increase from 1.3 million in 1996 to 4.4 million in 2040. This staggering forecast of healthcare need is intensified by a proliferation of research alluding to an industry wide crisis. These points constitute strong arguments for the prioritization of the nursing home setting as a target of reform. This paper is devoted to an examination of strategies for improving the quality of care in nursing homes in light of predicted increases in demand for such services. I begin by providing evidence for a crisis in the current

state of nursing home care and proceed to a discussion of the central role that organizational culture plays in supporting or inhibiting quality care. The adoption of resident-centered approaches and decentralized decision making are discussed as primary strategies for effecting culture change based on a review of the literature. The paper concludes with suggestions for future research.

Current State of Long Term Care

Faced with turnover rates well over 50%, absenteeism, call-ins, thefts, filing case worker compensation claims, criminal records, abuse violations, low morale and low job satisfaction, and negative media coverage, who would want to end up in a nursing home as a resident or employee? (Deutschman, 2005, p. 249)

The issues of high staff turnover, low staff morale, and safety concerns are recognized in the literature and are compounded by looming predictions of industry growth. Brunk (1996) echoes Deutschman’s sentiment by declaring, “Something’s rotten in the state of long term care” (p. 39). Brunk (1996) continues by offering the following analysis:

Low morale deflates today’s frontline caregivers for a number of reasons. For one thing, they’re asked to bathe, dress, and feed a burgeoning population of demented residents, often for little more than minimum wage. They’re often left caring for more residents than they should be, especially when colleagues call in sick or quit on a moment’s notice, and supervising staff rarely show appreciation for their efforts. (p. 39)

Excessive work demands contribute not only to low staff morale but to an increased risk of physical injury, which remains high in nursing home settings. Deutschman (2001) reports that, in 1994 there were 16.8 injuries per 100 workers, which places the nursing home employee at greater risk of physical injury than professionals in the fields of mining, construction, electrical work, and automobile repair. Although the nature and severity of injuries sustained remains unclear from the above data, the mere fact that nearly one in five nursing home employees reported a work related injury in the same year reveals an industry wide deterioration in working conditions that cannot be ignored.

Given the current state of working conditions in nursing homes, it is not surprising that high staff turnover emerges as the most widely documented threat

to consistent, quality care. Lapane (2007) identifies high turnover rates among nursing staff as the primary challenge facing the long-term care industry and refers to the recruitment and retention of quality nursing staff as a global mandate. Sikma (2006) attributes the blame for caregiver turnover to toxic work environments, which are often plagued by gross inequities in the division of labor across disciplines, and estimates the turnover rate in long-term care settings to be as high as 143%. Deutschman (2001) highlights the grim comparison between caregiving organizations and non-caregiving organizations with regard to turnover by offering evidence that the turnover rate in nursing homes may reach as high as 400% and often exceeds 75%, which far surpasses averages associated with the majority of non-caregiving organizations. One key culprit emerges as the driving force behind disproportionately high turnover rates in nursing homes. The literature resoundingly points to organizational culture.

The Link between Organizational Culture and Quality of Care

Organizational culture has been identified in the literature as a root cause of the harsh realities that plague long-term care. Scalzi (2006) describes recent trends in change efforts within nursing facilities primarily aimed at creating a more “home-like” atmosphere. Deutschman (2001) reinforces the importance of culture change measures in the following statement:

Neither a sense of pride nor competition seems to be enough of a motivator to encourage quality and excellence. For most facilities, a culture change must precede this transformation to excellence because it requires an organization with innovative leadership, considerable sharing of information, building a team, soliciting suggestions from them, being politically sensitive, and sharing rewards and recognition willingly. (p. 29)

According to an organizational theory model (Mattiasson, 1995), the work climate may be seen as a moderating variable in that it has the power to either strengthen or weaken the effects of available resources.

Given the established link between organizational culture and quality of care, numerous groups and coalitions have formed in an effort to pioneer culture change in nursing homes. The most prominent of these groups is the Pioneer Network, which began in 1995 (Krasnauskay, 2004). The Pioneer Network embraces the mission of advocating for the rights and needs of nursing home residents by engaging in consciousness raising efforts, which span from the realm of service delivery to the political arena, and by offering direct, consul-

tative services to nursing homes involved in culture change efforts. In these efforts to bring about change, an effort has been made to incorporate culture that resident centered.

Adopting a resident-centered approach implies the empowerment of direct care providers and occupies central importance as a culture change strategy. Defining organizational culture presents challenges given its subjective and elusive nature since organizations are defined by culture, rather than the other way around (Bolman, 2003). Three definitions from the literature include:

1. A pattern of shared basic assumptions that a group learned as it solved its problems of external adaptation and integration, that has worked well enough to be considered valid and therefore to be taught to new members as the correct way to perceive, think, and feel in relation to those problems. (Schein, 1992 as cited in Bolman, 2003, p. 12)
2. “the way we do things around here” (Deal and Kennedy, 1982, pp. 243) .
3. A shared belief system within an organization (Spender, 1983); widely shared core values (Peters and Waterman, 1982); collective understandings (Van Maanen and Barley, 1984); and the pattern of basic assumptions within an organization (Schein, 1985). In sum, these definitions all revolve around shared values regarding the character of the work environment. (as cited in Helms, 2001, p. 415)

Shared beliefs and values appear to be the most commonly held element of organizational culture.

An assumption supported by these definitions of organizational culture is that positive nursing home cultures are those that unite staff around the common values of resident care and well-being. Culture change efforts in nursing homes traditionally reflect the importance of patient care values and recognize the teamwork orientation created by resident-centered values. However, some authors recognize the static nature of organizational culture. Scott-Cawiezell (2005) contends the cultural climate in nursing home settings favors the observance of deep-seeded assumptions and governing norms to the extent that the introduction of new or different values may be viewed as a threat to equilibrium. Strategies for implementing resident-centered approaches to care, as a critical means of effecting positive culture change, are to be explored.

Resident-Centered Care as a Model for Culture Change Efforts

Historically, nursing homes have adhered to a medical model of care, for reasons pertaining to both regulatory considerations and function. In recent years this model has failed to meet the demands of an indus-

try over-burdened not only by consumer growth, but also by the neglect of personhood suffered by long-term care residents under its influence. What can be done to repair this damage?

The literature is aplenty with recommendations of person-centered care, which necessitates a myriad of transformations, both symbolic and structural. Tellis-Nayak (2007) asserts,

Promoters of culture change urge nursing facilities to abandon the traditional efficiency model of institutional caregiving and to adopt a culture of quality, which practices “person-centered” care, affirms the dignity of resident-centered staff, respects their individuality, maximizes their choice, and empowers them. (p. 47)

This statement holds nothing exceptional in terms of its logic. In fact, one may question the logic of embracing an oppositional approach, given the unmistakable supremacy of resident needs in a long-term care environment.

Krasnausky (2004) cites recent legislation as a precipitant of the widely adopted medical approach, which stresses problem-focused care. He concludes that the implementation of Medicaid and Medicare programs in the 1960's, while serving to increase access to much needed services, resulted in an efficiency based model of care; such a model focuses on the treatment of diagnoses, rather than individuals plagued by the delimiting effects of an illness. Increasing awareness of the social and human costs incurred by this state of affairs prompted remedial action. The Omnibus Budget Reconciliation Act was passed in 1987, which increased government regulation of nursing homes by creating a system of formal review. However, Deutschman (2001) proposes an explanation for why this legislation has failed to produce a remedial effect by asserting that the shift to governmental control has led to the creation of a “paper centered culture” (p.29) driven by punishments rather than rewards, and characterized by an adversarial relationship between surveyors and nursing home staff. The failure of remedial legislative efforts intensifies the need for micro level reform in order to avoid the perpetuation of social wrongs in an industry whose human territory threatens to subsume the fastest growing segment of our population.

Deutschman (2001) characterizes the nursing home environment under the reign of the medical model of care as both dehumanizing and disempowering, due to the virtual absence of resident participation in care planning. Meyers (2006) describes the woefully distant tenets of the current, medically based mode:

An unspoken assumption in the nursing home

environment is that we the professionals know what is best, and the goal is for people to fit into what we plan for them and to accept the facility's predetermined routines and programs. As with every other discipline, we call people ‘patients’ or ‘residents’ (thus reinforcing the us-versus-them model), and we, too label by disability and diagnosis, neatly pigeonholing people by slipping into the all-pervasive medical approach. (p. 273)

Robinson (2006) and Krasnausky (2004) echoes this sentiment by drawing attention to the bureaucratic nature of long term care organizations, as evidenced by their traditional practices of reserving decision-making power to administrative staff and maintaining strict schedules for bathing, sleeping, eating, and even leisure activities and religious services to the point that individual preferences are subjugated to institutional demands.

Additionally, direct care workers' needs must also be identified and met by the organization. Tellis-Nayak (2007) reinforces the poisoning effects of bureaucratic practices in nursing home settings by offering his contention that low turnover facilities may be distinguished from high turnover facilities based upon the ability of managerial staff to nurture the capabilities of direct care workers, rather than treating them as dispensable. The call for all-encompassing structural change in nursing homes resounds in the above proclamations.

The Creation of a Shared Vision and the Role of Teamwork

Enlisting the cooperation and dedication of staff members within an organization is essential to the change process and begins with a shared vision. This is not surprising given the central role common values play in influencing the culture of an organization. Sikma identified “belonging” as a critical, distinguishing factor that implies the existence of a reciprocal bond shared by members of a team within top rated nursing homes. Deutschman (2001) refers to an enculturation process within organizations, while recognizing the inevitable co-existence of sub-cultures, which can serve to enhance the environment of an organization as long as individuals remain grounded in the same values. It should be noted that any efforts toward the unification of staff, who may be overwhelmed by work demands and discouraged by scant recognition, must render explicit the complementary relationship between resident satisfaction and staff satisfaction in a way that personalizes the incentive for culture change. Simply put, happy residents mean happy staff. Accordingly, the act of infusing resident-centered care approaches with the interests of caregivers serves to bolster staff motivation

and to activate the self-reinforcing potentialities of the patient-caregiver bond.

While the unanimous support of staff members remains critical to the culture change process, the literature acknowledges the benefits of identifying enthusiastic individuals or leaders, often referred to as “change champions” in the culture change process. Scalzi (2006) contends,

The importance of having a critical mass of ‘change champions’ with shared values and common goals appears to have had a significant influence on implementing and sustaining some of the changes that were instituted. Since culture change requires broad-based stakeholder support to succeed, it is necessary to form what some have referred to as a ‘guiding coalition’ of people with the (formal and informal) power and influence sufficient to lead the change. (p. 373)

Krasnausky (2004) elaborates on the characteristics typically exemplified by change agents in the following remark:

What we especially liked was an image of those employees who would naturally perform their duties in respectful and loving ways, and do so outside of the formal care system—that is, the rules, policies, and schedules of care—as ‘positive deviants’ (to borrow a phrase social scientists sometimes use to describe good role models who emerge despite difficult situations). (p. 3)

Unification around the common value of respect for the autonomy and dignity of the resident provides a natural foundation for the adoption of resident-centered care.

Strategies for the Direct Empowerment of Residents

The empowerment of residents can be achieved in a myriad of ways; the preponderance of which involves simple, common sense practices. Bond (1999) identifies the following hallmark features of resident-centered care, which constitute the most cited organizational factors associated with resident well-being: Autonomy; choice; privacy; control; independence; and interactions with staff and other residents.

The simple act of spending time with residents and listening to their stories has the potential to create significant improvements in the well-being of residents and, in turn, in staff morale. Meyers (2006) states,

We should enable people to direct their own care; value the person over the task to be performed;

advocate and make things happen for that person; and truly value the autonomy, independence, and self-determination of each person. The only way this can happen is by getting detailed stories from the person, talking about and discovering their feelings, and engaging and partnering with the person. (p. 274)

Theoretical support for the benefits of narrative construction among the elderly may be derived from Haber (2006), who identifies life review and reminiscence as critical to the achievement of ego integrity, which she describes as a basic acceptance of one’s life as having been meaningful. The Eden Alternative (Robinson, 2006), one of the philosophies for promoting culture change, formalizes the process of narrative building with residents and proposes the formation of “neighborhoods” composed of staff charged with the task of implementing shifts in treatment protocol based upon resident preferences, such as menu choices and recreational activities. Buffet dining, the acquisition of two dogs, and a summer gardening program were among the concrete changes proposed and effected as a result of the neighborhood program.

A pilot project termed the Centura Health Initiative was launched in 2004 and enlisted the participation of various nursing homes willing to amend themselves to culture change initiatives. Buffet dining, as well as simple aesthetic transformations, was proposed as primary resident-centered tenets of care. Bodwell (2006) identifies the benefits of an “open-dining” system in the following statement:

Long-term care facilities report increased resident satisfaction with the open dining system. More important, several facilities report improvement in residents with unhealthy weight losses. When residents eat when and what they want, they tend to eat more and begin to replace lost weight. Some facilities also report decreases in resident agitation when they are allowed to get up when they want, rather than on schedule. (p. 7)

In addition to changes in dining, the importance of simple aesthetic changes emerges as a common theme in the literature. Modifications to the physical environment offer simple and immediate means of creating a more “home-like” atmosphere. In the Centura Health Initiative, team members toured their facilities and were often dismayed at the condition of bath and shower rooms and consequently took the initiative of making immediate, cosmetic changes and adding “homey” touches (Bodwell, 2006).

One of the most compelling suggestions for resident-centered changes involves recognition of the

need to provide residents with opportunities to fulfill their own sense of self-efficacy and reciprocate the care given to them. Robinson (2006) provides the following anecdotal illustration of the transforming power of such efforts:

P.W. was confined to a wheelchair. One arm was flaccid from a stroke. He was aphasic and difficult to understand. When he saw the dogs, his eyes lit up. Staff began taking the dogs to his room and asking him to watch the dogs for a while. Not only was his loneliness and boredom decreased, but his helplessness was reduced. He was helping others by watching the dogs. (p. 21)

It would be difficult to express opposition to the wisdom and inherent logic of the above resident-centered interventions. However, barriers exist to implementation within the high stress, high burnout environment of nursing homes. The most well-intentioned employees may espouse values aligned with a resident-centered approach to care yet may become easily over-burdened by the demands of excessive workloads and unrecognized efforts. The importance of empowering direct care staff will be explored next.

Protecting Front Line Staff and the Importance of the “Holding Environment”

Complimentary to the task of empowering residents is the task of empowering those who work most directly with them. Effective culture changes measures must emphasize the need to protect and prize the potentialities of front-line staff. Kahn uses the term “holding environments” to describe organizational cultures that promote resilience and protect direct care providers. Kahn (2005) explains,

Sharing experiences and acknowledging anxiety and painful affect helps to clear direct caregivers of difficult emotions soaked up from others or triggered by work. By collaborating across various divides of function, role, and hierarchy, they engage problems rationally and support one another. By creating temporary holding environments with one another, they fill one another up with experiences of being cared for, attended to, and valued. (p. 51)

Interdisciplinary collaboration and decentralized decision making reign in the literature as the most fundamental elements of effective culture change. Sikma (2006) identifies *acting together* as one of the central tenets of the culture change movement and describes this concept as a process that unites the distinct aspects

of teamwork and participation in a manner that connects caregivers to one another, while preserving a drive toward productivity. Brunk (1996) speaks to the importance of turning issues and challenges into a *we problem* and guarding against the isolation of staff members, who may be left alone to ruminate about problems.

Transforming the traditional top-down structure that pervades the industry becomes the most pressing, and perhaps the most difficult, task of culture change agents. Scott-Cawiezell (2005) conducted a study whose aim was to rank the effectiveness of various types of cultures in nursing homes. The study concluded that clan and adhocracy as cultural contexts surpassed bureaucratic and competitive cultures in producing quality resident outcomes. Based on a review of this literature, decentralized structures, which stress participatory staff configurations and lateral communication, are integral to resident-centered care. The previously mentioned Eden philosophy, assigns primary importance to the task of transforming structure and lends the following form to this idea: “The organizational structure is inverted, staff are valued for their suggestions, and decision making is placed in the hands of those who are closest to the older adults, which often is the direct-care staff” (Robinson, 2006, p. 20).

Further, the natural divisions created by specializations and role distinctions among staff present challenges to sustained collaboration across disciplines. Drucker (1998) emphasizes the need to establish a “crystal clear” mission as the optimal means of defending against organizational splits, which have the potential to undermine the integrity and established mission of an organization given the natural tendency of individuals to build specialty-based alliances. Brunk (1996) relates the concept of a team orientation to the issue of turnover by suggesting that teamwork provides a critical foundation for promoting key elements of job satisfaction, such as feeling valued and having opportunities to participate in decision making. As I have presented recommendations for changing the culture of nursing, let us consider the role of leadership in prompting change.

Leadership and the Culture Change Effort

The role that formal leaders, comprised of top-level and administrative staff, play in creating positive and lasting culture change is paramount. Numerous studies have analyzed the distinguishing characteristics of leaders who have presided effectively over culture change efforts. Deutschman (2001) contributes the following observations:

In these organizations, there appeared to be little or no gap between what their leaders say and do. Their leaders take an active role in demonstrating

that all jobs are equally important, even though different. For example, one of the administrators could be seen wiping urine off the floor—an important display of this philosophy and the values of this culture. (p. 38)

Scalzi (2006) adds,

In positive culture change facilities, the leadership style was generally participative. The leaders had built cooperative/supportive relations with staff, which emphasized ‘doing the right things’ for residents and families. The leaders were not particularly rule bound and were much more innovative in their problem solving, which encouraged staff to the same. (p. 371)

This statement reflects an understanding of the mutual and reciprocal force exerted by the “holding environments” created both between management and operational staff as well as between staff and clients. Effective leaders not only recognize the parallel processes that often emerge within this dynamic, emotional sphere of experience accessible only on the level of intuition, but are also able to interpret and respond to the imbalances exposed by an examination of these processes. Kahn (2005) describes such a leader:

Effective leaders understand that beneath the layer of observable organizational behavior run streams of emotions that shape how people think, feel, and act. They have some understanding of how those emotional undercurrents are shaped by the needs and emotions of careseekers. They sense the power of these emotional undercurrents, how they move people toward and away from one another in useful and less useful ways and ideally act on the basis of such understandings. (p. 213)

Without the active and sustained support of organiza-

tional leaders, change efforts will not move beyond the realm of well-conceived theories and plans. Bond (1999) concludes that the most important change agent of organizational culture is a committed leader. In the absence of this leadership, even the most impressive aesthetic transformations and programmatic modifications appear to have little benefit to residents and staff.

Conclusion

As a professional in the health care sector and a previous nursing home employee, I encountered the prominence of a corporate machine and bureaucratic structure that permeates this industry, which has become increasingly dominated by corporations. The body of research and literature pertaining to culture change in nursing homes succeeds in assigning cardinal importance to the task of decentralizing the structure of nursing homes. However, the literature fails to devote adequate attention to the broader task of restructuring and obtaining consent from those in power under the current system. The task of winning these power negotiations, which may require policy level intervention, must command the full attention of social workers, as researchers, professionals, and advocates for a growing population of consumers.

Future research should address the central issue of power and propose strategies for effecting its redistribution by appealing to shared values founded on patient welfare. Further research should be conducted to examine the influence of public versus private ownership of nursing homes on quality of care to residents. Current research suggests private ownership may have a negative impact on quality of care, but evidence to support this claim is very limited. Most importantly, future research should continue to convey the urgency of the need for reform and continue to promote client-centered values.

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Filial Anxiety Among Adult Children: An Exploratory Study of Planning Behaviors

By Stephanie Bradley, Jenna Miller, Bridget Murtha, Jill Parkinson, & Sarah Phend Horst

Abstract

This research study explored anxiety felt by Loyola University Chicago faculty and staff regarding their aging parents and plans for parents' future care. Researchers utilized the Filial Anxiety Scale (FAS) and self-constructed questions to gauge adult children's anxiety and planning behaviors, among other data. The study found that parental health and well-being was a greater source of anxiety than the prospect of providing caregiving support in the future. Although there were no statistically significant differences between respondents' level of anxiety and the extent of their planning behaviors, trends showed that the majority of respondents experiencing high anxiety exhibited few planning behaviors.

Statement of Problem

According to the U.S. Department of Health and Human Services (2007), the United States faces a sizable increase in the number of older adults due to increased life expectancy and the aging of the Baby Boomer generation. In 1900, persons aged 65 and older comprised only 4.1% of the total U.S. population (HHS, p. 2). By 2006, their representation had tripled to 12.4%, and by 2030 the age 65+ cohort is expected to grow to 20% of the population (HHS, p. 3). In 2004, persons reaching age 65 had an average life expectancy of approximately 18 to 20 additional years (HHS, p. 2). By 2030, there will be about 71.5 million older persons, almost twice their number in 2005 (HHS, p. 3).

With more Americans living longer, how these individuals will be cared for in their declining years is a significant issue for the health care system, the workplace, and the economy. Since the majority of care for frail older adults is provided by family members (Stone, Cafferata & Sangl, 1987), the financial, physical and psychological well-being of their families is also at stake. This research study focused on the population of adult children who have not yet assumed caregiving roles for their parents, but may in the future. The purpose of this study was to examine adult children's current level of anxiety related to their parents, as well as what actions they are taking now in anticipation of future caregiving responsibilities as their parents age.

Literature Review

The role adult children play in providing long-term support and care to their aging parents has been a

subject of considerable interest in social gerontology and family studies in the last quarter century (e.g., Brody & Brody, 1989; Logan & Spitze, 1995; Silverstein & Parrott, 2001). The factors that motivate some adult children to take on the task of providing support to their parents have led to a considerable body of research. However, the extent to which filial obligation, filial attachment, filial anxiety, or situational factors play a role in the willingness or refusal of adult children to prepare for and assume caregiving responsibilities for their aging parents has yet to be fully explored.

Filial Obligation

As a social norm, filial obligation reflects the generalized expectation that adult children should support their older parents at times of need (Cicirelli, 1988, 1990). Filial obligation signifies the adult child's willingness to fulfill the role of being depended on by one's parent and being dependable on their behalf (Blenkner, 1965). Although filial obligation may be legally required in some cases, it is most often understood in terms of personal attitudes and family customs (Osterkamp, 1995). More than an expectation of one's own behavior, however, filial obligation refers to the beliefs held by adult children of the social expectation of adult children with respect to their aging parents (Gans & Silverstein, 2006).

Although these generally expressed norms of filial obligation are predictive of the adult child's intentions to provide support (Bromley & Blieszner, 1997; Peek, Coward, Peek & Lee, 1998; Silverstein & Litwak, 1993), they are conceptually distinct from the support actually provided (Stein, Wemmerus, Ward, Gaines, Freeberg, & Jewell, 1998). Although evidence of a moderate relationship exists between filial obligation and adult children's helping behaviors, other motives, such as filial attachment, may be more important predictors of the extent to which adult children actually provide support to their aging parents (Cicirelli, 1993).

Filial Attachment

The adult attachment model of helping (Cicirelli, 1981), based on Bowlby's (1969) life span attachment theory, was developed to partially account for family helping behavior. Life span attachment theory is based on the concept of infant attachment, which involves the development of an infant's emotional bond to the mother or other primary caretaker. Although secondary or other multiple attachments develop through-

out life, the child's primary attachment to the mother or initial caregiver continues throughout adulthood (Cicirelli, 1993).

Bowlby (1979) theorized that primary attachment does not fade when the adolescent or young adult strives for autonomy or independence. There is evidence that family members maintain their relationships throughout life rather than withdrawing from them in adulthood (Brody, 1985; Shanas, 1979; Troll, 1971). Some empirical evidence also supports the notion that a stronger attachment to an elderly parent is associated with a greater degree of caregiving behavior (Adams, 1968; Finley, Roberts & Banahan, 1988; Marshall, Rosenthal & Synge, 1983; Walker, Pratt, Shin & Jones, 1989, 1990).

Filial Anxiety

In an oft-cited paper in the literature on intergenerational family relationships, Blenkner (1965), presented an ideal picture of filial maturity as a state of development in which the adult child comes to recognize the parent as an individual with personal needs and goals, apart from the parental role. When dependency needs arise, the filially mature adult will invariably assume the caregiving role for the parent. Although there is evidence that most adult children do respond to some degree to their aging parents' needs, there is a real question as to whether they do so in a filially mature way (Cicirelli, 1988).

To answer this question, Cicirelli (1981) explored the idea that some caregivers who provide smaller amounts of care can feel more burdened compared to caregivers who provide significantly more amounts of care. He found that adult children seemed to be worried about the extent of help which might be called for in the future and whether they would be able to manage this burden (Cicirelli, 1981). This phenomenon, termed "filial anxiety," (Cicirelli, 1988, p. 478) was quite different from the notion of filial maturity as a developmental stage that adult children will invariably achieve. Cicirelli (1988) defined filial anxiety as a state of worry or concern on the part of the adult child about both the anticipated decline and death of an aging parent, and the ability of the child to meet the parent's potential caregiving needs. This anxiety can be present prior to any actual caregiving or during the provision of care as the adult child anticipates further parental decline and additional needs for care.

According to Cicirelli, the theory of filial anxiety can be explained by Bowlby's theory of life-span attachment (Bowlby, 1979, 1980). The child develops a desire to maintain proximity to the parent in infancy and childhood. During adulthood the child seeks to preserve or restore the existence of the parent rather than restor-

ing proximity. Helping and caregiving behaviors are viewed as an attempt to guarantee the survival of the attached figure and preserve the emotional bond. Though the inevitability of death ensures that the child's efforts will not succeed, this does not prevent the adult child from experiencing a continuing sense of anxiety about the parent's welfare. Concurrently, the child realizes the enormity of the caregiving tasks, which would be required to protect the parent from continued decline and leads to the child experiencing further anxiety at the prospect of failing at this task (Cicirelli, 1988). Cicirelli's research on filial anxiety led to the development of the Filial Anxiety Scale (FAS). Based on further research by Cicirelli (1988) it was determined that this tool had sufficient reliability and validity to become useful in further studies of adult children's caregiving behavior.

Impact of Situational Factors on Caregiving

In studies seeking to determine which motive, attachment or obligation, was more important for daughters in providing help to elderly parents, both were determined to be important (Horowitz & Shindelman, 1983; Cicirelli, 1993). Perhaps more significant and predictive of actual caregiving behavior than any of these theories, however, are the situational factors unique to each adult child. With respect to adult daughters, studies have shown that factors such as marital status, number of minor children, socioeconomic status, and employment may impact the amount of care actually provided to aging parents, even where both attachment and obligation are strong (Cicirelli, 1993).

Preparing for the Caregiving Role

Most of the research on caregiving motivations, behavior, burden, and stress involve empirical studies of adult children, typically daughters, who were actively providing care to ailing parents. There has been much less research devoted to adult children whose parents are currently independent and the extent to which these adult children are preparing to provide care for their parents, should the need arise.

Theorists in the areas of stress and coping have suggested that stress experienced by caregivers may be buffered or even prevented by engaging in anticipatory or proactive coping (Aspinwall & Taylor, 1997; Bretznitz, 1983; Sorensen, Webster & Roggman, 2002) and by preparing for future caregiving responsibilities (Sorensen, 1998). Preparation for future caregiving for older relatives involves considering possible caregiving responsibilities *before* the onset of caregiving, as well as gathering information about and mobilizing resources, preparing for possible problems in caregiving, and

anticipating different aspects of the new role (Sorensen & Zarit, 1996).

Despite some evidence for the usefulness of planning for future care needs, research shows that thinking about their parents' health and future care needs is the extent of what most adult children do about planning for those needs, rather than initiating tangible actions. Studies have shown that adult children monitor their parents well in advance of parental need for support (Cicirelli, 1983; Hansson et al., 1990). However, while over 80% of adult children in the United States have thought about an elder's future care needs (Bromley & Blieszner, 1997), only 39-49% actually has discussed the matter with their parents or other family members (Bromley & Blieszner, 1997; Conway-Turner & Karasik, 1993; Sorensen & Zarit, 1996; Sorensen et al., 2002). Furthermore, the percentage of adult children who, together with their parents, have actually made preliminary plans and final decisions about future care is approximately 13% (Bromley & Blieszner, 1997).

Findings are few and inconsistent among studies addressing adults preparing for future caregiving for older relatives (Sorensen, 2002). Bromley & Blieszner (1997) reported that a positive relationship between the potential caregiver and potential care recipient predicts more preparation for future care. Alternatively, Sorensen (1988) found that relationship quality does not directly predict the extent to which adult daughters anticipate their mothers' care needs.

Relationship between Filial Anxiety and Planning Behaviors?

Cicirelli (1988) suggested additional research was needed to understand the factors that contribute to adult children's assumption of the caregiving role and continued commitment to sustained caregiving. He further suggested filial anxiety was one of those factors. Cicirelli postulated *moderate* levels of filial anxiety could lead to stronger motivation for caregiving, whereas *high* levels of anxiety could lead to avoidance of caregiving activities (Cicirelli, 1988). This hypothesis has not been tested in subsequent published research. What also appears untested is whether filial anxiety is a factor that relates to adult children's behavior in planning for future care of their aging parents.

The question explored by this research was whether there is a relationship between the existence and level of filial anxiety felt by adult children and the extent of their planning in anticipation of future caregiving roles. A quantitative research approach was used, utilizing both the FAS and a self-constructed measure of planning behavior.

Methodology

Design

The goal of this research was to extend the empirical knowledge base of social gerontology and family studies by looking into potential relationships between filial anxiety and adult children's anticipatory planning behaviors with respect to their aging parents. An exploratory, quantitative design was implemented using a correlational survey design. Quantitative data was collected using the FAS (Cicirelli, 1988) and a survey created by the researchers to provide follow-up questions to explore the relationship between filial anxiety and adult children's anticipatory planning behaviors. The survey was administered online using OPINIO survey software to ensure that participants were anonymous and their responses confidential.

Sampling

The university setting was selected due to the availability and accessibility of reaching respondents due to the researchers' affiliation. The target population for this study was adults over the age of 18, who had at least one living parent. The research setting was a large Catholic university in Chicago, Illinois. Due to the university's regulations that restrict the number of research emails that can be mailed to its employees, the final sample size was decreased to five hundred individuals from the original anticipated one thousand individuals. The researchers utilized stratified random sampling to collect quantitative data from 96 survey respondents of the study population.

Measures

The research was conducted using OPINIO, an electronic survey administered through the university's Information Technology Services. The survey was anonymous and confidential, to the degree permitted by the technology used. The survey consisted of the FAS and a non-standardized survey measure developed by the researchers. Five hundred surveys were distributed to the university's faculty and staff using OPINIO software. These surveys were sent to faculty and staff chosen randomly through the OPINIO software, which was operated by the head of the IT department.

Filial Anxiety Scale (FAS)

The FAS is a 13-item standardized instrument that was field tested with a sample of 71 adult children, who had a parent living independently, randomly drawn from a population list of adult children of elderly par-

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ents which was provided by a community organization (Cicirelli, 1988). Psychometric tests have previously determined this instrument is reliable and valid with the study population of adult children (Cicirelli, 1988). Dr. Cicirelli, Professor of Development and Aging Psychology at Purdue University, consented to the use of the FAS in this research study.

All potential participants were asked to complete the FAS. In scoring the items, a response of “strongly agree” received 5 points, whereas “strongly disagree” received 1 point. A total score was constructed by summing the 13-item scores, which could range from 13 to 65 points.

Anxiety Level	Item Scores
Low	48-65
Medium	31-47
High	13-30

Non-Standardized Survey Measure

Additionally, a 28-item non-standardized survey measure designed by this research team was administered which further measured thoughts, attitudes, and planning behaviors regarding future caregiving and collected demographic data about respondents and their parents. This instrument received peer review feedback. Data was collected about the types of anticipatory planning behaviors, if any, that adult children have engaged in regarding their aging parents. Data was also collected regarding the aging parent(s) level of functioning. Respondents were asked to answer closed-ended questions that were measured on a five-point Likert scale.

A 12-item scale, included in the non-standardized survey, was created to explore the anticipatory planning behaviors respondents engaged in regarding their aging parents. The researchers asked respondents to agree or disagree to statements such as: “I have considered and/or thought about future changes in my parent’s situation that could limit his or her ability to be independent.” An answer of “strongly agree” was scored as 5 points while an answer of “strongly disagree” was scored as 1 point. A total score was constructed by summing the 12-item scores with a range from 12 to 48 points. Low levels of planning behaviors scores ranged from 12-23 points, moderate levels ranged from 24-35 points, and high levels scored at 36-48 points.

Also, a 6-item scale was included within the non-standardized survey, which was created to explore the functioning level of aging parent(s). Respondents were asked to agree or disagree to statements such as: “My parent is able to run basic errands without assistance.” An answer of “strongly agree” was scored as 5

points while an answer of “strongly disagree” was scored as 1 point. A total score was constructed by summing the 6-item scores with a range from 6 to 30 points. Scores ranging from 6-13 points indicated low levels of functioning, while scores from 22-30 points indicated high levels of functioning. Likewise, scores ranging from 14-21 points indicated moderate levels of functioning.

Sample

Of the five hundred surveys distributed, 105 were returned and 96 were usable. The response rate for this study was 19.2%. About one third of the respondents were male (33.7%; N=32), and two thirds were female (66.3%; N=63). The mean age for participants was 43, with 21 being the youngest respondent and 72 being the oldest. The ethnic identity of our subjects included 4.2% (N=4) Asian, 10.5% (N=10) Black or African American, 3.2% (N=3) Latino or Hispanic, 1.1% (N=1) Multiracial, 80% (N=76) White or Caucasian, and 1.1% (N=1) Other.

Almost half, 45.7% (N=42) of our subjects had no children, whereas 16.3% (N=15) had one child, 26.1% (N=24) had two children, and 12% (N=11) had three or more children. The majority of our participants were married, 57.9% (N=55), while 17.9% (N=17) of respondents reported that they were single, 17.9% (N=17) were unmarried, but in a committed relationship, 5.3% (N=5) were divorced, and 1.1% (N=1) reported their relationship status as other.

The number of siblings our respondents reported was fairly evenly distributed across the categories. 6.5% (N=6) had no siblings, 32.3% (N=30) had one sibling, 30.1% (N=28) had two siblings, 31.2% (N=29) had three or more siblings. Finally, the respondents were asked to report their total family income: about 10% (N=8) fell below \$34,999; 30% (N=25) reported incomes between \$35,000-74,999; 40% (N=39) reported incomes of \$75,000-149,999; and, lastly, 20% (N=16) of participants reported household incomes between \$150,000 and more.

Data Collection/Procedures

Chosen participants received an email that included a link to the survey and a brief description explaining the survey. After clicking the link, participants had to read a statement related to informed consent. Only those who agreed to consent to taking the survey were allowed to participate further in the study. Participants answered a variety of multiple choice, mixed matrix, and short answer questions. After a period of two days, OPINIO automatically sent an email reminder to those individuals who had not yet completed the survey. A total of two email reminders were sent

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during the course of the data collection process. After obtaining over 100 completed surveys, the researchers ended the data collection process due to course-related time constraints.

Results

Our data was analyzed to look for statistically significant relationships and clinically significant trends between respondents' FAS scores and their anticipated planning behaviors. In conducting these analyses, T-Tests, Pearson's Correlations and Analysis of Variance (ANOVA) were used. Composite FAS scores indicated that most respondents experienced moderate levels of anxiety about their aging parents (see Table 1).

Table 1

Composite anxiety levels about each parent

Anxiety Level	About Mother	About Father
Low	16.9% (n= 15)	20.4% (n= 11)
Medium	63.6% (n= 49)	59.3% (n= 32)
High	19.5% (n= 13)	20.4% (n= 11)

Demographic Variables

Respondents' FAS scores were also compared with other variables in the self-constructed survey. For example, the researchers explored the demographic characteristics of respondents and the age of their parents to determine the extent to which other statistically significant relationships could be identified. There were no significant differences in anxiety scores with respect to either parent based on the gender or race of respondents, or age of the parent. However, there was some tendency for younger respondents to have higher anxiety scores than older respondents.

Table 2

Planning behaviors by composite anxiety level about mother

Anxiety About Mother	Minimal Planning	Some Planning	Substantial Planning
Low	38.5% (n= 5)	61.5% (n= 8)	0% (n= 0)
Moderate	46.9% (n= 23)	42.9% (n= 21)	10.2% (n= 5)
High	42.8% (n= 6)	42.8% (n= 6)	14.2% (n= 2)

1 . F (3, 73) = 4.205, p = .008, p<.05

2 . F (3, 71) = 3.093, p = .021, p<.05

Parents' Health and Proximity to Respondents

There was a statistically significant relationship in mean FAS scores between respondents who rated their mothers as being in average physical health and those who rated their mothers as being in excellent physical health¹. Respondents who rated their mothers as being in excellent physical health had lower anxiety (FAS mean = 45.0) than those whose mothers were rated as being in average health (FAS mean = 35.5).

There was a statistically significant difference in FAS scores between respondents who rated their mothers as being in poor mental health and those who rated their mothers as being in excellent mental health². Respondents who rated their mothers as being in excellent mental health had lower anxiety (FAS mean = 42.7) than those whose mothers were rated as being in poor mental health (FAS mean = 32.5). There were no statistically significant results regarding fathers with respect to either physical or mental health in FAS scores when compared to geographic proximity between respondents and either parent as indicated by the demographic data collected through the self-constructed survey.

Current Caregiving Support

The majority of respondents provide zero hours of care per week to their mothers (84%, N=81) or their fathers (91%, N=87). There were no statistically significant differences in mean FAS scores between respondents providing no care to their parents and those providing some amount of care.

Planning

We found no statistically significant differences between respondents' composite FAS scores and the extent of their planning behaviors for their mothers or fathers (see Tables 2 & 3). Few respondents engaged in substantial planning behaviors and, of those who did, most were within the moderate anxiety range.

Table 3

Planning behaviors by composite anxiety level about father

Anxiety About Father	Minimal Planning	Some Planning	Substantial Planning
Low	36.4% (n= 4)	45.5% (n= 5)	18.2% (n= 2)
Moderate	56.3% (n= 18)	28.1% (n= 9)	15.6% (n= 5)
High	27.3% (n= 3)	63.6% (n= 7)	9.1% (n= 1)

Among all respondents, the mean age of mothers was 68 years. There was a statistically significant difference between respondents engaging in minimal, some, or substantial planning behaviors and the age of the mother³. Among respondents engaged in substantial planning behaviors, the mothers' median age was 81. Among respondents engaged in some planning, the mothers' median age was 70. Among respondents engaged in minimal planning, the mothers' median age was 62.

Among all respondents, the mean age of fathers was 69 years. There was a statistically significant difference between respondents engaged in minimal, some, and substantial planning behaviors depending upon the age of the father⁴. The fathers' median age was 80 among respondents engaged in substantial planning behaviors. In respondents engaged in some planning, the fathers' median age was 71. Among respondents engaged in minimal planning, the fathers' median age was 64.

Discussion

With few exceptions, demographic variables appear to have limited value in accounting for the overall level of filial anxiety experienced by respondents. The majority of respondents, regardless of their age, gender, race, and income, are experiencing a moderate level of anxiety. Parent variables, such as their age, degree of functioning, or proximity to the adult child did not impact anxiety levels.

Parent variables that affected the filial anxiety scores were the mother's mental and physical health. As expected, respondents who rated their mothers as being in excellent physical and mental health had lower levels of anxiety than those who rated their mothers as being in poor physical and mental health. Despite differences in sample size, these results did not hold true for adult children with living fathers in regard to either physical or mental health. A possible explanation for this difference might be the general tendency of women to outlive men. This fact may be internalized by caregivers causing them

to have greater difficulty coping with the fact that their ill mother will not likely live to an age that was once expected, thus increasing their levels of filial anxiety.

Why were most of our respondents in the moderate range on the topic of filial anxiety? One possibility is that this large percentage of moderate responses reflects uncertainty, discomfort, and ambivalence regarding these issues. It may be that neutral responses were simply the easiest to commit to in the survey, which could have posed as a limitation to this study.

Although the response rate was almost twenty percent, the reduced number of surveys sent out may have impacted the results of our research. The reduced number of surveys sent out gave the researchers a smaller sample size and thus less power to find a statistically significant difference. Another limitation of this study was the lexicon utilized in the surveys. The researchers received some feedback from participants stating that the word "caregiver" was confusing. Attempts were made to clarify this term by providing a definition on the OPINIO survey.

A central question of this study was the extent to which adult children, particularly those experiencing higher levels of anxiety, engaged in planning behaviors to help reduce their anxiety. Cicirelli suggested the possibility that "moderate levels of anxiety could lead to stronger motivation for caregiving, whereas high levels of anxiety could lead to avoidance of caregiving activities" (Cicirelli, 1988, p. 478). While our study did not test this specific hypothesis, the possibility that high anxiety could have a deterring effect on planning behavior whereas moderate anxiety could promote it, is relevant to this study. Our results do not appear to support that proposition. Few respondents engaged in substantial planning behaviors. Of those who did, there were negligible differences between respondents experiencing high anxiety and those experiencing moderate anxiety. Put another way, while high anxiety did not stymie planning behaviors, moderate anxiety did not increase them.

As expected, age of the parent is more predictive of adult children's planning behaviors than any

3 . F (2, 73) = 11.831, p = .000, p<.05

4 . F (2, 51) = 8.638, p = .001, p<.05

other variable included in our study. Our research found that adult children were more likely to increase planning activities as their parents age. Certainly, planning caregiving support for robust 60 year old parents might not have the same level of urgency as for parents in their 80's or beyond. However, filial anxiety does not seem to know such distinction, as it was not impacted by parental age.

While adult children experience some anxiety regarding their ability to provide caregiving support, they are experiencing even more anxiety about the inevitability of their parents decline and eventual death. Cicirelli (1988) theorized that when indicators of the parent's decline are observed, such as an increase in poor health or an actual illness, the adult child seeks to protect the parent by engaging in caregiving behavior. Because most of the respondents in this study and their parents were relatively young, the need for caregiving support at this time was minimal. However, the study indicated an increase in planning behaviors as parents age, which may signify willingness to assume the caregiving role when the time comes, in an attempt to maintain attachment bonds by preserving the parent's life. Again, it is important to note the small sample size utilized in this study, as it is representative of the university's population and may not be generalizable to the U. S. population.

Implications

The results of this study have major implications for social work practice, as the population of older adults is expected to rise, it will inevitably reshape the demographics of the U.S. population. Social work must shift its focus in response to this dynamic change.

This study found that adult children worry more about the inevitable decline and death of their parents than they do about their own ability to provide caregiving support. Clearly, social work cannot completely alleviate the difficult emotional feelings and thoughts about the prospect of losing parents. However, there is a significant need for social work intervention, on both a macro and micro level, to help address the anxiety adult children experience in contemplating and assuming the caregiver role. On the macro level, social workers must advocate for more policies and resources that will support the caregiving role of adult children. For example, while the Family and Medical Leave Act provides job protection for adult children who must take time off to care for parents with a "serious health condition,"

employers also have a right to expect regular work attendance from their employees. Thus, resources in addition to the right to take unpaid time off from work are necessary to enable adult children to meet caregiving responsibilities.

Without the availability of adequate resources to support the caregiving responsibilities of adult children, increased levels of anxiety are likely to occur. Because many adult children also have responsibilities as workers and parents, it is in society's best interest to provide these resources. If too much of their time is devoted to parental caregiving, work productivity and the well being of children could be negatively impacted. Although more employers and states have begun providing supports for caregivers, such as subsidized respite care, the availability and affordability of elder care for a potentially long period of time are major issues for many families. As the population ages, these needs will exponentially grow. The social work profession has the responsibility to take a leadership role in advocating for greater resources and supports for adult children to help them effectively manage the care of their aging parents.

As cited in the literature review, stress experienced by caregivers can be addressed by engaging in proactive planning behaviors. On the micro level, social workers must support individual clients facing caregiving responsibilities for their aging parents. As this study shows, adult children are more likely to engage in caregiving responsibilities as their parents age. For this reason, adult children need to be informed of the available resources that will aid in the care of their elderly parent. Social workers must link them to formal resources, such as healthcare and financial supports, as well as to informal resources, such as support groups. However, while case management is an important practice tool in working with the children of older adults needing caregiving support, it is not enough.

The concept of filial anxiety provides a theoretical perspective for social workers to better understand adult children facing these issues. When parents no longer have decision making capacity, what may appear as denial or resistance when adult children "drag their feet" about making care choices or end-of-life decisions, might actually be filial anxiety. Therapeutic work with these clients is vital. Social workers can play an important role in helping adult children alleviate filial anxiety and make thoughtful decisions in spite of the intense feelings they may be experiencing.

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The Forgotten Person in the Adoption Triangle: The Biological Child

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Abstract

Although adoption adjustment studies have been plentiful, few have focused on the individual needs of biological siblings in adoptive families. This exploratory pilot study focused on the impact of adoption on these children through interviews with five adoption counselors. Two types of findings emerged as potential influences in the adjustment of these children. Family dynamics factors included proximity in the ages of adopted and biological siblings and the presence and types of special needs confronting adopted siblings. In addition, the adoption system provided services to prepare and support biological children in adoptive families, as well as placed expectations on the adoptive parents to assume full responsibility for knowing and handling the needs of their children, including their biological children. These preliminary findings highlighted areas for future research regarding the unique service needs of biological children in adoptive families.

Statement of the Problem

“Six out of ten Americans have a personal experience with adoption” according to the 1997 Evan B. Donaldson Adoption Institute survey (Adoption Statistics, n.d., Numbers and Trends, Types of Adoptions). Whether attachment, adjustment, and emotional stability have been precarious in adoptive families has been the subject of several adoption studies (WEGAR, 2000). Although some of the negative emotional and psychological influences associated with adoption have been looked at extensively, few studies have dealt with the biological children in the family (Ternay, Wilborn, & Day, 1985; Phillips, 1998; Sharma, McGue, & Benson, 1998; Barth & Miller, 2000).

The authors sought answers to the question, “Had biological children shown effects of adjustment to changes in conjunction with an adoption, and what had been helpful in preparing, preventing, or addressing these effects?” The purpose of this study has been to make an initial inquiry into the effects observed by adoption counselors in their accumulated experiences with families with biological children in their caseloads in order (a) to conceptualize a more coherent view of the needs of families as a whole, and (b) to identify the supports available within the family or community that had helped ease the adjustments of these children.

Literature Review

History of Adoptions

The United States has had a long tradition with adoption. Its roots date back over 150 years. “Between 1854 and 1929, the orphan train transported as many as 250,000 children from New York and overcrowded Eastern cities to towns in midwestern and western states, as well as Canada and Mexico” (Herman: n.d., Orphan Trains, ¶ 2). The idea, generated by Charles Loring Brace was an effort to rescue and Americanize poor immigrant children by placing them in upstanding Anglo-Protestant families (¶ 2). Often, however, these children were used as free labor within the family’s household or business (Adamec & Pierce, 2000, ¶ 8).

In 1898, “The New York State Charities Aid Association established the first specialized child-placement program” (Herman, n.d., Timeline, “1898”). Also that year, the Catholic Home Bureau was organized “to place children in homes rather than orphanages” (“1898”). The focus on home placements grew as specialized adoption agencies expanded to larger U.S. cities (“1910-1930”). During this period investigations were carried out to examine the issues of “baby farming, commercial maternity homes, and adoption ads” (“1912-1921”). This led to screening of applicants and reliance on assessments of the adoptive family and their home environment (“1917”). Regulations became the focus of both federal and state governments (“1917”; “1919”).

Adoption, historically limited to white infants placed with middle class families experiencing infertility issues (March & Miall, 2000), expanded to reflect social pressures to broaden the pool of eligible children. The Child Welfare League of America held a conference proclaiming a “special needs era,” the umbrella term for older children, minorities, and sibling groups as well as children with medical, developmental, or emotional issues (Herman, n.d., Timeline, “1955”). That period also saw the emergence of large numbers of intercountry adoptions from Germany, Japan, Korea (“1957”), and later Vietnam. Passage of the Adoption Assistance and Child Welfare Act provided significant new funding to states that supported subsidy programs for adoptions of children with special needs and “devoted resources to family preservation, reunification, and the prevention of abuse, neglect, and child removal” (“1980”).

International adoption expanded to include Romania, the former Soviet Union, and China as well as countries in Africa and Latin America (Adoption Statistics, n.d., Numbers and Trends, Types of Adoptions). Among the reasons cited were: (a) changes in social norms related to marriage, birth control, and abortion led to a disparity between the numbers of domestic white infants sought and those who were

legally free; (b) a mix of conflicting societal and professional views regarding transracial adoptions in the U.S. (“1948”; “1972”); and (c) changes in international, immigration and adoption laws, accompanied by global media coverage regarding deplorable orphanage practices in certain countries that dramatically expanded awareness and opportunities to adopt internationally. The Hague Convention outlined regulations for countries to protect children crossing international boundaries from being subjected to illegally transacted adoptions (“1993”).

U.S. adoptions peaked at 175,000 (Herman, n.d., Timeline, “1970”). Two decades later, the number leveled at “approximately 120,000 adoptions of children each year” (Flango & Flango, cited in Adoption Statistics, n.d., Numbers and Trends, ¶ 1). In 1993, Stolley wrote that the “number of American families that include an adopted child” ranged “between 2%-4%,” and estimated that “about one million children in the U.S. lived with adoptive parents” (cited in Adoption Statistic, n.d., Numbers and Trends, Types of Adoptions). The following statistics were summarized from the United States Department of State website. In 1990, there were 7,093 immigrant visas issued to orphans coming to the U.S.; of those, 2,620 came from Korea, 631 from Colombia, and 440 from Peru. In 1996, the number of visas issued was 10,641 and the leading countries were China, with 3,333; Russia, with 2,454; and Korea, with 1,515. The number of visas issued in 2006 nearly doubled. The Department of State issued 20,679 immigrant visas; of those, 6,493 were issued to China, 4,135 to Guatemala, and 3,706 to Russia.

Impact of Adoption on the Adoptee

The 1960s marked the beginning of the adoption research debate regarding the success of adoptive children within their new families.

Psychiatrist Marshall Schechter published a study claiming that adopted children were more likely to show up in clinical populations, 100 times more so than their non-adopted counterparts” This sparked a vigorous debate about whether adoption kinship was itself a risk factor for mental disturbances and inspired a new round of studies into the psychopathology of adoption (cited in Herman, n.d., Timeline, “1960”).

In 1964, H. David Kirk published *Shared Fate: A Theory of Adoption and Mental Health*, the first book to make adoption a serious issue in the sociological literature on family life and mental health (cited in Herman, n.d., “1964”; Wegar, 2000). In the more than three decades of research dedicated to adoption, several

studies have investigated the effects of adoption on the adoptive child in regards to his or her psychological, emotional, academic, genetic, and health issues with mixed results. For instance, when compared with non-adopted children, adoptees were frequently found to have higher levels of behavioral, academic, and emotional problems (Priel, Melamed-Hess, & Kantor, 2000; Brodzinsky, 1993). Sharma, McGue, and Benson (1998) reviewed several studies and found a range of outcomes from “no appreciable differences in adjustment levels between adopted and non-adopted person” to “significantly higher rates of maladjustment among adopted persons” (p. 791). Research comparing the academic achievements of non-adopted children with those of their adopted counterparts has suggested that the non-adopted students tended to score better scholastically (Plug & Vijverberg, 2000; Brodzinsky, 1993). More recently, Slap, Goodman, and Huang (2001) studied the correlation between adoption and suicidal behavior. They found that “attempted suicide is more common among adolescents who live with adoptive parents than among adolescents who live with biological parents,” but they were unable to distinguish the “mechanism underlying the association” (p. 1).

Impact of Adoption on the Biological Child

The lack of attention found in the literature devoted to the non-adopted siblings was striking. There has been very little research that has focused on how the biological child has tended to react to an adoption in the family. The following two studies did examine sibling issues within adoptive families.

Phillips’s study (1999) looked at stigma associated within adoption and gathered initial reactions of biological children up to a year post-adoption (p. 122). In addition to interviewing the biological children, parents were asked to share any reactions observed among their child’s peers. The study found that biological children’s developmental stage affected their reactions to the adoption. The latency stage brought out “fear of abandonment . . . and anxiety” (p. 123). Children at this stage relied on a stable home base for their increased explorations away from parents. Their peers were not afraid to ask questions or point out that these families were different. Adolescents were at a stage in which they might feel challenged and resist the adoption of a new sibling into their environment. Adolescents were also sensitive to appearances in this stage of life; thus, an adoption of a sibling from another race or culture tended to be perceived as distressing. Young adults, however, were able to detach themselves from the immediate family situation and to act more like a “spectator” than a sibling (p. 124).

Biological children were found to have their

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own views and opinions on adoption, yet needed encouragement to share authentic feelings (Phillips, 1999, p.125). Phillips recommended that parents and clinicians be willing to explain the reasons behind adoption, help the biological sibling understand the process at his or her current level of development, and be prepared for “unexpected reactions” (p. 125). Phillips acknowledged the diversity of the sample [N=17] as the strength of the study and described a number of limitations as well.

However, all the families lived in the same geographical region, income levels ranged from middle-class to affluent, and all the adoptions were private. These characteristics, in combination with the small sample size, limit the extent to which the findings can be generalized. A more comprehensive study involving a larger and more representative sample is needed for a fuller understanding of biological children’s reactions to adoption. Because of the limitations of this study, it is difficult to generalize these findings; therefore, further research needs to be conducted for a more enhanced understanding of the impact of adoption on the biological child. (p. 126)

The Ternay, Wilborn, & Day study (1985) also compared social and emotional adjustments among children in families with (a) all adopted children, (b) all biological children, and (c) a mix of adopted and biological children.

In addition, natural children in mixed families did not differ from the children in natural families. These results suggest that the placement of an adoptive child in a mixed family does not affect the overall adjustment of the natural child and may, in fact have positive effects on the adoptive child. (p. 261)

This study did not support the assumptions of the present study. The authors of the present study assessed a number of strengths and limitations. First, although the overall study was moderate in size, the subset of families with both adopted and biological children was self-selected, with a small sample size (N=44). Second, all the biological children studied in the adoptive families were the oldest sibling in their respective families. Although a group of interest in the present study, there was a question regarding the possibility that the first-born child in a family might have had more opportunity to develop a healthy attachment to his or her parents than a child born later. Third, the adoptive families in this study had all been volunteers recruited from four cooperating adoptive agencies (p. 263), and

the question arose regarding whether families with pressing adoption issues may have been less likely to volunteer. More studies were called for to address the methodological limitations, including studies of those biological siblings who were not functioning within the norm defined in this study.

Theoretical Frameworks to Study the Impact of Adoption

Researchers, as well as clinicians working directly with clients, have become increasingly aware of the role environment plays for both individuals and families. Brodzinsky, Smith, and Brodzinsky reviewed six theories that have served as a basis for understanding social interaction problems common among adoptive families: “biological-genetic theory, psychodynamic theory, attachment theory, social role theory, family systems theory, and stress and coping theory” (cited in Wegar, 2000, p. 365). Whatever the theoretical frame, applications have tended to miss various social or cultural points of view (p. 365) and exclude the biological child.

Pre- and Post-Adoption Services to Address the Impact of the Adoption.

Post-adoption resources generally have fallen into three categories: educational and informational services, clinical services, and material services. Although the range of public and private post-adoption services has grown over the past three decades, Barth and Miller (2000) found them to be “rarely and irregularly implemented” (p. 449). They also found that upon confirmation of a child’s significant problems, adoptive parents reflected on the pre-adoption services and information provided and found them to be insufficient and unsatisfactory. They alleged that the adoption agencies and their staff had not accurately portrayed the extent of the problems of the child placed with them prior to finalizing the adoption. Disclosure of the full extent of their child’s actual or potential problems was frequently the key topic in contention. Adoptive parents thought that better information and training to handle these issues would have helped them to be better prepared for the situations that later arose (p. 440).

According to family systems theory, individuals are not isolated entities; rather they must be understood as a part of the family unit (Ternay, Wilborn, & Day, 2001, p. 262). Certain social, political, and economic views have comprised the logic in funding clinical services through adoption subsidies. In fostering the needs of adoptees to adjust, other children in the family have sometimes been treated as collaterals, and not as individuals in their own right. This paralleled Wegar’s

(2000) observation, “Few authors approached the problems experienced by biological parents in the family as independent issues worth addressing in their own right. This narrow emphasis is a major theoretical barrier facing successful post-adoption services today” (p. 365).

Methodology

Design

A qualitative exploratory design was utilized in this study to develop a rich, in depth understanding of this little known, and often misunderstood, phenomenon. The research team conducted interviews with counselors in the field of adoption on their experiences in working with adoptive families. The merit of qualitative research lies in its ability to shed light on details and draw out the in-depth “stories of a few individuals” (Grinell & Unrau, 2005, p. 83). In this case, the reflections of the counselors regarding biological children in adoptive families.

Participants

Participants were recruited through the researchers’ internship connections or acquaintances from social service agencies based within the Chicagoland area. This sample of convenience was comprised of five mental health professionals experienced in working with adoptive families. Two of the participants had been trained in psychology or counseling, and licensed as licensed clinical professional counselors (LCPCs); three held social work degrees, two of whom were licensed clinical social workers (LCSWs). Their years of experience in private agencies ranged from 18 months to more than 30 years. All participants were female and two had been adopted as children.

Ethical Issues/Concerns

Names as well as codes to attribute comments to particular speakers were viewed as problematic in the effort to protect anonymity and confidentiality. Thus, participants’ comments were introduced in more general terms, such as “one stated” or “most thought.” Participants, in turn, were asked to reflect on their overall experiences with adoptive families and to take care to refrain from disclosing identifying information when providing examples. Each participant signed a consent form approved by the Institutional Review Board (IRB) of Loyola University Chicago acknowledging voluntary participation and informed consent.

Measures

The research team developed the attached interview guide (See Appendix I). Open-ended questions were constructed to permit respondents greater freedom in framing their responses. The selected items elicited responses regarding their (a) training and experience in working with adoptive families; (b) impressions of initial and long-term effects of adoption on the biological children in those families; (c) influences attributed to the adopted children’s characteristics, role, status, or functioning within the family; (d) awareness of social, behavioral, emotional, or academic issues within families served; (e) observations regarding family cohesion and the roles played by parents and biological children; and (f) opinions regarding effectiveness of available services or additional resources needed to improve preparation or support for biological children.

Data Collection

Once potential participants were identified, they were contacted regarding their interest in participating in the study. The five student researchers each interviewed one of the five respondents. By agreement, the researchers refrained from interviewing anyone they had referred to the project. A single, face-to-face interview was conducted at a convenient time and location for those who expressed interest. Copies of the questions were distributed to respondents in advance to assist them in preparing for the interview. The interview sessions ranged from 30 to 90 minutes in duration, depending upon the length of responses. Each exchange was audio taped in order to accurately record the information gathered. Following completion of the interview, the interviewer transcribed the data, edited the transcript, and identified the initial themes. Then the research team met to share their results; review one another’s findings; establish common themes; develop an outline; and prepare the report.

Results/Findings

The comments of the respondents clustered around two issues. The first cluster dealt with the reactions of the biological children as observed by the counselors. The second issue dealt with problem solving along an implied system-family continuum for the preparation and support of adoptive families, including those for their biological children. Figure 1 provides a chart with selected themes, participant observations, and results.

Several participants commented that most biological children had appeared excited and welcoming of their new siblings. However, each participant also indi-

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cated that the long-term effects of an adoption could be very difficult on families, particularly if a child with developmental delays, behavioral or emotional problems, or mental illness had been adopted into the family. Reactions among biological children were considered normal at first. When the needs of the adopted child were challenging in some way, respondents indicated they expressed feelings of “being slighted, ignored, resulting in jealousy; blaming the new sibling for family strife; feeling taken for granted; or doubting personal worth within the family.” Intensity and duration were viewed by respondents as indicators of the level of difficulty. Two trends were noted by one participant: “The children may become disruptive themselves, seeing the attention that the adopted child is receiving and hoping to redirect it back on themselves”; or “When families experience chaos, the biological children become the peacemakers in the family in an attempt to protect their parents from further stress.”

Younger children sometimes had difficulty understanding the meaning of adoption.

Many parents describe to their young biological children that adoption happens when a parent knows that they would have a better life with another family, and because they loved them, gave them to our family. This can rattle a child’s sense of security if they believe that their parents love them. They might feel, “What if my parents do this, too?”

In contrast, children born into families with one or more adopted children tended to accept the adoption status of the children who preceded them as natural. “The adoption placement was what they were born into. It was all they knew.”

Respondents thought that proximity in the ages of the biological and adopted children was a key factor in adjustment. “When the children are close in age, adoption can fuel healthy sibling rivalry and bonding.” At the same time, closeness in age of the children “could lead to comparisons that are unhealthy for children.” One participant stressed, “Being close in age increases the biological child’s level of performance in a competitive nature.” She later added, “Higher performance is not necessarily indicative of a healthy emotional self, but rather may reflect the need to prove one’s worthiness.”

The second issue dealt with who or where the respondents looked to prepare or support families to handle adjustment problems and particularly those that the biological children faced. Most respondents provided details about the effective skills and capacities they had observed among the parents. The questions about services for the biological child led some to reference

services in their responses, but this was limited. One respondent thought that “how the parents prepared their biological children for the impending adoption and how they handled issues that occurred once the adopted child arrived into the family unit” were important factors in how the family fared over time. Participants stated that, in their experience, “many biological children in adoptive families had experienced [healthy] sibling rivalry, including both competition and fighting that might be expected within any sibling group.”

As long as the parents maintain this is a normal function of siblings, and the parents refrain from splitting or directly blaming the adoption for the rivalry situation, the children usually benefit from sibling rivalry, a normal process whether children are adopted or not.

Another participant stated,

I think it is a stable parent . . . who appreciates differences in their family members, who encourages individuality in their children, and who has realistic expectations for their children, and who can differentiate between the needs of the biological child and the adopted child, but not in a sense that the children are treated differently, but just understand that they are completely different kids.

Several participants suggested a theme of loss. When an adoption placement was disruptive to a family, and the biological children were old enough to recall their family before the placement, some became resentful, remembering “how it used to be.” Biological children were noted as playing a part in either “diffusing or fueling parents’ frustrations” over the dramatic changes that the adoption placement had created. A few described the diffusing pattern as an unfair pseudo-parental role that some parents subconsciously placed on their biological children. Overall, the respondents thought the parents’ reactions were vital in creating the stability necessary for children to make a healthy transition.

Whenever parents act out of a place of strength, and are high functioning and competent, children are more likely to be informed and aware of their differences with a healthy identity. When parents are capable of softening the impact with compassion and empathy for their biological children, they succeed in deterring much of the resentment.

One participant suggested that anxiety was a significant factor in negative behavioral, emotional, social, or academic outcomes among biological children

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in adoptive families. She described some biological children as “too stressed out at home to focus” or as not having “time to rest” due to the changes that accompanied the adoption of a sibling.

Socially, children are not able to give attention or energy to their lives or friends, and parents are unable to attend to their children and remain abreast of their children’s activities. Emotionally, biological children may repress their feelings and shut down because they do not want to cause any more stress in a chaotic home. Children run the risk of flying under the radar and their parents ultimately suffer more because of it.

On the other hand, some mentioned positive aspects, such as the belief that biological children in adoptive families tend to do better in life in general. “Look at families that are diverse and their horizons are broader and there is more depth to these kids.”

All participants acknowledged some need for intervention services on behalf of the biological children. Three provided comments. The first of these said,

I think every [biological] child needs to be assessed, even if it’s in a real basic way. Even if it’s a real brief assessment, just to check in. I think that there is always concern that if there is a lot of focus on the adoptive child because of whatever their needs are, the biological child might not get a lot of focus, may not get as much time with their parents as they are used to, things are just assumed and so I think it’s always important to check in at different stages [in the child’s development] by addressing the child and to know how they’re functioning and how they are reacting. If it’s an adjustment, it could lead to more severe problems.

The second speaker concurred.

Prior to the adoption biological children need to be interviewed, and the counselor needs to examine their understanding of what the adoption will

mean to them, their openness or their hesitation about the arrival of the adopted child. During follow-up, the caseworker can usually discern if there is a problem and a recommendation can be made for post-adoption counseling.

The third respondent seemed to turn the different aspects of the issue over in her mind:

I think that there is definitely a need for intervention for the biological child, but across the board, I don’t think that is something I would ever generalize. Because families handle it so differently, and sometimes the problems that there are with the adopted children don’t really affect the biological children and don’t require an intervention. When parents adopt they go to classes and they go to training and what not, and as far as I know, biological children are involved in that. I think that could be really helpful because I think that they rely on the parents to prepare them and not all parents do a good job at that.

These comments, in response to questions about needs and services, led to the recognition that the project was operating with something of an implied system-family continuum for locating where the speaker placed the responsibility for preparing and supporting members of adopted families. This will be further elaborated in the Discussion section.

In summary, four of the five participants agreed that intervention would be relevant during the pre-adoption phase. Three out of five felt that treatment occurring down the road was also worthwhile, and that evaluations of the biological children should occur as soon as an adoptive family came in for treatment. Two of the five participants did not specify optimal timeframes for interventions. However, they indicated that they believed that certain factors (i.e., keeping open lines of communication between parents and children at the forefront, involving children in the process, and preparing them for the unexpected) needed to be instituted in order to make the placement, and all the transitions, easier from the outset.

Figure 1. Thematic Breakdown of Participants' Statements

Themes	Participant Observations	Results
Characteristics of Adoptee		
Special Needs (i.e., developmental delays, behavioral and emotional problems, mental illness)	When parents focused special attention on an adopted sibling, some biological children were observed to feel slighted, ignored, jealous, blaming, or unsure of their worth.	Some biological children became disruptive (externalizing) in an attempt to gain back attention; others repressed emotion (internalizing) to maintain peace.
Age: Adoptive & Biological Children Young Biological Children	Young children struggle to understand the abstract adoption concepts related to separation, loss, and instability (permanency).	Young children may experience fear, confusion, or other aspects of adoption as highly stressful.
Closeness in age of Adopted and Biological Children	Some biological children appeared to experience healthy rivalry and attachment; others faced unhealthy comparisons or unrealistic expectations.	Some biological children were then observed to be defensive in an effort to preserve or restore their places within their families.
Parental Response Preparation and Transition	When parents made an effort to stabilize and soften the impact with compassion and empathy, the biological child generally seemed secure.	This balance of attention and empathy was observed to be generally effective in creating a healthy transition and deterring resentment.
Sibling Rivalry	When parents viewed sibling rivalry as normal, and refrained from splitting and blaming, the children appeared to behave cooperatively.	Participants concurred: When parents maintained realistic expectations and encouraged individual differences, children generally did better.
Placement Characteristics Disruptive	When parents were unable to contain stress or build family cohesion, their children tended to either “diffuse or fuel” parental frustration. Some appeared parentified.	When children were unable to give attention or energy to their own lives or friends, or parents were unable to attend to their children’s needs, some became alienated.
Healthy	When children gain perspective from parents	Then children become more “well rounded.”

Discussion

The three key factors found within in-family dynamics were: proximity in age between biological children and their adopted siblings; characteristics of the adoptee, particularly special needs as defined in the study; and the capability and skills of adoptive parents to meet the needs of their biological as well as adopted children. The fourth key factor in considering preparation and support for biological children was the existence of tension between dual expectations for the state and the families with regard to commitments, expectations, responsibilities, and outcomes.

Proximity in age was found to contribute to increased attachment and cohesion among some siblings, but was also found to be divisive in families in which children were actively compared with one another. Unrealistic expectations were thought to be at the base of some of these negative comparisons. Issues of grief and loss were implied indirectly through references to “the way it used to be.” Proximity in age was anecdotally reported as a primary issue for families in distress. The closer in age the child was to his or her adopted counterpart, the more complicated the issues were likely to become. This finding resonated with that of Phillips’s study (1999), in which biological children’s reactions were influenced by their developmental stage at the time of placement (p. 123).

Participants acknowledged that it might be difficult for biological children when children with special needs, such as developmental delays, behavioral/emotional problems, or mental illness, entered the family. One of the participants used the term “increased chaos” to describe the dynamics in some adoptive families. It was thought to affect biological children at any stage of their development, and in a multitude of ways, depending on how well the parents attended to the issues. Most of the children’s responses to adoption whether positive, negative, or indifferent were viewed as directly dependent on how well the parents prepared their children and treated issues as they occurred within an adoption placement.

Despite the fact that the purpose of this study has been to draw attention to the needs of the biological child, and despite sending out the interview questions ahead of time; most interviewers noted a tendency for the respondent they had interviewed to drift from topics related to the needs of the biological child to issues from the perspective of members of the adoption triangle. This parallel experience in data collection may be an indicator of the boundaries that exist in relation to biological children and adoption personnel. State agencies have been charged with making every effort to protect the rights of biological parents and to limit the intrusion into their private family life to those procedures, which

are necessary to secure the adoptee’s placement within the family.

The focus toward the triangle and away from the biological child, to the extent it reflects strong social values, may explain the reasons why biological children feel invisible at times. Those advocating services for this population will benefit from the provisional findings of this study. Although the numbers in this study are too small to permit generalization, the findings regarding systemic tensions suggest an important area for future studies with a larger sample.

The general nature of the question, the small sample size, the focus on the biological child, and the fact that these respondents all worked in the private adoption sector, may all have contributed to the lack of explicit detail about post adoption services, a publicly funded program with eligibility requirements. On the other hand, the lack of detail about the adoption system, particularly in regard to post-adoption services for adoptive families as a whole, if not the biological children specifically, may lend support for Barth and Miller’s assessment as “rarely and irregularly implemented” (2000, p. 449). Future studies should include representation from both public and private sectors to explore current policies, public awareness and access, and efficacy.

In addition to issues of size, the entire sample of convenience was female. Although this may be indicative of the population working in the adoption and social work fields, there may also have been gender bias in the interpretation of the issues. Bias was also a possibility in the collection and analysis of the interview data. Two of the five participants were adopted siblings in families with biological children, and one researcher was a biological child in an adoptive family. Time constraints hindered the researchers’ ability to recruit and interview more participants. Indirect means were used to gather information about this population through interviews with professionals rather than clients. The researchers acknowledged that problems biological children might have brought to the adjustment process were beyond the scope of this study.

An important strength of the study was the diversity of experience among the participants and the opportunity to gather preliminary data for a future study with a larger sample.

Conclusion and Recommendations for Future Research

The effort to balance the social service needs of adoptive families with those of other families has been challenging because they have represented only 2-4% of the population, according to Stolley’s estimate in 1993 (cited in Adoption Statistics, n.d., Numbers and

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Trends, Types of Adoption). However, the Evan B. Donaldson 1997 survey finding that “six in every ten Americans has had a personal experience with adoption” (Types of Adoptions) has provided a much different perspective on the issues and a much larger social network in need of a variety of adoption related social services. The early adoption research focused primarily on issues related to the adoptee, the adoptive parents, and the birth parents—the adoption triangle. Less attention had been focused on the adjustments of biological children. Although generally found to function well in comparison to biological children in the all biological families in their study (Ternay, Wilborn, & Day, 1985), biological siblings were also found to experience different reactions to their experiences with adoption according to their developmental stage (Phillips, 1999).

Against this backdrop, one professional interviewed for this study noted that biological siblings have frequently been encouraged to “join forces” with parents in welcoming and supporting their adopted siblings, sometimes to the exclusion of their own needs. None of the respondents mentioned any promising services to help biological children in their adjustments.

The professionals attributed some of the problems experienced by the biological children to the closeness in age among siblings, the special needs of the adopted sibling, and the capability and skills of the parent to prepare and support the biological child’s needs along with those of the adopted child. The relationship of the adoption system to the training and support of adoptive parents was not altogether clear in the responses of the participants. Their role with the biological child was less clear. There may have been many reasons for this from the wording of the questions; the effects of a small, exclusively private adoption sample, or conflicts between competing social values regarding privacy as well as parental authority and responsibilities. These issues should be reviewed and considered for future study with a larger sample.

The results of this study pointed to the challenges the adoptive and biological children face when they are close in age. Inclusion and involvement early in the process found support with participants; however, they thought that particular attention should be given to the biological child’s age and developmental stage. A biological child’s issues may be further exacerbated when adopted child has encountered special needs.

Meeting the special needs of children also means providing special attention to the biological child. Once the adoption has taken place, routine follow-up measures should include checking in with biological children regarding their adjustment to adoption within their families.

The results of this study indicated that the parents’ attitudes and their communication skills have had an influence on the well being of their biological children. Participants in this study verbalized the importance of the parents’ stability, maturity, and ability to incorporate all of the children into the family unit. Therefore, a specific focus in the pre-adoption and post-adoption counseling should be on helping parents develop and maintain these crucial communication skills.

A suggestion for future research might be to use focus groups instead of personal interviews. Focus groups create an environment to encourage and help participants to recollect and share pertinent experiences they might not think of on their own. Three specific focus groups would enhance findings regarding supports for biological children in adoptive families: adult biological children, adoptive parents of biological children, and adoption professionals.

Another research design that might be useful with this target population is that of the longitudinal study. Its ability to track and monitor the biological child’s experience with adoption over time would contribute rich information to understanding whether and when follow up services were needed. Longitudinal designs, such as Vroegh’s (1992) study of the impact of trans-racial adoptions, have been used successfully to study a number of other issues in adoption.

Four out of the five participants of this study believed that there was a need for post-adoption follow-up and intervention on behalf of the biological children. The minimum timeframe recommended for such a demonstration project would be 5 to 10 years post-adoption. The rationale for longer follow-up is due to the belief that problems that influence biological children’s adjustments often correspond to the needs of their adopted siblings over time.

As issues experienced by biological children in the adoptive family are identified, further research will be needed to identify promising best practices in the field.

Carrie Myatt recently graduated from the MSW program at Loyola University Chicago. Currently she is working at Chicago Women's Health Center, which provides gynecological and mental health services, as well as alternative insemination to women. She plans on staying in the medical field and also hopes to work with Chicago Women's Health Center partner organizations on adoption.

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Melissa Elliot is placed at Youth and Family Counseling Libertyville, working with individual and family clients. After graduation, Melissa plans to get her LSW license and begin working with youth from the north suburbs, an interest she has held since interning her first-year MSW placement working in high schools and community development.

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Managed Care's Influence on Clinical Decision Making

By Corrie Callaghan Bennett, Rya Bea Naylor, Christopher S. Perri, Ryan G. Shirilla & Teresa Kilbane

Abstract

Social workers continue to grapple with managed care systems that exert varying levels of control over their clinical decisions. Social workers from the Illinois NASW membership, diverse in experience, settings and areas of specialty, were sent a self-created electronic survey to assess their attitudes towards managed care and examine how managed care impacts their clinical decision making. The influence of managed care was measured across five clinical decisions. Results suggest social workers are more likely to be influenced by managed care in regards to altering number of sessions, reducing fees and advocating for clients and less likely to change a diagnosis or treatment plan because of ethical reasons. Recommendations include advocating for change in policies, procedures, and practices; highlighting possible avenues for future research; and educating and training social workers to more efficiently, effectively, and ethically navigate the managed care system.

Introduction

Since the passage of the Health Maintenance Act of 1973, managed care has played a significant role in the provision of mental health services. Many of the changes to the mental health delivery system implemented by managed care have been a result of efforts to contain costs. Some of the consequences of these cost-containment strategies include restrictions on the previously independent clinical decision making of mental health professionals. Because managed mental health care provides a variety of mechanisms that affect the delivery of mental health care, such as prior authorization, utilization review and capitation, it is important for professionals to understand how outside forces affect their practice and whether ethical concerns raised by providing service in this environment are being adequately addressed. It is also necessary for managed care organizations to understand how cost-containment strategies could affect the quality of care and offer disincentives to qualified and ethical practitioners who contract with their network.

While many studies have been conducted that illustrate managed care's impact on the clinical decision making of mental health care professionals, the extant literature does little to describe how and in what ways managed care specifically impacts the views and practices of clinical social workers (see, for example, Gibelman & Mason, 2002; Keefe & Hall, 2001; Kontosh, 2000). This study builds upon the current state

of knowledge by examining, with qualitative and quantitative methods, how the clinical decision making of social workers is impacted by assessing the practices and attitudes of social workers regarding clinical decision making in a managed care environment. Because this study's sample includes social workers from varying specialty areas, practice settings, and degrees of experience, it illuminates the pervasive impact of managed care on practice. The study also suggests which areas of clinical decision making are most likely to be affected by managed care. The qualitative responses provide examples of how social workers have adapted to the managed care environment as well as their feelings about practicing social work within this system.

Literature Review

Terminology

Managed care refers to a system of "procedures for controlling, coordinating and monitoring the delivery of health care to control overuse of services and over-charging by professionals and to ensure that health care planning is consistent with accepted standards" (Gibelman & Mason, 2002, p. 200). Managed care provisions include: *prior authorization*, which requires service providers to obtain permission from the payor before providing a service; *capitation*, a system in which the payor pre-pays the service provider a set amount to provide health care services to a certain group; and *utilization review*, a process in which the payor closely monitors the service providers decision making in order to determine usage, cost and outcome (Gibelman & Mason, 2002). A managed care organization (MCO) is defined as an entity, such as an insurance company, that administers and controls the cost and quality of mental health care (Gibelman & Mason, 2002). The term social worker refers to a person with at least one of the following credentials: MSW, LSW, or LCSW, and who currently is employed in the provision of mental health services. Clinical decision making refers to a cognitive process that is strongly influenced by the social context and is characterized by uncertainty and risk (Murdach, 1995). Social workers use clinical decision making in the provision of mental health services in a managed care environment by making judgments regarding assessment and diagnosis, treatment modality, length of treatment and adherence to the profession's code of ethics (Gibelman & Mason, 2002).

Historical Trends in Mental Health Managed Care

While the current managed care system has evolved from its inception in the 1960s and 1970s, a recurrent theme in the literature from the 1990s is the revolutionary emergence of managed care as the dominant force in service delivery (Keefe & Hall, 1999; Galambos, 1999). Professionals have come to the realization that managed care is likely to persist for quite some time as the primary form of health care service delivery (Gibelman & Whiting, 1999). The number of Americans enrolled into managed care health plans is rapidly on the rise. In fact, it recently has been estimated that 50 percent of the United States' population is served by health plans provided by more than 200 managed care companies and that these numbers will increase significantly in a few years (Cohen, 2003). This evolution into a managed care context can be understood as a paradigm shift in which the provision of mental health services is increasingly taking on the characteristics of a business enterprise (Crotty, 1999).

Within this system of mental health managed care, there are limitations for both the client and the clinician. MCOs generally limit a client's ability to choose a clinician and the clinician's ability to choose which services will be provided to the client. Clinicians are pre-selected for clients enrolled in managed care plans and act as intermediaries to balance the needs of the client against the desire of managed care organizations to provide efficient and cost-effective service (Berger & Ai, 2000b; Cohen, 2003; Gorin, 2003). In terms of mental health service provision, managed care companies prefer to see their beneficiaries enrolled in short-term, cost-effective outpatient therapy rather than expensive psychiatric inpatient units and long-term psychotherapy (Gorin, 2003).

Effects of Managed Care on Mental Health Professionals

The field of mental health has undergone a noticeable transformation over the past 15 years (Cohen, 2003). Historically, psychiatrists have been responsible for psychotherapy and the diagnosis of clients as well as prescribing medications to clients. The major roles played by non-medical mental health professionals, such as psychologists and social workers, were that of psychological testing, group therapy, limited individual therapy, family assessment and discharge planning (Cohen, 2003; Coleman, 2003). Recent trends in psychiatry have led to a more narrow focus on the biological etiologies of mental illness and the prescribing of psychotropic medications. Therefore, in recent years, psychiatrists have largely been steered away from in-depth psychotherapy with their patients. Psychologists and social workers have begun filling the void of providing psychotherapy and individual coun-

seling (Cohen, 2003; Coleman, 2003).

Several studies, notably an exploratory study by Gibelman and Mason (2002), have illustrated the impact of managed care on mental health professionals. Other disciplines affected by managed care include counseling, vocational rehabilitation, childcare, and home health care (Galambos, Rocha, McCarter & Chansuthus, 2004; Kontosh, 2000; Jones, 2006; Lee & Rock, 2005). The common thread in these studies' findings is that managed care organizations create situations in which clinicians' decision making is constrained causing a reduction in their independence and presentation of ethical dilemmas.

Gibelman and Mason's (2002) exploratory study also found that mental health professionals voiced concern over managed care's incompatibility with preferred practice and its negative influence on earnings and job satisfaction. Respondents indicated that managed care's low rates of reimbursement reduced their income and the increased paperwork and ethical dilemmas caused by MCOs decreased their job satisfaction (Gibelman & Mason, 2002). In addition, managed care has altered the ways in which practitioners assess and treat patients by favoring interventions that are cognitive-behavioral, time-limited, and group-oriented (Berger & Ai, 2000a; Cohen, 2003; Gibelman & Mason, 2002).

The literature also discusses various ethical implications for mental health providers, such as confidentiality and informed consent (Strom-Gottfried, 1998); fiduciary relationships and distributive justice versus injustice (Galambos, 1999); implications of premature terminations and inadequate treatment options; the relationship between managed care compliance and lawsuits regarding negligence and malpractice (Reamer, 1997); and trends in treatment documentation (Keefe, 1999).

Effects of Managed Care on Social Workers

Initially, the implications brought on by managed care were seen by most practitioners as a barrier to clinical social work practice (Berger & Ai, 2000a). The introduction of the MCO as the predominant model of mental health service delivery forced changes in the social work profession. These changes included the development of increased skill and awareness in successful business negotiations and competitive contracting for access to the delivery of mental health services; an increase in interdisciplinary practice groups; a reduction in long-term therapy and community-based practice; and a need for schools of social work to adjust their curricula accordingly (Gibelman & Whiting, 1999).

As the role of managed care in America grows, clinical social workers are increasingly becoming the

preferred mental health care providers of managed care organizations (Coleman, 2003; Cohen, 2003). The nature of psychotherapy and individual counseling makes it difficult to assess outcomes and effectiveness across various disciplines within the mental health field. Therefore, because there are no marked differences in client outcomes whether clients see a psychologist or a clinical social worker and, because the cost of therapy with a social worker is less expensive, clinical social workers are largely becoming the preferred mental health providers by managed care companies (Coleman, 2003; Cohen, 2003). Berger & Ai (2000b) state that nearly 22 percent of all professional social workers are involved in mental health care, while it also is estimated that managed care contracts provide mental health professionals with upwards of 30 percent of their incomes (Coleman, 2003). Because social workers are becoming the provider of choice for managed care companies and receive a significant percentage of income from MCOs, it is increasingly important for social workers to understand how managed care impacts their clinical decision making.

Despite this seemingly close relationship, there is a sense of agreement in the literature that some of the basic principles of managed care are in direct contradiction with the NASW Code of Ethics, which point to serious concerns for social workers (Riffe, 1998). Some of the recurrent themes found in the literature include the social worker's changing role; the alteration of intervention strategies (Galambos, 1999); the quality of care and concerns about equal access to services (Gibelman & Whiting, 1999); and the need for more research (Keefe, 1999), especially on clinicians' experiences of the impact of managed care on their practice (Riffe, 1998).

Gibelman and Whiting (1999) explain that the core values of the social work profession are not always congruent with the principles and practices of MCOs. For example, the NASW Code of Ethics states that "social workers' primary goal is to help people in need and to address social problems," which is apparent when social workers put the interest of their clients' above their own self-interest (National Association of Social Workers, 2007; Gibelman & Whiting, 1999). MCOs, however, tend to put profit before people (Gibelman & Whiting, 1999). Another ethical principle challenged by managed care is consumers' freedom of choice (Gibelman & Whiting, 1999). By authorizing services and limiting clients' choice of providers, MCOs become intermediaries in the therapeutic relationship between a social worker and a client, interfering with both clients' and social workers' autonomous decision making.

Future Implications for Social Workers

Despite negative effects of MCOs, there is a window of opportunity for social workers in the managed care environment, especially through the auspices of groups such as the NASW, to effect change by adhering to their obligations to pursue social justice and clients' best interests. As a result of social workers' value of advocacy, they are uniquely poised to help guide and direct the path of the MCOs' administration and service delivery (Galambos, 1999; Keefe, 1999; Reamer, 1997). Furthermore, patients' perceptions indicate that MCOs may not impact social workers' ability to deliver quality care as much as is believed (Mitchell, 1998). However, "the implication for social work practice is clear: Professional competence, treatment effectiveness, cost containment and businesslike practice must go hand-in-hand" (Gibelman & Whiting, 1999, p. 188).

Although the literature indicates concern that managed care has changed and challenged the role of social workers, Cohen (2003) states that managed care must be seen as both a challenge and an opportunity. Social workers are "uniquely suited to respond to the conditions of managed care" in that they are used to navigating complex systems, in various practice settings, with multiple populations" (Neuman & Ptak, 2003, p. 1). It is also documented that new priorities in managed care actually recognize the need for preventative, consumer driven, and community-based services (Berger & Ai, 2000a). There still is a tendency for practitioners to criticize the constrictions and ethical dilemmas resulting from working with MCOs (Berger & Ai, 2000b); however, by learning how to use managed care constructs, such as utilization review and accreditation standards, clinicians can better advocate for clients (Neuman & Ptak, 2003). As managed care continues to expand and evolve, social workers must collaborate with other practitioners, as well as managed care companies, to improve systems of care (Berger & Ai, 2000a).

This study asks the question, "How does managed care impact the clinical decision making of social workers?" The goal of the study is to explore how social workers describe ways in which their clinical decision making is affected by managed care. By learning more about how managed care affects social workers' clinical decision making, it is hoped that social workers in the field will be better equipped to assess and reflect on their own practice decisions, educate new social workers, and work more effectively with MCOs toward a common goal of continuous improvement in the quality of mental health care.

Methodology

This descriptive, quantitative study used survey methodology to assess the likelihood of social

workers altering their clinical decisions because of the influence of managed care policies and practices. Quantitative data was augmented by qualitative data using open-ended questions to better understand how managed care influenced their decision making.

An email was sent by the National Association of Social Workers – Illinois Chapter (NASW-IL) to all 2,390 members in the Chicago area soliciting their participation in the study. Members were asked to click on a link that led them to a cover letter and an electronic survey created in Opinio, a software survey program supported and approved by the Loyola University Chicago Institutional Review Board. Strengths of this method are that it allowed the project to access a large number and a wide range of social workers. The use of Opinio provided an anonymous and convenient means for respondents to participate in the study and complete the survey, resulting in a potentially greater response rate. Weaknesses included the self-selecting nature of survey research, reaching members who do not work with managed care, not reaching members who did not have email access, and the NASW-IL's inability to use screening filters and reminders to participate.

A self-created survey was used, which included five areas where social workers' clinical decision making may be influenced by managed care. These five areas included the likelihood of social workers to: 1) modify a diagnosis in order to be reimbursed; 2) modify a treatment plan in order to be reimbursed; 3) continue treatment after allowable number of sessions have been used; 4) reduce fees to continue treatment after allowable coverage has ended; and 5) advocate for a client with the MCO for more treatment sessions. Respondents who scored four or above on a seven-point scale, which indicated the likelihood to be influenced by MCOs, were asked to elaborate and provide examples from their practice. Additional information on the survey included the respondents' level of experience, practice setting, area of practice and demographic data. While the survey was pilot tested among peers and revised based on their feedback, the survey's reliability and validity remain untested.

This project was approved by the Institutional Review Board of Loyola University Chicago. All the responses were submitted electronically and stored through the Opinio electronic survey system, an anonymous and electronically-secured system. Informed consent was obtained through an electronic cover letter informing participants their responses were anonymous, participation was voluntary, and there were no direct benefits for their participation. Minimal risk was anticipated due to the scope of this study and the nature of the respondent population. However, the cover letter did include contact information should a respondent experience distress related to the respondent's ethical values

being seriously challenged by working within the constraints of the managed care environment.

Although the survey was sent to 2,390 potential respondents, many did not qualify for our study. Based on data from the NASW-IL regarding their current membership, those currently not in direct clinical practice, school-based social workers and students were ruled out. Thus, the total number of qualified potential respondents was approximated to be 700 members. Because the NASW-IL was unable to send follow-up emails and there were time constraints to complete the project, the study had a low response rate. Therefore, given the limited generalizability of the results, this study is considered a pilot study needing further investigation.

A total of 133 surveys were electronically submitted. Fifty-one surveys were rejected because of missing data or because the respondents answered "not applicable" for all Likert scale questions. Therefore, 82 surveys were used for analysis.

Results

Survey results were imported from the Opinio electronic survey system into SPSS software for analysis. For the quantitative data, descriptive statistics and simple frequency analysis were conducted. For the qualitative data, relevant themes were identified to supplement the quantitative data.

Characteristics of Respondents

Respondents' ages ranged from 26 to 72 (N=78). The mean age was 46.62 with a standard deviation of 13.06. This finding is representative of the NASW-IL Chicago membership, which has 42% of its members older than 46 and 58% younger than 46. Three-fourths of the respondents were female (N=59, 75.6%) and one-fourth (N=19, 24.4%) were male. This finding also is representative of the NASW-IL Chicago membership, with 80% of their members being female and 20% of members being male. Sixty-three respondents (N=73, 86.3%) were white and 10 (13.7%) were non-white. This finding is not representative of the NASW-IL Chicago membership which has 56% non-white membership and 44% white membership.

Survey respondents were fairly evenly distributed across years of experience; 12.2% under 2 years, 9.8% 2 to 5 years, 12.2% 6-10 years, 18.3% 11-15 years, 12.2% 16-20 years, 15.9% 21-25 years, and 19.5% over 25 years. Forty-three respondents (52.4%) were from private practice, 26 (31.7%) were agency-based, 12 (14.6%) were from hospital-based settings, and 14 (17.1%) were from other settings. Respondents also were asked to further describe their type of practice

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setting. Multiple responses were allowed. Responses included individual behavioral (N=59), families (N=44), grief/bereavement (N=37), conflict resolution (N=27), other (N=26), alcohol/drug abuse (N=22), health (N=21), violence/victim services (N=13), disabil-

ities (N=11), HIV/AIDS (N=8), housing (N=8), employment (N=6) and international (N=2). The number of clients covered by managed care averaged 49 percent (SD = 35.79) of the respondents' caseloads.

Clinical Decision Making

Five Likert scale questions targeted the likelihood of modifying a client's diagnosis in order to be reimbursed, modifying a treatment plan, continuing treatment beyond sessions allowed by an MCO, offering reduced fees, and advocating to receive more treatment sessions. "Likelihood of influence" was defined by a respondent selecting a four or higher on a seven-point scale. The quantitative results for the likelihood to be influenced by managed care for these five decisions are displayed in Table 1. Table 2 summarizes the qualitative themes and results.

Table 1.

<i>Likert Score</i>	<i>Diagnosis n=70 (%)</i>	<i>Treatment Plan n=70 (%)</i>	<i>Continuation n=63 (%)</i>	<i>Reduced Fees n=66 (%)</i>	<i>Advocate n=73 (%)</i>
Not Very Likely	44.3	40.0	3.2	4.5	4.1
2	14.3	14.3	3.2	4.5	1.4
3	5.7	10.0	1.6	3.0	1.4
Likely	8.6	11.4	7.8	6.1	2.7
5	14.3	11.4	17.5	12.2	4.1
6	5.7	4.3	12.7	15.2	12.3
Very Likely	7.1	8.6	54.0	54.5	74.0
%Likely Influenced (score ≥4)	35.7%	35.7%	92.1%	87.9%	93.2%

- a. Likelihood to **modify a diagnosis** in order to be reimbursed.
- b. Likelihood to **modify a treatment plan** in order to be reimbursed.
- c. Likelihood to **continue treatment** after allowable number of sessions has been used.
- d. Likelihood to **reduce fees** to continue treatment after allowable coverage has ended.
- e. Likelihood to **advocate** for client with MCO for more treatment sessions.

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Table 2.

Themes from Qualitative Responses to the Five Clinical Decisions made by Social Workers

1. Likelihood of social workers to modify a diagnosis in order to be reimbursed

I. Reimbursement Matters

- i. "I would never give a diagnosis that doesn't fit the client, but if there were several diagnoses that fit the client's symptomology, I would err towards the one that would be reimbursable."
- ii. "I take PPO only and will be reimbursed. If I didn't get reimbursed I wouldn't see the client in the first place. I check the insurance benefits before the first session."
- iii. "So the client can get reimbursed; not me."

II. Future Implications of Diagnosing

- i. "Because diagnoses made on insurance claims can be accessed by future insurers, I would never give a diagnosis that was not warranted."
- ii. "I won't modify a diagnosis to get reimbursement, but I have modified it in terms of putting an Adjustment Disorder instead of Major Depression if a client is concerned about the diagnosis 'following' them in a negative way."
- iii. "I am concerned about giving a diagnosis that will constitute a 'preexisting condition'..."

III. Concern for Fraud/Ethicality

- i. "I think that is considered fraud."
- ii. "...I must be honest and truthful about what I am seeing..."

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- i. "I think that is considered fraud."
- ii. "...I must be honest and truthful about what I am seeing..."
- iii. "This is unethical practice, so I would not do it. That's not an option you give."

2. Likelihood of social workers to modify a treatment plan in order to be reimbursed

I. Modifying to Meet the Need of the Client

- i. "I may exaggerate symptoms in order to obtain more sessions for my client if I feel they need more time and sessions to work through whatever brought them in."
- ii. "This all depends on the options available to meet the needs of the patient. There may always be desirable things to do, and if it's impossible for the client to pay for them, we do what is medically necessary and make other arrangements for the desirable, but unnecessary aspects."

II. Modifying to Meet the Requirements of the Provider

- i. "On paper, not necessar[il]ly in actual practice."
- ii. "Because of limits on the number of sessions, I often see clients less frequently than I would otherwise advise."
- iii. "I might write my treatment plan in different language (more behaviorally focused) than I would otherwise, but the basic plan for treatment is the same...just using a different clinical language to describe it."

3. Likelihood of continuing treatment after allowable number of sessions have been used

I. Alternative Methods of Payment

- i. "I will not stop nor rush treatment because the benefits end; we typically continue, often with a reduced fee."
- ii. "I feel that I personally end up 'subsidizing' a good number of my MCO clients both by accepting the MCO's much reduced fees and by offering reduced rates so clients can continue treatment when insurance no longer covers..."
- iii. "I offer clients a reduced fee, usually at the rate I have contracted with the insurance company or less. I do whatever I can to make the services they need accessible to them."

II. Alternative Delivery of Services

- i. "I talk to clients about this early on, so we can make a plan together about how to proceed once insurance stops paying; i.e. billing insurance every other week to spread out the expense, or sliding their fee once insurance runs out."
- ii. "I will negotiate a reduced fee. If the client cannot afford private practice even with a reduced fee, I will recommend further treatment by referring to community mental health."
- iii. "I would refer them to someone that can continue seeing them. Unless, I made it a teaching case and saw them for no

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Results reveal that 35.7 % of the respondents indicated they were likely to be influenced by managed care to change a client's diagnosis. Similar results were found for the decision to modify a client's treatment plan, with 35.7% of respondents indicating they are likely to be influenced by managed care to take such action. The vast majority (92.7%) of respondents indicated the likelihood to be influenced by managed care to continue a client's treatment beyond the sessions allowed by an MCO. When asked about their likelihood to be influenced by managed care to offer a client reduced fees to continue treatment after coverage by an MCO has ended, 87.9 % of respondents indicated a likelihood to do so. The acts of extending services and offering reduced fees are complementary, thus, similar themes were found. When asked about their likelihood to be influenced by managed care to advocate on behalf of a client to receive more treatment sessions, 93.2 % of respondents indicated likelihood to take such action.

Qualitative results reveal certain trends for each of the five clinical decision making questions. In response to diagnosis, the three themes that emerged included reimbursement matters, future implications of diagnosing, and concern for fraud/ethicality. The two themes elicited in response to treatment plans address either modifying to meet the need of the client or modifying to meet the requirements of the provider. Two major themes emerged about continuing treatment. Clinicians were in favor of using either alternative methods of payment, such as sliding scales or out of pocket payment, or alternative delivery of services, such as referring out or spacing out sessions. The main theme that appeared in the responses about fee reduction is that social work clinicians are willing to accept reduced fees for clients as long as the reduction is discussed before treatment begins. Finally, there were two apparent themes regarding client advocacy. First, clinicians are more than willing to advocate for their clients. The second theme that emerged is that clinicians often advocate for their clients in vain as they are rarely awarded extra sessions.

Treatment Outcome Differential and Additional Thoughts on MCOs

With the remaining survey questions, a slight majority (N= 46, 59%) of respondents reported they experienced no difference in treatment outcomes

between clients covered by MCOs and clients covered through fee for service or other plans. Qualitative responses demonstrated that respondents were torn on this issue. While most stated they do not think there is a difference in outcomes between those with MCOs and those who pay privately, several respondents robustly stated that treatment outcomes for clients who use private insurance or fee for service plans are much better than those clients who have managed care plans. No respondents stated a preference for MCOs over private pay.

Some of the responses that highlighted the lack of a difference in outcomes included: "I have never had MCOs to end sessions too soon," "I work in the same manner," "Individuals progress on their time frame not MCO's or mine," "It varies depending on client diagnosis and severity of the condition," and "I will qualify this answer, because I have not had to terminate treatment due to insurance refusal to pay. If I did not advocate successfully, and the client had to stop or transfer, the outcome would be adversely affected."

A response suggesting a difference in treatment outcomes included:

Based on experience supervising managed versus non-managed cases, the former lack the same degree of depth and intensity of relationship. The client seems to experience the process more like a commodity rather than a, well, process. And the clinician is far less likely to engage the client thoughtfully, but more likely practices in a symptom-driven, consumer-driven, frenzy . . . not a helpful clinical stance.

Other responses were: "Managed care patients tend to be discharged at a faster rate, well before they are ready"; "MCO clients with limited sessions cannot come as frequently as they would otherwise. As a result, treatment gets 'watered down' and is not as intensive and effective"; "Those covered by private insurance usually have more sessions available to them and consequently, are able to get beyond mere problem-solving and into more understanding regarding issues that brought them in"; and "When worrying about insurance reimbursement becomes a treatment issue, there is less time available to concentrate on what brought the client to treatment initially, unfortunately. It can get in a therapist's way, too."

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Table 3.

Major Themes from Qualitative Responses on Additional Thoughts on the Impact of Managed Care on Clinical Decision-Making by Clinical Social Workers

I. Increased Paperwork

- i. "Although managed care in some ways forces us as social workers to be more accountable and more concrete with client goals, the amount of time spent on the phone just to get information on claims or request more sessions or try to correct a problem is enough to make me not want to take clients who have HMO insurance."
- ii. "The amount of justification that is required to obtain a few sessions for a client is ridiculous and sometimes feels insulting to me as a clinician, especially if I'm having to justify it to someone who has never done any direct treatment."
- iii. "It does impact the amount of services that I can deliver when I am spending my life logging and logging contacts."

II. Low Reimbursement

- i. "I choose not to participate with most MCOs because the fees they pay are very low. I would rather reduce my fee to the client and let them decide if they want to bill their insurance themselves. This saves a lot of unreimbursed time on my part. Some clients have decided to pay the reduced fee, and not bill insurance because the financial return is small and the loss of privacy and time are great. I realize that the client and I are in affect subsidizing the insurance company by bypassing them, and I don't like doing that, but it's more practical that way."
- ii. "Two particular large companies have not raised their reimbursement rates in 25 years. This is not realistic."
- iii. "Such low reimbursement rates are a disservice for patients because there are fewer clinicians to choose from."

III. Early Contracting

- i. "Be aware of insurance coverage immediately to determine your best course of action with the client."
- ii. "I feel that it is unethical to allow managed care to affect clinical judgment, but awareness of the impact of increased client cost for sessions not conforming to managed care guidelines (session number, frequency, need for un-billable couple work, etc...) is best discussed early on with the client in order to construct a viable treatment plan with that client."
- iii. "It is imperative that clinicians discuss these issues (regarding all third party reimbursement) at the front end of treatment. It has everything to do with developing a clear and useful contract for service (informed consent) so that there are no surprises."

IV. Impact on Therapy

- i. "Having been in the field for 25 years, I have seen many changes regarding 'care' of the client and I can say unequivocally, managed care has diminished and devalued the mental health field tremendously, thereby putting their client's mental health in much more jeopardy."
- ii. "Clients often complain about confidentiality (for good reason) when MCOs want to review their cases."
- iii. "I don't believe that my clinical decisions are affected by managed care, but my ability to provide the best service for the client is."

At the end of the survey, respondents were asked for additional thoughts on the impact of managed care on clinical decision making. The major themes elicited from this open-ended question included increased paperwork, low reimbursement, the importance of early contracting, and the impact of insurance on therapy content. Table 3 summarizes these responses thematically. Examples of these responses included: "I will be opting out of my last insurance-based contract at the end of this year. I find it negatively impacts the treat-

ment process, takes excessive wasted time and pays unfairly"; "Sometimes both client and therapist are pre-occupied with the threats posed by managed care, cutting into valuable therapeutic time"; and

I feel that it is unethical to allow managed care to affect clinical judgment, but awareness of the impact on increased client cost for sessions not conforming to managed care guidelines (session number, frequency, need for un-billable couple

work, etc...) is best discussed early on with the client in order to construct a viable treatment plan with that client.

Not all respondents reported being negatively influenced in their clinical decision making by managed care. One respondent wrote, "I haven't had problems with managed care. Most of the people I see are within the national statistics of terminating therapy by the fourth or sixth session. When there are serious problems warranting additional sessions, for the most part I receive them." Other more accepting examples included, "Fortunately most of the time the MCO's approved number of sessions for my organization's specialty of treating addictions is close enough to what is needed that we can add a few more at no charge as needed to ensure a good outcome," and

Most managed care companies do not require in-depth treatment plans at this time. There also seems to be more flexibility in obtaining at least the amount of sessions allotted. I have only been denied additional sessions due to the patient's diagnosis. I refuse to give anyone a more serious diagnosis than warranted. The only concessions I might make are in developing a reasonable treatment plan that I know the managed care company will approve.

While the comments suggesting that managed care has little or no influence on clinical decision making were clearly in the minority, there are clinicians who did not perceive the policies and practices of MCOs as a barrier.

Discussion

While only a minority of social workers report being likely to change a diagnosis or treatment plan, the overwhelming majority report they are likely to alter the number of sessions, reduce fees or advocate for their clients as a result of the restrictions placed upon them by MCOs. The first two decisions on whether clinicians would alter a diagnosis or treatment plan are actions that can be considered fraudulent, while the last three decisions do not cross any legal boundaries. Respondents rated themselves much more likely to do what they can do for their client, but not at the expense of being unethical. Respondents voiced many concerns with MCOs in the areas of increased burdens and barriers to quality practice with clients.

The results of this study confirm the findings of previous studies. Clinicians often act as intermediaries to balance the needs of the client with those of the MCOs (Berger & Ai, 2000b; Cohen, 2003; Gorin, 2003). Almost all of the study respondents indicated

they are likely to advocate for clients with their MCOs. This study also confirms the trend noted in the literature that managed care has negatively impacted clinicians in terms of their preferred practice, earnings and job satisfaction (Gibelman & Mason, 2002). Many survey respondents reported spending an increasing amount of time navigating the managed care system while receiving a decrease in reimbursement. Several respondents explained they offer clients reduced fees in order to continue treatment that their MCOs will no longer cover.

An unanticipated aspect of the results was the level of emotion expressed in some of the responses. Some clinicians wrote long, passionate paragraphs bemoaning the realities of working in a managed care environment, while others expressed indignation that clinicians would ever consider altering their clinical decisions to suit the needs of MCOs. It is clear that the social workers who participated are passionate about this issue.

The response to the question regarding whether treatment outcomes are different for clients covered by an MCO was surprising because more clinicians responded that there is no difference. It would seem that clinicians would have responded that treatment outcomes are worse for clients covered by MCOs because of the restrictions placed on the clinician. However, another way of interpreting this data is that, in cases where MCOs constrict social workers' provision of services, it is not the client who necessarily suffers, but the social worker who ends up spending long hours advocating for the client or agreeing to take reduced fees for clients whose coverage has ended and can only pay out-of-pocket. One might assume that if social workers were not going to these lengths to provide treatment for their clients whose MCOs were not cooperating with the social worker's treatment plan, outcomes for these clients might be much worse.

As far as the reportedly low incidence of social workers' altering the diagnosis and treatment plan, it is possible that respondents self-censored their responses. While the more obvious explanation is that social workers are not willing to cross ethical boundaries, it is possible that, because there are serious ethical and legal implications for altering a diagnosis or treatment plan, these actions simply were underreported.

Limitations

The fact that this study relied on the accurate self-reporting of unethical behavior is one of its limitations, however, it was hoped that the anonymity of the survey would increase accurate reporting. There might have been concerns about the anonymity and security of an online survey that was delivered directly to someone's personal email address. While the cover letter

addressed anonymity and security of data provided by Opinio, the sensitive nature of the questions combined with the skepticism of Internet security might have resulted in a lower response rate and less accurate self-reporting.

Another limitation in this study is that it was designed to be completed in a 15-week graduate level social work course. A higher response rate could have been achieved if more time was available as well as if NASW-IL was able to screen out respondents not meeting the study's criteria and to send additional reminders to encourage participation in the study.

The use of a self-created survey that has not been adequately tested for reliability and validity is another limitation of this study. While the survey items and content were based on ideas and themes found in the literature review, time constraints permitted the survey to only be pre-tested with peers. It also should be noted that the survey itself may contain an unintended negative bias towards MCOs influence on clinical decision making. This may have manifested as a result of the bias existing in the literature reviewed, as well as from the authors' own personal experiences.

Recommendations

Social workers are spending a great deal of valuable time preparing paperwork for appeals to advocate for additional services for their clients. Clinicians are faced with reducing the number of sessions because of MCO policy. One recommendation that may help social workers better address these realities would be the addition of support staff to one's practice. It might be useful for a group private practice to employ a bachelor level social worker, whose job would not be in providing direct service, but solely in navigating and negotiating with managed care so the clinicians' time can be dedicated to direct care. A group practice might find this additional expense in fact ends up paying for itself in terms of clinicians' increased capacity to meet with clients.

The results of this study suggest several possible avenues for future research. Questions to be further explored include: To what extent is there a decrease in practitioners offering long-term treatment because of the constrictions placed upon them by the managed care environment? What impact do clinicians perceive these restrictions are having on their choice of treatment, and subsequently, on client outcomes?

Another topic for further exploration is determining to what extent working under managed care affects social workers' job satisfaction. Many social workers in this study reported their job satisfaction has decreased because of MCOs constraints such as low reimbursement, paperwork and time limits. Some

respondents indicated they no longer work with MCOs because of the problems they have encountered. Because a lack of job satisfaction can influence the quality and availability of care, this is an important area for further research.

Additionally, giving clients a voice is an important next step for research in this area. A more complete picture of the impact of managed care could be achieved from a study in which clients are surveyed regarding their perceptions of and experiences with mental health managed care. A related topic to further explore is the impact of managed care constructs on practitioners' treatment modality. It also may be beneficial to conduct a study that explicitly seeks to gather positive feedback about the managed care system. This would provide a needed contribution to the limited amount of literature currently available with regard to the positive impact of MCOs on social work practice.

An interesting qualitative study might be exploring the practices and attitudes of clinicians who have successfully adapted to the managed care system. While these responses were among the minority in this study, several clinicians reported they have no problems working in the managed care environment. It would be helpful to have a better understanding of how these clinicians have adapted to this system in order to determine whether these adaptations can be emulated by other clinicians.

In general, social work educators can apply current findings on the ethical challenges facing social workers and evaluate and adapt their curriculum to help prepare students for the realities they will face upon entering the workforce. For example, students could be better educated on how to manage the workload that corresponds with requirements set by MCOs. This may include: the development of skills in advocating for client services; understanding mechanisms such as prior authorization, utilization review and capitation; and practical techniques related to billing and record-keeping procedures. Schools of social work also might consider offering more education on evidence-based practices and programs that have been found to be a good fit with managed care.

The most salient recommendation this study suggests is that social work as a profession more heavily invest in its efforts to advocate for change within the managed care environment. The current literature in the field, as well as this study, paints a picture in which social workers are increasingly frustrated by working within this system. MCOs also have a stake in improving this system in that they might begin to experience a decrease in the number of qualified providers willing to contract with them if no improvements occur. Several respondents suggested they either have or plan to stop contracting with MCOs because of the challenges they

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have encountered working in this system. MCOs potentially could avert this problem by engaging social workers directly in efforts to address existing concerns. With strong skills in navigating complex systems and in

advocating for others and themselves, social workers are well-equipped to undertake the challenge of working for lasting structural change in the mental health care delivery system.

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Dissertation Abstracts

Congratulations and best wishes to Doris Ayala, Jin Hyung Bae, Carnecia Clark, Dianne Green-Smith, Heewon Helen Kim, Deborah Major, Shipra Parikh, and Seth Wollwage. 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.

Developmental, Biological, Psychological and Sociological Correlates of Sexual Behavior Problems

By Doris Ayala

The present study was designed to examine whether five variables are correlated with serious sexual behavior problems in a sample of youth in substitute care. It is a cross-sectional design using retrospective survey data measuring early and late childcare taker's identity, sexual abuse experience and exposure to pornography. The children with less serious sexual behavior problems were used as a control group. The data analysis strategy focused first, on examining whether rates of severe sexual behavior problems varied by gender of the child; second, whether the potential association varied across the whole sample with severity of offense; and third, whether any significant effects of the sample were independent of or interacted with gender of the child. Secondary data from a previous study conducted by Spaccarelli, Edejer, Bushell, Karaitis, and Jones (2002) from the Child Abuse Unit for Sexual Educational Services (C.A.U.S.E.S) with wards of the Illinois Department of Children and Family Services was used.

The study found that there was a significant difference in gender (GEN) for systems learning sexual abuse (SLSA) and social learning pornographic exposure (SLPE). There was a significant difference in gender where males were the greater percentage in the seriousness of sexual abuse. Early and late childcare taker's identity was not found to be significant for either gender.

Initial School Adjustment Difficulties, Coping, and Help Seeking Needs of the Newly Arrived Korean Junior High Students: Grounded Theory

By Jin Hyung Bae

Increasing immigrant student population challenges the service providers in dealing with the students' school adjustment issues in the U.S. Initial school experience is the first and the most primitive indicator of successful adjustment in their new environment. This study is to explore initial school adjustment difficulties, coping and help seeking needs among new Korean junior high students in American school systems. Through snowball and convenience sampling, ten new Korean junior high or high school students were recruited. Their first six months of American school experience were in junior high schools. Their length of residence did not exceed two years in the U.S. Data were collected through interviews, field notes, and memoing. Grounded theory methodology (Strauss and Corbin, 1998) was implemented for data analysis. Data analysis process included open coding, constant comparison, making categories and subcategories, saturation, creating tables, core category abstracted and checking the theory with the raw data.

The major finding revealed that newly arrived Korean junior high students' initial adjustment difficulties, coping strategies, and help seeking needs were found to be unique. From a grounded theory perspective, the core category emerged: The subjects were mostly unexpected, but not too overwhelmed by their new school experiences. First, in adjustment difficulties, they had nervous and flurried first day of school, but they were able to resolve. Their major difficulties resulted from not being able to speak or understand English, cultural differences, unfamiliar rules/system, lack of information, and sometimes personal passiveness. Second, in coping, although being unprepared, their coping became rather instant or situational responses, not knowing the situation or background clearly. In that they received some general help from their peers and teachers, followed after what other peers did or made their own individual efforts. Third, their help seeking needs included making friends, connecting with a Korean speaking peer helper, understanding rules and school system operation, and in-classroom assistance in the context of a more effective emotional and system's connection. They lacked of knowledge about the role of school social workers.

In the domain of the initial school adjustment difficulties, data were organized by eight sub areas (first day of school, study/class, peer relationship, teacher relationship, rules and system, special subjects, bus using, and after school activities). In the coping and responding domain, there were seven sub areas in accordance with the difficulty areas

above. In the help seeking needs domain, there were four areas (participant's recognition of school social workers' existence in American schools, thought about the school social worker's role, whether participants want help by school social workers, and things that could be better with school social worker's help in their initial adjustment). This research advanced the understanding of new Korean junior high students' initial school adjustment difficulties, how they coped, and in what areas they needed more help from their own experiential perspectives. It provided school social workers and other related personnel culturally appropriate service information from which preventive and remedial programs can be developed. Also for the potential Korean immigrant students, this study can make them more prepared with real and living information.

Social work implications at three different levels (individual, school social work, and school system) were suggested in a practical way to apply. Policy implications for the school districts, State Board of Education, and Korean side parties concerned were addressed. Further research implications that need future investigation based on this study's result were also suggested. Followed by implications, the researcher's insider perspective and several other methodological limitations are enumerated.

The Relationship between Early Object Relations and Battered Women

By Carnecia Clark

This study examined the relationship between early object relations and battered women. The problem of violence toward women is an epidemic in America. Evidence collected over a 20-year period indicates that physical, emotional and sexual violence against women is an enormous problem. Much of the violence is perpetuated by the woman's intimate partner. Object Relations theory explains the dynamic that causes women to remain in a life threatening abusive relationship. The effect of neglect and unmet childhood dependency needs on the development of personality impacts the woman's selection of men in intimate relationships. The woman who is repeatedly a victim of physical, emotional and sexual abuse has most often times been deprived due to childhood experiences that did not allow for the development of a sense of self or a healthy ego structure. This study addressed those unmet early childhood needs as well as therapeutic interventions that can assist in helping the woman to break the cycle of violence.

The study was an exploratory study of 12 female victims of domestic violence. The purpose of the study was to explore the relationship between Early Object Relations and Battered Women, using the (AAI) Adult Attachment Interview protocol instrument. The AAI is a structured, semi-clinical hour long protocol of twenty questions with structured follow-up probes. The study looked at probable characteristics of early deficits in the developmental environment that predisposed the women in the study to unconsciously seek out relationships with men who abused them.

Results of the findings indicated that although 83% of the women were abused as children both sexually and physically, only 50% of the subjects lacked good object relations. Fifty percent (50%) of the research subjects had unresolved trauma and loss in their lives. Narratives detailed that research subject's experiences of abuse and neglect in early attachment relationships, in addition to estranged family relationships which were evident by the Adult Attachment Interview coding of "Summary of Experiences" for each subject. Research findings indicated a correlation between deficits in early object relations and battered women. Evidence of trauma and loss suggest future research in the resiliency of women from domestic violence relationships.

The findings provide critical information which can enhance the psychodynamic and relational understanding of early experiences and development of self. The psychodynamic therapeutic approach should be the treatment of choice with this population to stop the cycle of violence for future generations to come. Policy implications impacting this population include the need for advocacy to obtain a variety of social services (housing, employment, education) in addition to raising public awareness. There is also a need to change legislation and public policy regarding the plight of the abused woman

The Influence of Culture: African Immigrant Women's Experiences of their HIV/AIDS Status in the United States

By Dianne Green-Smith

The problem under investigation was to determine if sub-Saharan African immigrant women positive with HIV/AIDS experienced empowerment in their intimate relationship whereby they had to ability to practice self-care behaviors to prevent re-infection of HIV with another viral strain and to prevent the infection of others as they recall

their experience in their native environment, and as they experience life in their host environment. Eight women between the ages of 25 to 56 from East and Central Africa participated in this qualitative study. Seven of the eight women lived with a partner, either a husband or a boyfriend. All participants were recruited from a medical facility in an urban area in a mid-west section of the United States. Participants have resided in the area from 1? to 13 years. Their educational background consists of primary school to some college. Participants completed a semi-structured demographic form and an in-depth interview that was audio-taped and transcribed for predetermines themes. Research methodology was demonstrated from a phenomenological perspective, and participants were theoretical-ly studied from three paradigms: Africentric (Akbar, 1994; Asante, 1990; Schiele, 1994); Black Feminist (Collins, 1989, 2000); and Empowerment (Gutierrez, 1990). Both the Africentric and Black Feminist paradigms call upon an ethic of personal accountability, and empowerment allows opportunity for greater choices regarding self-care behaviors. Study findings reflect individual growth and decision- making abilities in view of socio-cultural, economic and political dynamics on the subjective experiences of each participant. Service providers are called upon to recognize the influences of cultural factors on behaviors.

Impact of Spirituality and Religion on Attitudes toward Death and Dying among Korean Seniors Living in Chicago

By Heewon Helen Kim

There is an increased need for study of minority populations such as the aging Korean senior citizen immigrant population. The United States has always been a melting pot of various ethnic groups. It is important for social workers to develop a greater understanding of the needs of these groups as they enter the population and particularly as they advance in age. As we grow old, we often become more helpless and more dependent on external resources. Therefore, it is critical for social workers to understand how the specialized needs of a minority population may differ from the population at large.

This study explored the impact of spirituality and religion on attitudes toward death and dying among Korean senior citizens living in the Chicago area. The study looked at the beliefs and attitudes of Christians and Buddhists as well as Korean seniors with no religious affiliation. The methodology of this study was phenomenology. The researcher interviewed selected participants encouraging them to discuss their own understandings in their own terms during the interview. The researcher then incorporated a sensory and noetic component to the structure of intentional experience.

The researcher found through the interviews that: 1) Spirituality and religion have an impact in coping with the stress associated with life-threatening crises; 2) People who have positive attitudes have strong ego-integrity and better physical and mental health; 3) Elderly people have lower death anxiety than people in middle age, especially when they have religion, believe in the afterlife and have completed their life tasks; and 4) Culturally, many Korean seniors adhere to traditional Korean burial customs even when these customs conflict with their current religious beliefs and even though they do not expect their children to carry on these traditions.

The Bridge Home: Exploring the Healing Nurture of Foster Parents' Insightful Availability

By Deborah R. Major

This study used a concurrent triangulation mixed method design to investigate two hypotheses: that there is a caregiving phenomenon called insightful parent availability that can be discerned and defined, and that foster parent availability will be systematically related to foster children's recovery from disabling, trauma-caused behavioral and social symptoms. Severity of children's symptoms at placement were verified using official file documents and were coded using the Child and Adolescent Needs and Strengths Assessment. To explore foster parent availability, foster parents caring for children with serious disorders were administered a standardized parenting questionnaire (the Parental Acceptance-Rejection Questionnaire) and discussed their subjective experiences of caring for these children via semi-structured qualitative interviews. Findings showed that the hypothesized construct of insightful parent availability may be defined and discerned in caregiving patterns of nurture, insight, and child-tailored structure. Further findings suggest that variations in foster parent availability are related to children's recovery from disabling emotional and behavioral disorders. Foster parents assessed as "most available" showed strengths in all domains of insightful availability, with parents in other groups showing relative strengths in fewer domains. The study highlights the importance of coherent relational fields via the use of wide-ranging system and community supports for foster parents, as all parents in the sample relied heavily on staff availability and multiple external supports as a way to strengthen their caregiving of disturbed children.

Factors associated with Continued Paternal Involvement of Young Fathers

by Shipra S. Parikh

Although fathers represent an integral half of the parental unit, the study of young, unwed fathers from disadvantaged backgrounds and their relationships with their children lacks sufficient exposure in the field of social work. Utilizing a generative perspective and a qualitative, grounded theory approach, 14 in-depth, semi-structured interviews were conducted with young, self-described involved fathers, in order to identify factors associated with their continued paternal involvement beyond two years post-partum. The study focused primarily on men who fathered between the ages of 18 and 30, adapted from Arnett's emerging adulthood phase of life. Study findings indicate that involvement is promoted by factors from a variety of contexts, both internal and external, which appear to be mutually influential in shaping involvement and supporting young men's fathering abilities. Social exchange and social cognitive theory concepts also highlighted several trends in data: 1) fathers commonly received *validating reflections* from their children, and 2) young fathers viewed their continued involvement with their children as a highly rewarding endeavor, in terms of an emotional cost-benefit ratio. The results of the study suggest that social work professionals should reconsider the deficit models of low-income young fatherhood and adopt perspectives that recognize the existing motives of young fathers to form deep emotional attachments with their children.

Resilience: An Examination of Well-Being and Optimism of Youth

By Seth D. Wollwage

This study is an examination of resilience and treatment interventions that enhance qualities of resilience in youth identified as "at risk". This study is descriptive in nature and based on secondary data collection of multiple case studies. The data collected was from a non-probability sample in that youth were not randomly assigned to a specific group. The purpose was to explore the concept of resilience in youth by examining score changes in the Child and Adolescent Needs and Strengths Scale (Buddin Praed Foundation, 1999) in the sub-categories of "well being" and "optimism" over time, pre and post intervention and which interventions correlate with improvement in scores. Questions addressed in the study were: Do community based interventions correlate with improved scoring in well being and optimism for adolescents? What patterns emerge that correlate with an improvement in resilient qualities? Results suggest that multiple service intervention approaches with youth yield better overall results in strengthening resilient qualities rather than one service intervention by itself, that group based treatment approaches may have the most positive impact on youth optimism in the short-term, and that financial supports that address non-mental health needs have a beneficial impact on psychological strengths.

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