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Changes in Labor Force Activities and Income of the Elderly Before and After Retirement: A Longitudinal Analysis

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This paper analyzes the changes in work hours and the economic profile of the elderly for a period of 11 years before and after retirement. Workers of all economic status decreased their work hours gradually as retirement approached. But findings show that, as they decreased their work hours, workers with higher preretirement economic status experienced more drastic reduction in income than those with lower economic status. Nevertheless, the preretirement income gap was maintained in postretirement economic status mostly due to differences in asset income and pension benefits. Policies to assist low-income retirees are recommended.

As the length of time an elderly person has to spend in retirement has increased because of increased longevity, retirement has become the most important life event that requires careful financial planning. Despite the replacement of earnings with Social Security benefits, public and private pension benefits, and other transfer payments, retirement is characterized by reduced income for a majority of workers whose preretirement income consisted mostly of earnings. Although the economic status of the elderly for the past two decades has improved faster than that of the general population, owing especially to public transfer payments, reduction in the absolute level of income caused by retirement has been documented as the source of low life satisfaction, to say nothing of lower living standards, in the lives of many retired elderly (Maxwell, 1985).

Primarily because they anticipate these financial problems, an increasing number of workers have made a gradual, not an abrupt, transition from the world of work to the world of leisure. Many workers approaching retirement age gradually

detach themselves from paid employment by reducing their work hours (therefore, earnings) and substituting pension benefits, Social Security benefits, and other types of transfer income for the lost earnings. Others, not fortunate enough to expect pension benefits, continue, after retirement from their primary occupation, to work in a secondary job on a full- or part-time basis; most of them then work at the secondary job for only a few years. For many workers, therefore, the transition from work to leisure is not a very finite process, at least in the early years of retirement.

Given that the modern-day trade-off between work and leisure can be a very fluid situation, especially during the early years of retirement, analysis of the dynamic process of retirement can be a valuable addition to the current body of knowledge regarding retirement income and income policy. In particular, possible differences between races, genders, and income strata in the process of retirement and postretirement economic status need to be analyzed so as to understand differential implications of retirement for people in these groups. The analysis in this paper of the changes in work hours and in various income sources is intended to present a more clear picture of the dynamic nature of the retirement processes of whites, blacks, men, women, rich, and poor. That is, this study analyzes the changes in work hours and the changes in the economic profile of the elderly before and after retirement by following, for a period of 11 years, sample members of the Panel Studies of Income Dynamics (PSID) who retired between 1978 and 1982. Specifically, the study analyzes, first, the longitudinal changes in the sources and amounts of income for 5 years prior to retirement and 5 years following retirement. Second, it analyzes the relative importance of each source of pre- and postretirement income. Third, it examines the adequacy of retirement income by analyzing the changes in the poverty status of elderly people before and after retirement. Fourth, it analyzes the sociodemographic and occupational determinants of an individual's income 5 years after retirement. In all these analyses, special emphasis is placed on differential effects of race, gender, and income strata.

Previous Studies

The general economic status of elderly in the United States has been remarkably improved over the past two decades. Poverty rates among the population aged 65 and older have been declining faster than those of the younger population, and the elderly's mean/median income has also been rising faster than that of the younger population for the same period. Indeed, the remarkable economic gains of the elderly in the midst of growing federal budget deficit, inflation, and budget cuts for many domestic social programs have often led to criticism of federal social policy as having tilted disproportionately in favor of the aged. But treatment of all elderly persons as a homogeneous group and examination of a point-in-time distribution of income do not capture the real dynamics of the elderly's economic status. Duncan, Hill, and Rodgers's study (1985), based on the PSID, in fact showed that the much-heralded economic gains of the elderly did not necessarily mean real improvement in the economic status of all elderly persons. The appearance of economic improvement of the elderly as a group is due largely to the entry of new cohorts of elderly persons whose economic status is much better than that of previous cohorts.

Nevertheless, most people who have become elderly even recently experience serious economic setbacks with retirement and widowhood. The immediate negative economic consequences of retirement and widowhood are indeed so great that they constitute a greater reduction in the economic status of most elderly persons than even the long-term consequences of erosion in retirement income due to inflation, illness, and so forth. For example, Holden, Burkhauser, and Feaster's study (1988) found that the initial fall into poverty among those who had not been poor before the husband retired is more closely linked to the event of retirement or widowhood than to the slowly eroding household income over the period of retirement and widowhood. Ross, Danziger, and Smolensky's study (1987), based on 1949–1979 census data, had also concluded that the decline in the average income of each birth cohort, controlling for sex, retirement, and marital status, was due not to aging itself (passage of time) but to changes in income that occur at retirement and at widowhood.

Especially with respect to retirement, a marked decline in income due to loss of or reduction in earnings puts most elderly people in a postretirement economic circumstance inferior to their preretirement economic status. Despite Social Security benefits with COLAs (cost of living adjustments) and a host of other old-age income-maintenance programs that support postretirement life, the income reduction created by the loss of or reduction in earnings experienced by most workers and their families at retirement is still the largest of any caused by various lifetime events.

Because they expect the economic consequences of retirement to be devastating, however, many workers tend to gradually decrease work hours as retirement age approaches. As evidenced by Fox's study (1984) which followed Social Security beneficiaries for 4 years after their first benefit receipt, "retirement is a gradual process rather than an immediate cessation of all paid work" (p. 3). That is, retirement in reality is a process of change, from work to leisure, that often takes more than a couple of years. The study showed that about half the persons continued some paid employment after they began receiving benefits. In particular, a considerable number of those whose only pension was from Social Security and whose total income was by and large not very high continued to work, at least part time, although mostly for only a few years after receiving their first Social Security benefits (Fox, 1984). So, those who expected to experience the greatest decrease in their economic well-being because of retirement are the least likely to sever their link to the world of work completely at the time of retirement. On the other hand, one study indicates that nearly half of those opting for early retirement before age 65 had second pensions (Meier & Torrey, 1982). These people were more likely to cease work completely and to have a shorter period of transition to retirement.

Of course, some people continue to work full time past age 65 because they love to, whereas others are forced to quit for reasons of poor health or job-related pressures. But for an average worker, the trade-off between work and leisure may be a calculated movement based on the projection of retirement income. When the projected retirement income is not adequate,

these older workers appear to prolong the transition process to assure that the drop in economic resources will not be too sudden and devastating.

The issue of the adequacy of pre- and postretirement income can also be examined by analyzing the changes in the poverty rate and, to a certain extent, in the level of median income. As mentioned, downward changes in income typically occur as people prepare for retirement by reducing work hours. Data on labor force participation rate show that a lower proportion of those aged 55–64 years are engaged in full-time work than are those aged 45–54 years. Data on the distribution of income also show that median income of all those aged 55–64 years has been significantly lower than that of those aged 45–54 years. Median income of full-time workers aged 55–64 years, however, has been on a par with median income of full-time workers aged 45–54 (U.S. Bureau of the Census, 1978–1990).

As previous studies have shown, the gradual deterioration in real income during retirement may not be as serious as the immediate effect of reduced or stopped earnings. Nonetheless, studies have also indicated that the elderly experience a substantial drop in economic status with the passage of time (Duncan et al., 1985). Fox's study (1984) also found that during the 4-year period following the initial benefit receipt, the average Social Security beneficiary experiences about 10% deterioration in real income. Thus, as indicated by the higher poverty rate and lower median income among older cohorts of retirees, retirement income may become less adequate over time, and a retiree's risk of failing into poverty may grow as he/she ages. Even the elderly who continue some paid employment after retirement from their main jobs to supplement their Social Security benefits stop working as they age. Although Social Security benefits are protected against inflation to ensure constant purchasing power, the majority of private pensions are not. During times of high inflation, fixed-dollar-value pension benefits quickly lose their real purchasing power. Moreover, further erosion in the level of income due to illness and widowhood (especially for women) is more likely as the retiree ages. Especially with the current Medicare policy, which provides limited coverage for hospitalization, elderly people with chronic

illness must buy medigap policies and/or pay medical expenses out of pockets.

Data and Sample

The data for this study are drawn from the Panel Studies of Income Dynamics (PSID), 1973–1987 interview waves, which were conducted by the Institute of Survey Research, the University of Michigan. The PSID are longitudinal surveys of about 6,000 nationally representative sample families that began in 1968 and cover such matters as sociodemographic variables, employment, and economic status. Although the PSID collected information on each family member (individual files), they amassed detailed employment, earnings, and other income information only for household heads (and wives, to a certain extent). Therefore, the sample for this study consists of 331 household heads (221 whites and 110 blacks) who were in the original PSID sample, had worked 10 or more years since age 18, and retired between 1978 and 1982. (The PSID oversampled blacks by 3 to 1.) The year of retirement—1978, 1979, 1980, 1981, or 1982—is defined as the year when the respondent indicated that he/she had retired. Previous studies have shown that self-definition of retirement is usually identical to objectively defined retirement based on such criteria as work hours and Social Security or pension benefit receipt.

In addition to grouping of the sample members by race and gender, the top and the bottom quartiles were also chosen, on the basis of total income 5 years prior to retirement, and compared in demographic and economic profiles. The top income group consisted of 98.9% white and 94.5% male, whereas the bottom group consisted of 76.1% white and 55.3% male.

Data in Table 1 show that the gender distribution was 78.2% male and 21.8% female, with no significant racial differences in gender distribution. At retirement, 70% of the sample were married. Because the PSID ascribed the status of household head to a woman only when she was the single head of a household, however, all women included in the sample were widowed, divorced, separated or never married. On the other hand, 89.5% of men were married. The mean level of education was 11.1 years, with a median of 12 years. But, significant racial

differences were found in the level of education and marital status. As expected, blacks had a lower level of education and were less likely to be married than whites. Those in the bottom quartile strata of income also had a lower level of education than did those in the top quartile strata of income. The mean number of years of employment since age 18 was 38, with a median of 40 years, with significant differences between genders only. In terms of the type of occupation 5 years prior to retirement, 22.4% of the sample held professional, administrative, or technical positions, 37.0% held service, sales, or clerical positions, and 40.5% held other types of positions. As expected, however, significant differences in the type of occupation were found between races, genders, and income strata.

Because the sample consisted of household heads only, the findings may not be generalizable to all elderly. Especially for women, the generalizations are limited to single people. Despite these shortcomings, this panel study provides the most accurate tracking available of income changes before and after retirement.

Methods

The process of retirement was examined by the changes in work hours starting from 5 years before retirement to 5 years after retirement. As for changes in income, given that earnings, asset income (including income from business, market gardening, roomers and boarders, dividends, interest, and rent), Social Security benefits (for a couple if married), pension benefits, and other transfer payments (Supplemental Security Income (SSI), food stamps, miscellaneous transfers, money received from relatives) constitute the majority of income for most people, this study utilized the following methods: (1) comparison of the amount of income (all in 1987 dollars) from each major source every year from 5 years before retirement to 5 years after retirement; (2) comparison of the proportion of income from each income source to the total income for the same 11-year period; and (3) comparison of poverty status for the same 11-year period. (Except for the analysis of poverty status, wife's income from such sources as earnings, income from assets, and pensions was not included. On the other hand, wife's

Table 1.

Demographic and Work-Hour Characteristics of Sample

N (%)	Race			Gender		Income Stratum	
	All 331 (100)	White 221 (88.8)	Black 110 (11.2)	Male 244 (78.2)	Female 87 (21.8)	Top Quartile 83 (25.0)	Bottom Quartile 82 (25.0)
Race (%)							
White	88.8			89.2	87.5	98.9***	76.1***
Black	11.2			10.8	12.5	1.1***	23.9***
Gender (%)							
Male	78.2	78.6	75.7			94.5***	55.3***
Female	21.8	21.4	24.3			5.5***	44.7***
Level of education (yr.)	11.1 (0.2)	11.6*** (0.2)	7.7*** (0.6)	11.1 (0.2)	11.3 (0.3)	13.3*** (0.3)	9.1*** (0.3)
Work history (yr.)	38.1 (0.5)	37.8 (0.5)	40.2 (1.7)	40.0*** (0.4)	31.0*** (1.4)	37.8 (0.6)	38.8 (1.5)
Age at retirement (yr.)	64.0 (0.4)	63.8 (0.4)	65.6 (1.3)	63.5** (0.4)	65.8** (0.7)	62.1*** (0.6)	68.6*** (0.8)
Marital status 5 years before retirement (%)							
Married	70.0	71.7*	56.4*	89.5***	0***	85.4***	39.8***
Single	30.0	28.3*	43.6*	10.5***	100***	14.6***	60.2***
Pre-retirement occupation (%)							
Prof/adm/tech.	22.4	24.1***	9.2***	25.5**	11.4**	55.9***	1.5***
Services/clerk	37.0	38.9***	22.5***	35.2**	43.7**	31.9***	31.8***
Laborer/others	40.5	37.1***	68.3***	39.3**	44.9**	12.2***	66.7***
Annual work hours (hr.)							
5 years before retirement	1,776 (47.1)	1,811* (48.9)	1,488* (157.9)	1,854*** (52.1)	1,404*** (94.9)	2,158*** (64.6)	982*** (91.9)
4 years before retirement	1,771 (49.7)	1,812** (52.0)	1,438** (154.6)	1,871*** (54.3)	1,342*** (105.4)	2,113*** (73.7)	1,070*** (108.4)
3 years before retirement	1,669 (49.2)	1,705* (51.4)	1,377* (158.5)	1,777*** (55.4)	1,279*** (94.5)	2,075*** (70.6)	1,006*** (98.3)
2 years before retirement	1,590 (51.0)	1,619 (53.6)	1,356 (160.1)	1,681*** (56.8)	1,262*** (106.5)	2,030*** (79.9)	948*** (99.3)
1 year before retirement	1,352 (49.7)	1,373 (53.0)	1,182 (141.5)	1,440*** (57.1)	1,033*** (91.6)	1,729*** (89.9)	700*** (82.0)
Year of retirement	634 (39.2)	646 (41.9)	545 (111.1)	651 (45.6)	575 (74.6)	735*** (72.8)	346*** (59.4)
1 year after retirement	181 (23.8)	185 (25.3)	147 (70.0)	196 (28.3)	126 (39.4)	191** (48.1)	78** (22.5)
2 years after retirement	175 (26.7)	180 (28.4)	130 (79.7)	192* (33.0)	114* (31.2)	140 (42.0)	97 (33.7)

Continued

Table 1

Continued

	Race			Gender		Income Stratum	
	All	White	Black	Male	Female	Top Quartile	Bottom Quartile
N (%)	331 (100)	221 (88.8)	110 (11.2)	244 (78.2)	87 (21.8)	83 (25.0)	82 (25.0)
3 years after retirement	176 (29.4)	180 (31.8)	150 (72.5)	192 (35.7)	120 (41.4)	157** (50.3)	29** (12.5)
4 years after retirement	185 (29.3)	191 (31.8)	137 (69.2)	214** (36.6)	80** (25.1)	201** (68.8)	41** (18.9)
5 years after retirement	180 (27.8)	187 (30.3)	131 (62.0)	204** (33.7)	94** (39.4)	210** (62.5)	58** (23.3)

(): Standard error of the mean.

*** $p < .001$; ** $p < .05$; * $p < .10$: Denote significant differences between races, genders, or income strata.

Note: Statistics are all weighted.

Social Security and SSI benefits were included, because the earlier interview waves of the PSID did not separate the wife's benefits from the husband's.) In all analyses, racial and gender differences as well as differences between those in the top quartile and those in the bottom quartile of preretirement income strata were examined, because blacks and women, to say nothing of those whose preretirement income is relatively low, are more likely than other sample members to experience hardship from inadequate retirement income. Because of lack of space, however, findings regarding the changes in the proportion of income from each source and poverty rates are reported in 5 years before retirement, 1 year before retirement, year of retirement, 1 year after retirement, and 5 years after retirement only.

For the determinants of total income 5 years after retirement (logged), two models of multivariate ordinary least squares (OLS) regression analysis were conducted. In Model 1, race, gender, years of education, years of work history since age 18, age at the time of retirement, marital status 5 years before retirement, and the amount of total income 5 years before retirement (logged) were entered as explanatory variables. It has been previously noted that these variables are good predictors of

retirement income. In Model II, to examine differential effects of race and gender, the interaction effects between these variables and race and gender were also entered.

Findings

Changes in work hours. Examination of annual work hours of the members of this study's sample shows that they worked 1,590 hours (with median 1,840 hours) and 1,352 hours (with median 1,581 hours) on the average 2 years before retirement and in the year preceding the retirement year, respectively (see Table 1). These represent 11% and 24% decrease, respectively, from 1,776 annual work hours 5 years prior to retirement. The sample members worked 634 hours on the average (with median 364 hours) in the retirement year. In the year following retirement, the average work hours were 181 with median 0. In other words, 71.0% of them did not work at all in the year following retirement. Five years into retirement, 80.4% of them did not work at all. Thus, the data show that workers indeed decreased their work hours gradually as retirement approached. Nevertheless, the data also indicate that 1 of 5 retirees continued working after retirement. Although the proportion of retirees who were found working after retirement is not huge, the finding still renders support to the gradual process of detachment from work for some workers.

An interesting finding with respect to racial differences is that blacks, in the 5 years prior to retirement, worked significantly fewer hours annually than did whites. Data showed that this significant difference continued until 3 years before retirement but disappeared thereafter. This means that, as retirement approached, white workers were reducing their work hours faster than were black workers.

For most of the study period, women also worked significantly fewer hours than did men, implying that more women than men worked part time. As retirement approached, both men and women apparently reduced their work hours at the same rate. As a result, gender differences in work hours were maintained until retirement. Four years after retirement, gender differences were again significant, indicating that more men (21.8%) than women (11.2%) were engaged in post-retirement

work. As mentioned, however, women retired at a later age than did men.

The most persistent differences in work hours were found between those in the top quartile and those in the bottom quartile of income. Throughout the study period, the differences between the two groups were maintained: The top income group always worked at least twice as many hours as did the bottom income group. In other words, 24.5% of those in the top quartile versus 9.3% of those in the bottom quartile continued working 5 years after retirement. As in the case of women, however, the bottom group retired at a significantly later age than did the top group, 68.6 years versus 62.1 years ($p < .001$).

Thus, for both women and those in the bottom quartile, delaying retirement may have been a means of avoiding the precipitous decline in income expected to accompany retirement. Also, given that the total number of hours worked annually was significantly lower than those of men and people in the top quartile, respectively, it is possible that women and those in the bottom quartile were supplementing their Social Security benefits with earnings, as was indicated by Fox (1984). In fact, further analysis shows that 2 years before the self-claimed retirement year, 69.5% of those in the bottom quartile, as compared to 9.8% of those in the top quartile were receiving Social Security benefits ($p < .0001$). The proportion of women receiving Social Security benefits 2 years before retirement was 46.5%, as compared to 32.7% for men ($p < .02$).

Changes in pre- and postretirement income. Table 2 shows changes in the average total income and the proportion of income from each income source for the 11-year study period by race, gender, and income strata. For all categories of retirees, total income 1 year after retirement was significantly lower than total income in years preceding retirement. And incomes 1 year prior to retirement and at the retirement year were lower than incomes in earlier years. The significant differences between races, genders, and income strata, needless to say, were not unexpected.

The most interesting change that occurred with retirement, however, was the shift in the proportion of income from each income source. Naturally, the share of earnings in total income

Table 2.

Comparison of the Changes in the Proportion of Income from Each Source by Race, Gender, and Income Strata

	Total Income (\$) ^a		Earnings (%)		Asset Income (%)		SSA (%)		Pension		Other Trans.	
	White	Black	White	Black	White	Black	White	Black	White	Black	White	Black
N	221	110										
5 years before retirement	29,356 (1,258.4)	15,656*** (1,896.2)	77.4	76.4	8.8	1.3***	10.1	16.7	3.4	1.3	0.3	4.4
1 year before retirement	28,853 (1,354.6)	14,181*** (2,206.6)	61.7	63.4	13.6	6.8**	19.0	23.0	5.5	1.9	2.2	5.0
Year of retirement	24,573 (1,499.3)	12,032*** (1,731.2)	32.4	33.7	17.9	8.1**	33.0	36.7	14.3	15.2	2.8	6.3
1 year after retirement	19,780 (906.8)	9,918*** (1,016.7)	8.6	7.0	23.8	9.8***	42.8	58.5**	23.1	19.5	1.7	5.3
5 years after retirement	19,009 (1,067.2)	10,289*** (1,341.0)	5.5	6.2	21.8	10.0**	49.8	56.4	21.5	19.1	1.0	8.3***
N	Male 244	Female 87	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
5 years before retirement	30,722 (1,353.5)	16,451*** (1,433.2)	80.1	67.4**	8.2	7.2	9.0	17.6**	2.5	5.5	0.3	2.3
1 year before retirement	29,589 (1,411.5)	16,782*** (1,427.9)	65.4	49.1**	12.8	13.3	17.4	26.8**	3.0	4.5	1.4	6.3**

Year of retirement	25,683 (1,579.0)	14,177*** (1,172.3)	33.3	27.7	17.7	15.4	31.9	37.9	13.9	15.9	3.2	3.1
1 year after retirement	20,604 (998.1)	11,372*** (886.3)	8.8	6.9	23.8	16.8**	42.6	51.4*	23.6	19.4	1.1	5.5**
5 years after retirement	20,140 (1,177.0)	10,496*** (1,022.7)	6.4	2.6**	21.2	17.9	49.1	55.9	21.6	20.0	1.3	3.6

N	Top Quart. Bottom Quart.		Top Bottom		Top Bottom		Top Bottom		Top Bottom		Top Bottom	
	83	82										
5 years before retirement	55,512 (2,426.5)	7,939*** (477.9)	85.8	55.3***	11.9	7.6	0.5	30.9***	1.8	4.1	0	2.1*
1 year before retirement	52,206 (3,210.4)	11,284*** (946.5)	71.2	35.8***	19.9	9.6**	4.1	44.4***	4.2	3.1	0.6	7.2**
Year of retirement	44,462 (3,600.8)	9,271*** (769.1)	36.8	15.3***	27.7	12.3***	12.1	57.7***	21.3	8.4***	1.1	6.3**
1 year after retirement	34,225 (2,180.5)	8,137*** (629.0)	8.3	6.0	33.8	13.9***	23.3	68.9***	34.3	5.2***	0.3	6.1**
5 years after retirement	34,653 (2,790.2)	7,956*** (809.8)	6.9	1.8**	29.2	15.5***	31.2	71.2***	31.6	5.0***	0	6.6**

() : Standard error of the mean.

*: In 1987 constant dollars.

***p<.001; **p<.05; *p<.10: Denote significant differences between races.

Note: Statistics are all weighted.

decreases most dramatically upon retirement and in the immediately ensuing years, and for most categories of retirees the share of Social Security benefits in total income is the largest of all. Only for those in the top quartile stratum of income was the share of Social Security benefits in total retirement income sometimes a little lower than or the same as those of asset income or pension benefits. For other groups of retirees with low total income—blacks, women, those in the bottom quartile stratum of preretirement income—the share of combined income from assets, pension plans, and other transfer programs was still smaller than that of Social Security benefits.

In terms of changes in real dollar amount of income with retirement, Figs. 1–5 provide a clear picture. Figure 1, in fact, shows that average total income for sample members in most categories started to decline 2 years before their self-claimed retirement, apparently due to declining earnings in the same period. Especially between 1 year before retirement and 1 year after retirement, earnings of sample members in all categories dropped sharply. As shown in Fig. 2, the incomes of those

Figure 1.

Changes in Mean Total Income Before and After Retirement by Race, Gender, and Income Strata

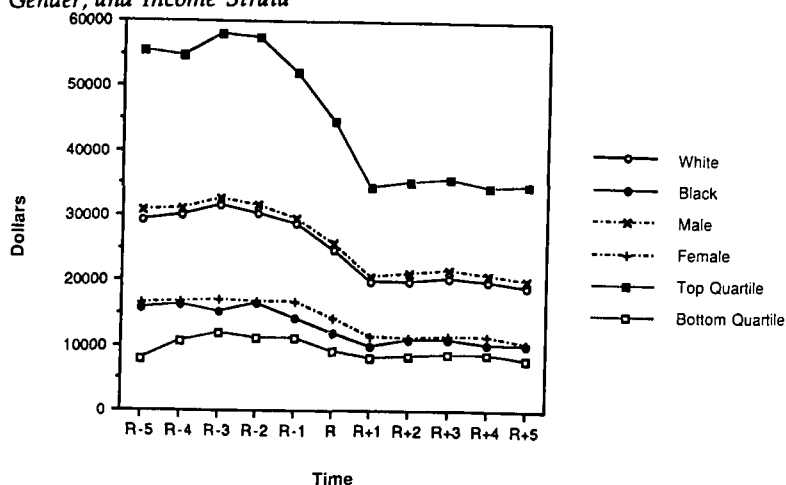


Figure 2.
Changes in Earnings Before and After Retirement by Race, Gender, and Income Strata

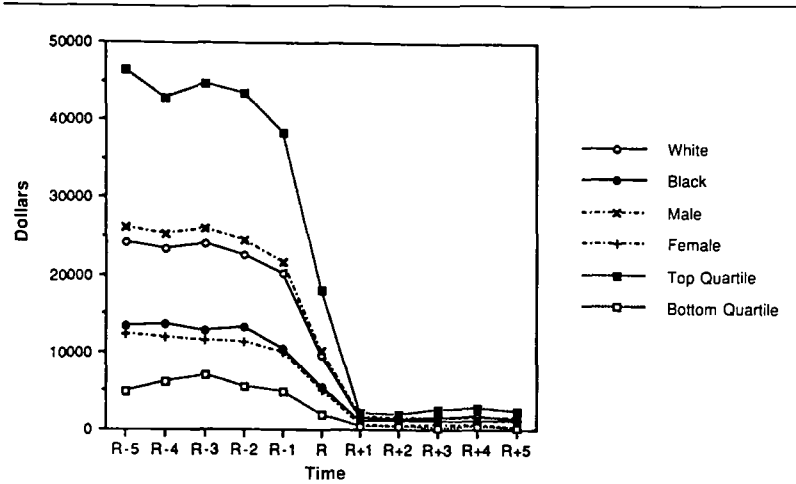


Figure 3.
Changes in Income from Assets Before and After Retirement by Race, Gender, and Income Strata

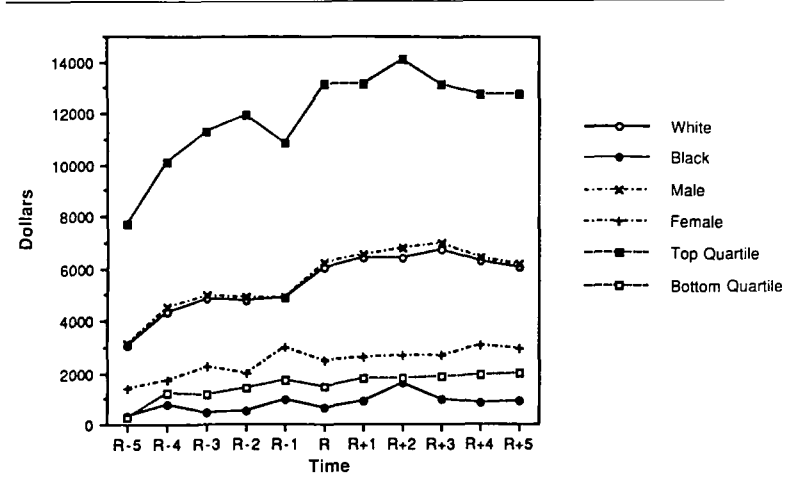


Figure 4.
Changes in Social Security Benefits Before and After Retirement by Race, Gender, and Income Strata

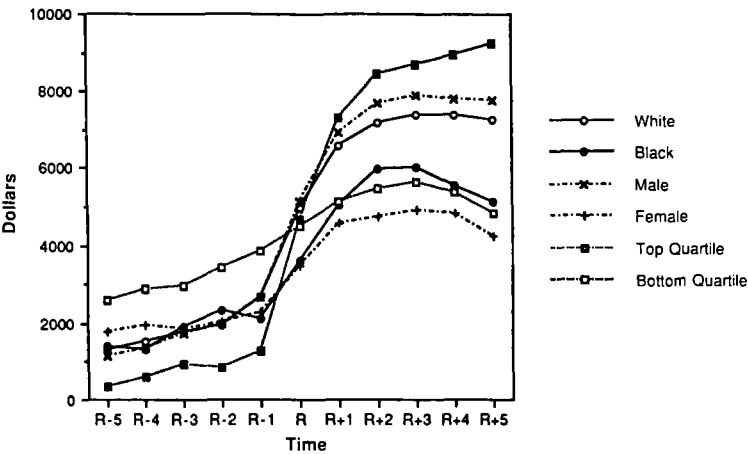
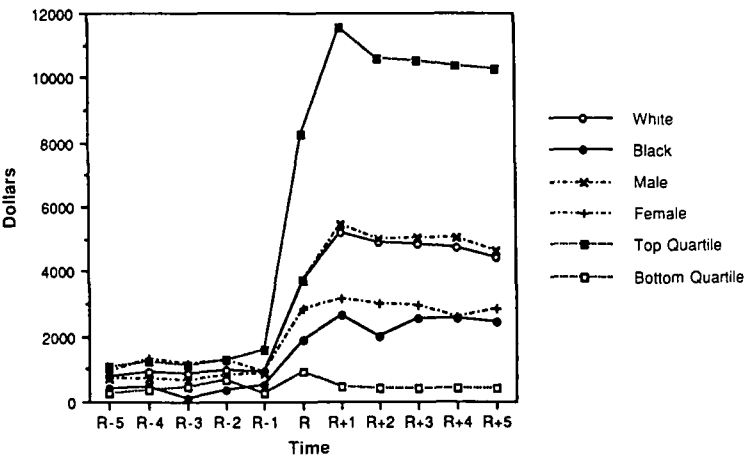


Figure 5.
Changes in Pension Benefits Before and After Retirement by Race, Gender, and Income Strata



who had the highest preretirement earnings dropped the most drastically, yet they still managed to have higher postretirement earnings than any of the others.

Owing to increased Social Security income, pension benefits, and income from assets at and after retirement, however, mean postretirement income appears to have been quite stable for all retirees throughout the study period. Fortunately for those in lower economic strata—blacks, women, and those in the bottom quartile—their retirement income did not quite represent a precipitous decline from preretirement income. Although the preretirement economic gap between races, genders, and income strata continued after retirement, those who experienced the most precipitous decline in income due to retirement were the ones who had the most income before retirement.

The continued income gap between races, genders, and income strata in postretirement years can be explained by significant differences in the amount of income from assets and pension benefits (see Figs. 3 and 5). For income from both assets and pension benefits, the difference in the average dollar amount between the top quartile and the bottom quartile was as high as \$10,000. More importantly, further analysis showed that fewer than 15% of those in the bottom quartile received any pension benefits after retirement, whereas about 65% of those in the top quartile did. A little more than 50% of those in the bottom quartile, in contrast to approximately 90% of those in the top quartile, had income from assets to support their retirement. Moreover, especially in terms of income from assets, blacks appeared to be the most disadvantaged of all. Although a noticeable gap also exists in the distribution of postretirement Social Security benefits (see Fig. 4), it is relatively small compared to the gaps in income from assets and pension benefits. An interesting but expected finding is that single women received the smallest amount of Social Security benefits after their retirement due mostly to their shorter work histories and lower wage levels than those of workers in other categories.

Changes in the poverty rate. In fact, the most important indicator of the differences in the level of retirement income between races, genders, and economic strata was the poverty rate. (For the calculation of poverty rates, both household heads'

and wives' incomes were used for married couples, while obviously only the head's income was used if he/she was single.) That is, 5 years prior to retirement, 6.1% of all sample members had total income (including food stamps) below the official poverty threshold, still with significant racial differences. A difference was also found, naturally, between the top and the bottom quartiles of income, with 24.6%, or almost one quarter, of those in the bottom quartile having had income below the official poverty line. But slipping of economic status was quite evident for almost all sample members in the year of retirement, with the addition of 3+ percentage points in the poverty rate. Five years after retirement, the overall poverty rate was increased by more than 300%, to 19.9% as compared to that 5 years before retirement. The significant differences between genders as well as races were still maintained, as shown in Table 3. That is, 5 years after retirement, about one third of black and female sample members were living below the poverty line, and close to one half of all those who had been in the bottom quartile stratum of income early on were living below the poverty line at the end of the study period. Even the proportion of white and male sample members who were poor was quite high. So, although the average income of retirees appeared to be stable in postretirement years, the findings essentially confirmed those of earlier studies that showed the precipitous drop in income at retirement and its gradual deterioration afterward.

Determinants of postretirement income level. As shown in Table 4, the results of the OLS regression analyses show that those who were married, those who had higher education, and those with a higher preretirement income were more likely to have a higher postretirement income than those who were single, those who had lower education, those with and a lower preretirement income. Although Table 4 presents coefficients that are significant at a level .05 or lower, further analysis shows that being a male in itself is significantly positively associated with high postretirement income at a .10 level. Interestingly, despite the obvious racial differences in the level of both pre- and postretirement income, race in itself was apparently not a significant determinant of total income 5 years after retirement.

Table 3.

Changes in Poverty Rate (%) Before and After Retirement

		Race		Gender		Income Stratum	
	All	White	Black	Male	Female	Top Quartile	Bottom Quartile
N	331	221	110	244	87	83	82
(%)	(100)	(88.8)	(11.2)	(78.2)	(21.8)	(25.0)	(25.0)
<hr/>							
5 years before retirement	6.1	4.5***	19.2***	5.1	9.9	0***	24.6***
1 year before retirement	8.3	5.1***	33.4***	5.8**	16.9**	1.7***	24.6***
Year of retirement	11.3	9.1***	28.6***	9.7*	17.0*	3.4***	33.0***
5 years after retirement	19.9	18.5*	30.8*	16.2***	33.1***	3.3***	46.7***

*** $p < .001$; ** $p < .05$; * $p < .10$: Denote significant differences between races, genders, or income strata.

Note: Statistics are all weighted.

It is most likely that differences in education and preretirement income between whites and blacks are real causes for their postretirement income differences.

In Model II, in addition to the variables found significant in Model I, gender and the interaction terms between gender and preretirement income, education, and work history were also significant. The interaction effects indicated that being a male significantly added to the positive effects preretirement level of income and education had on the postretirement level of income. Although work history in itself is not a significant predictor of postretirement income, being male and having long work history were significantly positively related to postretirement income level. But it should be noted that the gender variable and all the interaction terms added only 3% to the total variance explained.

Table 4.

*Determinants of Income 5 Years After Retirement: Stepwise OLS
Regression Coefficients*

Dependent variable: Income 5 years after retirement (logged)	Model I		Model II	
	<i>Beta</i>	<i>T</i>	<i>Beta</i>	<i>T</i>
Marital status	.187	4.232	.257	3.853
Education	.154	3.245	.508	4.793
Age at retirement		n.s.		n.s.
Income 5 years prior to retirement (logged)	.558	11.019	.283	2.764
Work history since age 18		n.s.		n.s.
Race		n.s.		n.s.
Sex		n.s.*	1.639	3.016
Sex × education			.732	3.737
Sex × income 5 years prior to retirement (logged)			2.070	3.327
Sex × work history			.227	2.209
Multiple R	.725		.230	
R ²	.526		.563	
Adjusted R ²	.521		.552	
SE	.237		.230	

*Significant at a .10 level.

Note: For interaction effects, only those that are found significant are listed.

Discussion and Summary

The findings of this analysis confirm our hypothesis. Older workers were indeed found to reduce their work hours and earnings 2 to 3 years prior to retirement in preparation for the retirement. The sharpest drop in work hours was found in those in the highest income group who have had the longest preretirement work hours. The comparison of changes in average total income due to retirement also showed that the higher the preretirement income, the wider the range of change. So, retirement leveled off the income gap between rich and poor to a certain extent, owing especially to Social Security benefits; the

average difference between the two groups 5 years after retirement, though, was still more than \$25,000. This postretirement income difference was due largely to differences in income from assets and pension benefits, whereas the preretirement income difference was due to differences in earnings.

Significant differences in the level of income and in poverty rates were also found between races and genders. Blacks and women had lower pre- and postretirement income than whites and men, respectively. But multivariate analyses showed that the racial effect is more spurious than real. The real cause of blacks' low postretirement income level lay in their low education and low preretirement income level. And the effect of gender, when the other variables were held constant, was also marginal.

An interesting finding, however, was that examination of Social Security benefit receipt, as shown in Fig. 4, indicated that many workers in low-income groups, including women and blacks, had in fact received Social Security benefits well before their self-claimed retirement. Previous studies have often defined the receipt of Social Security benefits as coterminous with retirement and thus have reported frequent postretirement work activities of low-income retirees in an effort to supplement their retirement income. This study also showed that some low-income retirees continued working after self-claimed retirement, but not to the extent of what previous studies have indicated. The difference is believed to be due to the difference in the definition of retirement. What this study found was that many low-income workers in reality started to receive Social Security benefits to compensate their decreasing earnings as they approach retirement. Social Security benefits were thus found to serve as an equally important safety cushion for both those approaching retirement and those retired in low economic status.

It should be also noted that the income of 1 out of 5 retirees in this study was below the poverty line 5 years after retirement. Specifically, approximately one third of blacks and women were in poverty 5 years after retirement. Given that the average ages at retirement were 65.6 years and 65.8 years for blacks and women, respectively, they were in their early seventies when they had been retired for 5 years. So, it appeared that most of

them were not able to engage in any income-producing work and that they were likely to live in old age on whatever they received from current sources of income. In addition to the increasing cost of health care in old age, however, the dwindling value of pensions even for those who now enjoy some pension benefits puts a higher proportion of retirees into poverty as the length of their retirement increases.

The policy implications of the findings are these: (1) Given that Social Security benefits constitute a major source of income for low-income elderly people, especially blacks and women, we have to continue providing the cost of living adjustment (COLA) for the benefits. (2) Low-income retirees should be encouraged to take postretirement jobs, to a greater extent, which will supplement their meager retirement income. Policies and programs can be designed to help connect low-income retirees with jobs. (3) Given that the low level of preretirement income is the real cause of the low level of postretirement income, a system to promote and guarantee private pensions or individual or group retirement account for low income workers should be studied and instituted.

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A View From the Inside Out: Recipients' Perceptions of Welfare

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Welfare use is a highly stigmatized behavior in American society. The word itself conjures up various images of disdain in the minds of most Americans. Yet how do the recipients of welfare discern and react to being on public assistance? The focus of this paper is on understanding the manner in which recipients view their own situation, how they perceive the general public's attitudes toward themselves, and their views on fellow welfare recipients. Also examined are how such attitudes influence recipients' behavior towards welfare. These perceptions and behaviors are explored in detail through the use of in-depth, open-ended qualitative interviews with a random sample of welfare recipients. The concept of managing and coping with stigma is utilized to provide insights into the results.

Much has been researched and written about how Americans view welfare and welfare recipients, and more generally their views concerning those in poverty (e.g. Nilson, 1981; Hendrickson and Axelson, 1986; Smith and Stone, 1989). For the average citizen, individuals in poverty and on welfare are perceived as responsible for the situation in which they find themselves. That is, lack of effort, thrift, morality, ability, and so on, are typically cited as major reasons for poverty and welfare use (see Feagin, 1975; Kluegel and Smith, 1986).

Much less has been written about how welfare recipients themselves view their own and other welfare recipients' situations, and their perceptions of how the general public views and acts toward their situation (e.g. Briar, 1966; Handler and Hollingsworth, 1971; Cole and Lejune, 1972; Kerbo, 1976; Goodban, 1985; Popkin, 1990). Furthermore, the limited number of studies which have looked at welfare recipients' perceptions have predominately used a quantitative analytical approach.

While informative, such an approach has generally not been able to provide an in-depth examination into the content of recipients' attitudes and perceptions of welfare.

This paper explores these different perceptions in detail through the use of in-depth, qualitative interviews with welfare recipients. It is a look at attitudes from the inside out, providing a revealing juxtaposition. Also addressed are how such attitudes influence recipients' behavior towards welfare. Coping with stigma is used as an overriding framework to interpret the attitudes and behaviors of welfare recipients.

The concept of stigma has provided a powerful tool for interpreting and understanding the attitudes and behaviors of individuals who fall into discredited categories (Pfuhl, 1986). These have included a wide range of groups, including gays and lesbians, individuals convicted of crimes, those suffering from physical handicaps, and so on.

Research has shown that considerable social stigma is also attached to the use of public assistance programs (Horan and Austin, 1974; Williamson, 1974; Keith, 1980; Moffit, 1983; Waxman, 1983; Camasso and Moore, 1985; Kluegel and Smith, 1986). There are several reasons behind such stigma. Use of welfare tends to jar against the individualism which most Americans pride themselves in (Gans, 1988). From this ethos, those who rely on government assistance for financial support rather than their own efforts are perceived as failures. Consequently, individuals receiving welfare tend to be highly stigmatized by a general public who hold strongly to individualist beliefs.

An example of this comes from a 1978 study by Coleman, Rainwater, and McClelland. In interviews conducted in Boston and Kansas City, participants were asked who they felt were the lowest class in society?

The word used most often by our sample members to characterize the life style and income source of people at the bottom was welfare... The principle enunciated ... was that the welfare class and people at the bottom are nearly synonymous terms, that any American for whom welfare has become a way of life is thereby to be accounted among the nation's lowest-class citizens (1978: 195).

A second reason behind the stigmatization of welfare and welfare recipients is the fear of encouraging dependency upon the state. As Goodban notes, "Afraid that handouts will encourage dependency, assistance programs stigmatize those who receive benefits to prevent them from asking for more, and to make it clear to others that there is an emotional price to pay" (1985: 404).

The idea goes back to the English Poor Laws. If public relief were an attractive alternative to employment (according to this argument), individuals would opt for relief rather than work. As de Tocqueville noted in his 1835 lecture to the Royal Academic Society of Cherbourg,

Any measure which establishes legal charity on a permanent basis and gives it an administrative form thereby creates an idol and lazy class, living at the expense of the industrial and working class. This, at least, is its inevitable consequence, if not the immediate result (1983: 113).

The concept became known as that of less eligibility, which "meant that persons on relief should be kept in a condition necessarily worse than that of the lowest paid worker not on relief, the objective being to make relief undesirable and to provide the recipient with a clear and strong incentive to get off the relief rolls" (Waxman, 1983: 82). Along with such undesirable conditions would come a hefty dose of stigma as well.

Thus, stigma surrounds public assistance and its participants. What is less apparent is how and in what ways recipients' perceptions and behaviors regarding welfare are shaped and influenced by this stigma. The focus of this paper is on understanding the manner in which recipients view their own situation, how they view the general public's attitudes toward themselves, and recipients' views on fellow welfare recipients. The discussion section utilizes the concept of coping with stigma in order to provide insight into these findings.

Methodology

The data analyzed in this paper comprise one component of a larger study designed to explore the lives of welfare recipients

both quantitatively and qualitatively. Three separate yet complementary sources of data were gathered—a large, longitudinal caseload sample of welfare recipients; in-depth interviews with a small number of families on welfare; and fieldwork of the welfare system. All three sources of data were gathered in the State of Wisconsin. This paper focuses entirely on the in-depth interviews with families. The strength of such interviews is that they have the potential to provide considerable richness and insight into welfare recipients' lives, including attitudes and perceptions.

The in-depth interviews were conducted during the summer of 1986. A random sample of welfare recipients was generated based upon access to the entire universe of recipients in one county during May, 1986. The sample was stratified by household type, as well as by welfare eligibility status. Of interest were different types of families both on, and currently exiting the welfare rolls. These included female headed families, married couples, singles, and the elderly.¹ Because the interviews were face-to-face, it was impractical to randomly sample the entire state given the cost and time constraints involved. A representative county was chosen which roughly reflected the overall state population, containing urban and rural areas, occupational diversity, and so on.

The response rate was 76 percent. This rate represents the number of interviews conducted, divided by all households we attempted to locate (whether contact was made or not). For those whom we were able to contact, the refusal rate was 5 percent. Individuals without telephones were tracked down, several interviews were conducted in Spanish with the aid of an interpreter; in short, all avenues were used to contact sampled recipients. Participating respondents were paid 15 dollars.

Fifty families were interviewed (in addition, five households were interviewed in the pretest). By design, the demographic composition of the sample approximately mirrored that of the caseload data set.² The interviews were conducted in respondent's homes, and averaged between one and a half to three hours long. All interviews were tape recorded.

For female headed families, the elderly, and single welfare recipients, the head of household was interviewed. For married

couples, we attempted to interview both the husband and wife together. However in several cases we were only able to interview the wife.³

At the onset of each interview, respondents were informed that there were no right or wrong answers to the questions being asked, rather our concern was in understanding their honest appraisals of their feelings, experiences, and behaviors. In addition, it was stated clearly to all recipients that we were not a part of the welfare administration, and that our affiliation was university based. We also stated verbally and in writing that all responses would be confidential.

Most respondents appeared open and frank about their feelings and behaviors. For example, individuals would often volunteer sensitive information (e.g. incest, violence in the family, painful childhoods, etc.), and would frequently express genuine emotion during the interviews. Overall, rapport between interviewer and interviewee was excellent. This was assessed in two ways. Following each interview the overall perceived rapport during the interview was recorded. In addition, by listening to each interview several times, rapport was also assessed.

The interviews were open-ended and semi-structured around several major topics such as attitudes regarding welfare, family dynamics, employment, the experience of getting on and off public assistance, and so on. As a reliability check on the answers given during the interviews, they were compared with the information from respondents' caseload records (which had been made available from the state). The match was high, thus lending confidence in the interview data.

In addition to the actual interview, fieldnotes were taken which described the setting in which the interview took place, the recipient's dwelling, the surrounding neighborhood, the physical appearance of the recipient, and any other relevant information which might provide greater understanding into the recipient's situation.

The interviews were then transcribed from the recording tape. These were entered as files into a mainframe computing system. The transcriptions reflected the exact wording and manner in which responses were given. Each transcription was then triple checked with the original tape for accuracy.

Names and places have been changed throughout the paper in order to protect the confidentiality of respondents. In addition, the interviews have been slightly edited. For example, phrases such as "you know" have been largely edited out. However, none of the original wording has been altered from that contained in the transcriptions. The intent is simply to provide greater readability by editing out unnecessary phrases.

Recipients' Views of Welfare

Three distinct perceptions are explored. First, how do recipients view being on welfare? Second, how do they perceive and react to others attitudes towards them? And third, what are their views regarding the predicament of their fellow welfare recipients? The comparison of these three different perceptions provides an intriguing juxtaposition which is interpreted in the discussion section.

Recipients' Perceptions of their Situation

How do recipients view being on welfare? This issue is explored in terms of two questions. First, what are recipients general attitudes towards being on welfare? And second, to what extent do they feel responsible for their situation?

General Attitudes. Research has shown that most individuals applying for public assistance feel considerable anxiety and/or embarrassment during the application process (Briar, 1966; Schwartz, 1975; Prottas, 1979; Lipsky, 1980; Goodsell, 1984; Susser and Kreniske, 1987). Furthermore, most recipients clearly hope to get off public assistance, and believe in the ethic of work (Goodwin, 1972; 1983). Such attitudes were found for this sample of welfare recipients as well. Thus it is not surprising that virtually all able bodied recipients in the sample reported disliking being on welfare and expressing a clear desire to exit from public assistance programs.⁴

Two specific reasons underlie this. First, many recipients desire independence, rather than being reliant on the taxpayer's dollars. This view is consistent with the overall dominant ideology of individualism. As one woman noted,

I'd rather be able to support myself, you know, work, and make the money myself instead of having someone sign a check and

send it to me once a month. 'Cause I don't really like to live off other people. I'd rather work and make the money and support myself, in the best way that I could.

A second and closely related reason why recipients wish to get off the welfare rolls is the lack of privacy and the stigma associated with public assistance programs. Extensive documentation is needed to qualify. This need for documentation continues with update checks, six month reviews, and so on. When asked if she would like to get off welfare, a female head of household with two children responded,

I'd love to get off. 'Cause aid makes me sick. They just interfere in your life so much. You gotta do this, and you gotta do it when they say do it. And you gotta go to the doctors they want you to go to. And I don't like that. Unhuh. You don't have any privacy with aid.

Likewise, a 19 year old married woman who had recently gotten off of assistance commented,

'Cause when we were on welfare, I didn't really like the feeling. And I always felt like I was bein' watched. I always heard stories that they'll have you investigated or follow you around, see what your living status is like. And I didn't like the feeling of it. So I'm just glad that we're off from it. Really glad (laugh).

While welfare recipients desire to get off the rolls, most were nevertheless grateful for the assistance available to them. These attitudes became evident when recipients were asked what they would do if there were no welfare programs at all. Karen Davis, a 24 year old separated mother, responded,

I probably would have perished a long time ago. I really would have. Starvation, or something. When you've got two kids you do what you have to do. That's really the main reason I went on it too, because of the kids. I had no choice. But if it wasn't for that . . . I would have to say we would have perished a long time ago.

Others mentioned relying on family members more, and several discussed illegal activities as alternatives to not having access to public assistance. In general, recipients' attitudes towards being on welfare are that they clearly want to get off

the programs in the future, but are nevertheless grateful for the assistance available.

The Issue of Responsibility. To what extent do welfare recipients feel that being on public assistance is their responsibility? Within the interviewed sample, 82 percent felt that their being on welfare was due to circumstances beyond their control. Only 6 percent felt that they were solely responsible for being on welfare, while 12 percent felt that being on welfare was some combination of the two.

Recipients often referred back to the reasons for entering the welfare system in order to illustrate why it was that they felt their being on welfare was due to circumstances beyond their control. For example, the elderly discussed illnesses they had encountered. Singles mentioned incapacitation or other traumatic events. Female heads of households mentioned not being able to support their families on low paying jobs, no child support, and lack of affordable day care. Married couples discussed layoffs or jobs simply not paying enough.

An example is Colleen Bennett and her husband. They had been on and off welfare sporadically for several years. Colleen was asked to explain why she felt that their being on welfare was due to circumstances.

Loss of jobs, layoffs. Well, when Randy was born we just financially could not pay for a hospital, or a doctor, and stuff like that. It usually was something that just came up out of the blue and happened, and you didn't have any other income.

For most recipients, being on welfare is perceived as the result of unfortunate circumstances and situations over which the individual has little control.

Recipients' Perceptions of How Others Act and Feel Towards Them

Having explored how recipients feel about being on welfare, how do they perceive others attitudes towards them? Furthermore, how do they react and adjust their behavior to such perceived attitudes? As noted earlier, most Americans hold quite negative attitudes about the welfare system and its recipients. The question then is whether those receiving welfare encounter

such negative attitudes firsthand, and if and how they adjust their behavior in light of such attitudes?

The General Public. Slightly over two thirds of the interviewed sample reported specific instances of feeling that they were treated differently by the general public when it became known that they were receiving public assistance. These occurrences ranged from blatant antagonism to more subtle forms of disapproval. The most frequently cited cases occurred with the use of food stamps.⁵ Several examples are illustrative. Janice Winslow, a 37 year old separated mother of three, discussed the difficulties in using food stamps.

You really do have to be a strong person to be able to use food stamps and not get intimidated by how people treat you when you use them. And even then it's still hard. You feel people's vibes, you know, in the line. And the checkout people are almost without exception rude, unless you really get to know them. And I always feel like, "God, I'll be glad when I don't have to use these." They never ever leave any change in there. So every time you check out, they always have to go up to the office to get change, so you got all these people waitin' in line—it's like, you know, "These food stamp people."

Once about six weeks ago I turned to the woman behind me and said, "I don't know, I have not once come up here and bought something with food stamps where they didn't have to go and get change for, like a five or something, that they had in the drawer." She says, "Well, I guess it's just one of those ways that they're not making it easy for you."

A second example comes from a married couple who were asked if they had noticed any difference in the grocery store when they used food stamps:

It's absolutely blatant in the stores. They'll smile and be chatting with you, and then they see you pull out the food stamps—they just freeze up. And they scrutinize the food. I mean, I get really hyped. If it's a birthday or something, and I'm buying steak so that we can have a birthday dinner at home—ohh, the looks they get on their faces. Once I had a clerk tell me, "You buy really good food with your food stamps" (laughter). Jeez. Yeah, there is a difference.

Recipients may develop several strategies for dealing with the stigma of having to use food stamps. Some shop at off times or with checkers whom they know personally. For example,

When I go to buy with food stamps, I try to go at night so not too many people get behind me. Especially when the employees ask about the I.D. And then they want to see one more I.D. And it's very, very uncomfortable. I guess I cannot be like other people that just carry their food stamps in their hands like money. I just . . . can't do that.

Similarly, Jody Edwards, a 23 year old single parent, explained,

I try really hard to hit a day that nobody's gonna be at the store because I just get all flustered. I have a terrible time using my food stamps. Just hate it! Just hate it.

Others may go to stores where the use of food stamps is fairly common. For example, one rural woman often went into the metropolitan area to shop.

Well, when I went grocery shopping, I usually went to Ceders (a supermarket). Because I figured a lot of people go in there and use 'em, you know, so I wouldn't feel out of place. Otherwise, it would look bad, and I still felt stupid.

Alternatively, recipients may send someone else to use their food stamps, or perhaps dress differently,

I feel like I have to be dressed really nice and look nice to use 'em. I don't wanna look all dumpy and look like I fit it (the image of a welfare recipient).

Beyond food stamps, recipients felt stigmatized by the general public in other ways as well. Cashing their AFDC check, using a Medicaid card, telling an employer that they have been on public assistance, all may result in perceived differential treatment. A separated woman with two children discussed one such instance,

When I was looking for apartments, I was living with my mom for a while. And when I was looking, I couldn't prove the fact that I was turned down because of it, but you just know that yourself. The minute you say, "Well I'm getting aid, or AFDC," then all of

a sudden they sing a different tune. Or the place gets rented out to somebody else.

In discussing the use of her medical card, 29 year old Cindy Franklin noted,

Some receptionists turn off the friendliness when they see Medical Assistance. Sometimes I catch them looking at me, maybe if I have on a necklace or something. I don't think I look like the stereotypical welfare mother, and I see them scrutinizing me and thinking it over. It's pretty subtle.

Not as subtle were the reactions to Denise Turner's daughter.

My oldest daughter, she graduated from middle school. And she told me last year that she did not want to receive the hot lunch program because the children made a difference. So I had to scrape for the last couple of years while she was in middle school and try to make ends meet so that I could send her with a dollar or two dollars every day. Which is a big chunk out of our budget. The food program at school is a big help. But rather than see her mistreated, or have her friends sit away from her, this is what I had to do. Either have her bring a lunch, or give her money. And I don't think it should be that way. But people are very class conscious about these kinds of programs.

These examples illustrate some of the ways in which welfare recipients experience firsthand the negative attitudes held by the general public. Although not all recipients reported such occurrences, over two-thirds did. Furthermore, many recipients noted that these negative occurrences were experienced frequently, rather than as single instances.

Family, Friends, and Acquaintances. What are the perceived reactions of family, friends, and acquaintances to the individual's situation of being on welfare? As might be expected, there is a tendency for more positive support and understanding among close friends and family. Thus, while family members or close friends may dislike the concept of welfare, many are also understanding of the need for their relative or friend to have sought assistance.

However, there is also a degree of perceived animosity as well. For example, particular family members may express

strong disapproval of any member of their family relying on welfare. Such was the case with Kelly McGrath, a divorced mother of four. She was asked about the reactions of her family to her situation.

It varies. The female family members understand. And they never give me any problems or anything. But my brothers always figure I should be out working. I think it's just all the stereotypes that go along with it (receiving welfare). They just don't want their sister in with that stereotype.

In order to deal with the perceived negative feelings among both acquaintances and the general public, many recipients adapt the strategy of letting as few individuals as possible know that they are receiving public assistance. When asked if his friends had any opinions about his being on welfare, 24 year old David Grey responded, "Well, I really don't let 'em know about it. I don't think it's really anything I have to advertise, nor do I want to." Likewise, when Mary Summers was asked if her relatives expressed any feelings about her situation, she replied,

They don't talk about it. In fact, I like to stay away from some of the relatives until I go back to work. I mean, it's just a situation that you don't even wanna get into. Let it blow over, and when you get back (on your feet) and have a little dignity again, well then you can go back.

Finally, a woman living in a small rural town was asked about her friends reactions:

Well, there's alot that don't know that I am (on welfare). There's alot of 'em I work with. They make some nasty comments about people on ADC or welfare, as they call it. And I always say ADC, 'cause it sounds better. But, I don't really say anything. It doesn't really bother me, 'cause I figure, well, keep my mouth shut. What they don't know don't hurt 'em. It's none of their business. It used to bother me when they'd make their snide remarks, but I figure, well . . . let 'em. Wait 'til they have to do something like that, and it happens to them. They'll find out.

It is evident that most welfare recipients report various degrees of stigma in their dealings with the general public and/or acquaintances, ranging from obvious discrimination to more subtle forms of behavior.⁶ Recipients may develop several strategies for dealing with such animosity. The most obvious is to conceal the fact that they are receiving welfare. If that strategy is impossible (as with the case of food stamps), then an attempt may be made to either minimize their contact with the general public (when having to reveal one's welfare status), or to physically dissociate oneself from the image of a "typical" welfare recipient (by dressing according to middle class standards, watching what one buys in the supermarket, and so on). Given the general public's widespread disdain towards the welfare system, these perceptions and strategies should not be surprising. What may be surprising is the view of welfare recipients towards other welfare recipients.

Recipients' Perceptions of Other Welfare Recipients

Having looked at how welfare recipients view their own situation, and their perceptions of how others act and feel towards their situation, we now look at how welfare recipients view the predicament of other welfare recipients. In order to address this issue, several questions were asked which focused on the needs, behaviors, and reasons why other welfare recipients were receiving aid.

To a large extent, welfare recipients were critical in their assessment regarding the plight of their fellow welfare recipients. In fact, the opinions of welfare recipients appeared quite similar to that of the general public's assessment of welfare and its participants. That is, individuals viewed other welfare recipients as largely to blame for the situation in which they have found themselves.

Approximately 90 percent of the sample felt that those on welfare were either partially or fully to blame for being on public assistance. While a variety of reasons for welfare use were given, most mentioned either a lack of ambition and/or laziness as important factors in explaining why others are on welfare. A typical assessment is the following quote from Pam Bucholtz, a

married woman who was living with her unemployed husband on the outskirts of a rural town.

In my point of view I think they're too lazy to get out and find a job. In our case we're not. We're out looking. But some of these other people they're the ones that don't wanna work. They just don't wanna get out and work. They'd rather sit and collect on the government.

Related to such attitudes, is the idea that there are many on welfare who are abusing or cheating the welfare system. An example of this attitude is from Lisa Hicks, a 22 year old female head of household,

The money is to take care of your bills and your kids. Except they don't do that. They take it and party off of it. Or go out and buy new clothes for themselves. And their kids don't have anything. They walk around with holes in their clothes and hungry all the time because they take and gamble, or whatever with the money.

Certainly not every recipient felt that those on welfare were lazy or abusing the system. Some mentioned circumstances over which individuals had little control. Others mentioned becoming less harsh in their assessment having been on welfare themselves. However, as with the general public, most on welfare are quite critical of many of their fellow welfare recipients.

In addition to the negative reasons for why recipients felt other recipients were on welfare, many also discussed aspects of the common welfare stereotype in characterizing fellow recipients. This stereotype includes the idea that most on welfare are minorities, that those on welfare are there for long periods of time, that women have more children to get higher welfare payments, and so on. Several examples illustrate such attitudes. An elderly man commented,

I don't know what the percentage is but I would venture to say that 80 percent of the people on welfare are black, hispanic, or some of the boat people. And they're on there for year after year after year after year. They never get off it. It's just a way of life.

Take these welfare mothers out here. Alright, they're getting \$560, \$570, \$700 a month. Now you know, and I know, that they don't spend that much on groceries or rent. All they have to do if

they wanna increase their salary is go out and have another kid. And it seems to me, that's what they do. (laughter)

Likewise, another recipient remarked,

I think that's why a lotta these people have children because they don't wanna work. They wanna have everything handed to 'em. And they figure if they have two, three of 'em (children), they get more money. And a lotta these people, these young women that get that help, they're always in the bars. Out drinkin' and that.

Again, not every welfare recipient referred to such stereotypes in characterizing other welfare recipients. However, many did. What is surprising about such characterizations is that they come from fellow welfare recipients.

To summarize, welfare recipients view being on public assistance as largely beyond their control, and express a strong desire to leave the welfare rolls. Second, many recipients experience firsthand a variety of negative attitudes towards receiving welfare, and often adjust their behavior in order to minimize their encounters with such attitudes. Finally, recipients tend to be quite critical in their assessment of their fellow welfare recipients. A lack of ambition and/or laziness are seen as key factors in explaining why others are on welfare. In the discussion section below, the concept of coping with stigma is used to provide a broad framework for understanding these differing perceptions.

Discussion

As mentioned earlier, welfare use is a highly stigmatized behavior in American society. The word welfare conjures up various images of disdain in the minds of many Americans. This would appear as true for those on public assistance as for those looking from the outside in. It is this disdain and stigma which provides a backdrop for interpreting the perceptions and behaviors found in the preceding pages.

Erving Goffman defined stigma in the following way,

While the stranger is present before us, evidence can arise of his possessing an attribute that makes him different from others in the category of persons available for him to be, and of a less desirable

kind—in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and usual person to a tainted, discounted one. Such an attribute is a stigma, especially when its discrediting effect is very extensive; sometimes it is also called a failing, a shortcoming, a handicap (1963: 2–3).

Being on welfare is indeed such a stigma. As Kerbo notes, “to be a welfare recipient in the United States means degradation; to be stigmatized at the hands of the general society, politicians, and even social workers” (1976: 174). It is not surprising then that most who receive public assistance desire to leave the rolls in order to excise such stigma.⁷ That desire is consistent with research findings indicating that most individuals who begin a welfare spell, exit in a relatively short period of time (Bane and Ellwood, 1983; Duncan, 1984; Coder and Ruggles, 1988).

The fact that welfare recipients experience such stigma is also not startling given its pervasiveness. Various degrees of stigma are experienced firsthand—from the grocery store, to cashing an AFDC check, to telling one’s relatives about being on welfare. The result of these disclosures is often scorn.

Nor is it surprising that recipients should attempt to conceal their identity as a welfare recipient in light of these attitudes. As Goffman noted,

The issue is not that of managing tension generated during social contacts but rather of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case, to whom, how, when and where (1963: 42).

For most welfare recipients, the decision is to conceal this aspect of their life as much as possible.

The use of food stamps is therefore particularly hard for many individuals because it constitutes a stigma symbol—it identifies the user as a member of a stigmatized group. Likewise, living in subsidized housing, the use of a Medicaid card, and so on, function as stigma symbols and hence cause various degrees of anxiety among recipients.

Finally, the fact that many on welfare exhibit the same negative attitudes about their fellow recipients as those in the general public, is again not surprising. As Goffman wrote, "a stigmatized person is first of all like anyone else, trained first of all in others' views of persons like himself. . ." (1963: 134). Therefore, "it should come as no surprise that in many cases he who is stigmatized in one regard nicely exhibits all the normal prejudices held toward those who are stigmatized in another regard" (1963: 138).

The recipient, however, is often careful to distinguish between his or her case, and that of others. Briar (1966) has described this as a distancing process. That is, while many recipients may feel that the common welfare stereotype holds true, in their particular case it does not. This distancing process is clearly evident in the remarks of Dan Wilensky, an out of work husband,

Like the people that hang out downtown, the bums. I can't see how they can just be a bum. I mean everybody can find a job one way or another. Like I said we're on General Assistance to survive, okay. And not just to be on it. But once I find a job we'll be off of it. And we probably won't be back on it. 'Cause I can keep a job. But like people that are downtown, the bums and everything, I'm sure they're to the point now where they're so lazy that they won't wanna get a job. So they're just sittin' back and sayin', "Hey, let somebody else pay everything for me." There's both kinds of people. The bums, and then people like us that are having trouble finding the first job.

This type of sentiment was not unusual. It was voiced in numerous interviews. As Briar noted, such distancing "reflects the desire of these recipients to dissociate themselves from the image they have of other recipients" (1966: 51).

The concept of coping with stigma is thus central to understanding recipients' perceptions and behaviors regarding public assistance. It is a key component in interpreting why recipients feel and act the way they do concerning their own situation, the general public, and other welfare recipients. Like most Americans, recipients attach stigma to the welfare system and its participants. Yet they themselves are welfare recipients and hence

must face such stigma, including their own. It is precisely that contradiction and its resolution which are the keys to understanding recipients' attitudes and behaviors regarding welfare.

Finally, it is often assumed that the poor in general and welfare recipients in particular are somehow different in their attitudes, perceptions, and beliefs regarding the welfare system (Banfield, 1974; Gilder, 1980; Murray, 1984; Mead, 1992). For example, that recipients are resigned to living on welfare, not motivated to leave the welfare system, do not care or feel embarrassed about using public assistance, are sympathetic to other welfare recipients, and so on. The results from this qualitative study stand in sharp contrast with such a viewpoint. In fact, welfare recipients would appear quite similar to the general population in terms of their dislike of welfare and how they cope with such feelings of disdain.

What is important about these findings is that the policy debate regarding welfare recipients is often premised on the assumption that recipients' perceptions and motivations need to be altered in order to conform to more mainstream values (e.g. Domestic Policy Council, 1986). Yet it is precisely these mainstream values which underlie the recipient's view of the welfare system. Policy discussions should be based not upon how different the recipient is from the rest of us in terms of their perceptions of welfare, but rather upon how much they have in common.

Notes

1. The definitions of these categories were: (1) female heads of household with children under age 18 (no spouse present); (2) married couples (with or without children); (3) single heads of household (no children or spouse present); and (4) elderly household heads (age 65 and over).
2. Among several of the demographic characteristics of the qualitative sample are the following: (1) Household structure — 44 percent female headed/20 percent married/18 percent singles/18 percent elderly; (2) Residence — 86 percent urban/14 percent rural; (3) Race of household head — 64 percent white/28 percent black/8 percent other; (4) Education of household head — 52 percent 12 or more years of education/48 percent less than 12 years of education; (5) Employment status of household head — 38 percent employed/62 percent not employed; (6) Average length on welfare — female heads (4.2 years)/marrieds (1.6 years)/singles (.9 years)/elderly (3.1 years).

3. Six of the ten interviews with married couples were conducted with both the husband and wife. The remaining four were conducted with the wife only.
4. The exception being the incapacitated, who were thankful for the assistance and planned to remain on the programs unless a viable alternative could be found.
5. And, of course, one of the latent functions of food stamps is indeed to stigmatize the recipient, thereby increasing their motivation to remain on the program only briefly.
6. A final example of stigma perceived by recipients comes from my field-work. One of the social service agencies that I visited was located in a very small town. Across the street was a tavern. The case workers detailed how individuals would often sit and gaze out the window of the tavern to observe people going into the office. They would then gossip and joke about who was on welfare, what their situations were, and so on. Potential welfare recipients entering the office were generally well aware of this.
7. Furthermore, it is often posited that stigma surrounding welfare programs plays a functional role in the rationing of scarce resources, recruiting and maintaining a labor force, and preventing deviant behavior (Loewenberg, 1981).

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An Examination of the Ecosystems Perspective in Consideration of New Theories in Biology and Thermodynamics.

BARNEY MCDOWELL

Eco-systems perspective and its predecessor, systems theory, have been put forth as the guiding methodological framework for social work. In fact, operationally and theoretically most of these formulations are mechanistic and dualistic. Social work systems theory claims ecology, thermodynamics, and biology as its historical roots. It is, therefore, incumbent on the profession to examine the fundamentals of those disciplines. This paper examines social work's eco-systemic formulations in light of new hypotheses in biology and thermodynamics as well as the ecological crisis of our times. Professionalism will then be discussed as the operational demonstration of social work's mechanistic philosophy.

Social work theorists have invoked general systems theory [GST] and ecology as the guiding lights for social work practice. GST is the cross disciplinary search for a shared core of epistemologies to explain the most complex of systems. In social work formulations of eco-systems perspective, Allen-Meaures and Lane (1987) reference the fields of ethology and ethnology while Siporin (1980) cites biological ecology and information theory. Numerous others reference an outdated (Martin & O'Connor, 1989) and non-consensual interpretation of the second law of thermodynamics (Weber, Depew, & Smith, 1988, p. 3) and almost all credit general systems theory. While social work literature references these "hard" sciences to corroborate their theories, that same literature leaves the reader without an examination of the philosophical assumptions of that science. In this paper, some core concepts and assumptions of systems and ecological theory are explored as well as new hypotheses in biology and thermodynamics. Biologist Rupert Sheldrake's hypothesis of morphogenesis with his critique of the theory of genetic causality will be introduced along with Nobel Laureate Ilya Prigogine's non-equilibrium thermodynamics. In an attempt to jolt the reader across the premise-boundaries of the

"normal science" of social work, their theories are offered 1) to underscore the inadequacy of the engineering and marketing paradigm which dominates social work and 2) to support the alternative institutional forms suggested by Ivan Illich (1971).

The Failure of Engineered Systems

In the 1960's, creation of genetic hybrid seeds was hailed as an end to human starvation—the green revolution. Hybrids were manufactured which produced greatly increased yields. There were warnings in the early 1970's that these seed varieties might not withstand adverse conditions like drought. This is exactly what happened. Famine and the death of millions around the globe resulted (Mooney, 1979) when hybrid seeds failed against fungus, high winds, and unusual weather conditions! The hybrid seeds didn't have the encoded "wisdom" of native seed varieties which benefitted from centuries of relationships with earth and elements. By 1984, there was a scramble around the world to recover forgotten buckets of "native" seed varieties from the barns of forgotten farmers. Narrowly purposeful geneticists failed to account for the multitude of transactions which besieged their hybrids. Perhaps, a sub-system (hybrids under experimental conditions) was successfully engineered, but the whole system was beyond engineering control. Of course, those millions of deaths stand in the shadow of political and economic forces as well as the Promethean scientific arrogance of geneticists. The geneticists didn't err alone or simply by miscalculation. In Bateson's (1972) terms, their errors were grounded in our society's self-selecting epistemology: the purpose of controlling nature as paradigm.

Bateson (1972) drew very large system boundaries in order to bring into relief the importance of human purpose. The common engineering application of systems concepts involves defining the system boundaries beyond which all effects can be calculated as negligible. A refrigerator which gives off too much heat must be redesigned. The insulation in a high rise is weighed against energy loss on a cost-efficiency basis. In the 1980's, global warming was just one example of startling feedback about the choice of boundary design which postulated

heat exchanges as negligible. Holes in the ozone are feedback about the neglect of a different boundary vector, the molecular nature of refrigerants passing across that boundary. Unfortunately, so called eco-systemic solutions typically seek to add more sophisticated feedback loops, more refined controls, to re-engineer the disasters of our engineering and marketing way of life; in this they are merely a subset of the mechanistic problem-producing-solution which excludes fundamental vectors of human consciousness like purpose or wishfulness. Where we eliminate that feedback, we have ceased thinking in terms of broad systems concepts and revert to an engineering mode of linear causality: How do we build the system in order to cause the desired effect?

Bertalanffy (1981, p. 116) warns that systemic ideas are most often merely applications of engineering principles to more complex problems. That is, purpose and goals remain primary though increased degree of difficulty is acknowledged. Typical of the social work field, Longres (1990, p. 8), a systems advocate, dismisses Native American Russell Means' critique of European rationalism and "its assumption that progress is possible through the use of technological inventions—including the technology of social welfare—to overcome human suffering." Longress asserts without argument that western social work must continue to try to fix things: "In the meantime, social service workers ought to realize that progress through the use of rational planned change . . . is what social services stand for". In other words, he presupposes the priority of rational purposefulness to effect control irrespective of how large the system is. Ironically, he dismisses Mean's critique without a rational argument. However, general systems analysis indicates that boundary considerations for social welfare are mind boggling from an atomistic perspective. While in physics the movement of two bodies in a gravitational field can easily be predicted, the three body problem is so complex that it hasn't been solved in 400 years (Hagihara, Y., 1970). Bremmerman estimated that 10^{47} is the most information that can be computed per gram of matter in an imaginary computer of fantastic efficiency, but permutations of elements in very simple systems quickly go beyond the "Bremmerman limit" (Klir, 1972). Consider the formation of

something as simple as a visual image; it is far too complex to be explained in terms of the summation of transactions between component cells (Ashby, 1972). Systems theory will never be adequate to explain human behavior in terms of calculating transactions in order to control life though it may appear so in the short run or a narrow context.

Examples of current ecological "solutions" are more efficient refrigerators, non-leaking microwaves or drugs with fewer side effects for schizophrenia. However, these solutions still focus on the paramount if implicit system dimension of performance within the same purpose. Wolfgang Sachs (1990) reviewed over eighty world watch documents, reporting on the state of the earth's ecology. Virtually, all of these argue for efficiency and preservation as a solution to ecological disasters. However, there are many others, including ecofeminists (Plant, 1990), with Sachs who expose the racist, sexist, and ecologically disastrous effects of this philosophy. For example, the efficiency model indicates to end exploitation of the Amazon because Amazonian plants are the resource for many major drug discoveries. The use and dominance of nature are still the underlying philosophy in this engineering solution. In contrast to the engineering efficiency paradigm, many indigenous cultures historically considered themselves and the earth through a sufficiency or wholistic, "as is" perspective, alive and worth revering as an expression of life—not as a resource for the human form of life.

Social Work: Determined to Engineer Life

Allen-Meares and Lane (1987) adopt eight key concepts of "eco-systems perspectives" for social work assessments. One of these emphasizes determinism as a property of living systems analysis: "The relationship of the parts within the ecosystem are considered to be orderly, structured, lawful, and *deterministic* [emphasis added]" (p. 518). As discussed later, this is antithetical to much of modern science. Determinism implies a set of laws which if known along with the initial conditions of the system permit prediction of the system's behavior. Then to the degree that complementary technology is available, the system can be engineered for the desired result. Social work language is clearly an engineering/marketing metaphor. Populations are

targeted. Social services are tested by experts and prepackaged before delivery. Linear accountability is supposedly based on a cost-benefit analysis. In social work lore, the distinction between human service organizations are the people themselves" (Holland & Petchers, 1987, p. 204). But there is no scientific basis for that raw dualistic analogy; it is an engineering, manufacturing metaphor!

The deterministic view serves social work's conception of professionalism. Professionals stake the right to determine in theory and in court the "self-determinism" of the client. This legal/moral claim is based on an extension of what is rationally right or wrong as distilled through the prevailing dualistic paradigm. Professionalism denies creative self initiative by delimiting the boundaries of self-determinism by virtue of superior theoretical and technological knowledge. Counterpoised to this stands the work of leading intellectuals as well as indigenous people. The life work of Ivan Illich (1971, 1976, 1977) illustrates the destructive effects of professionalism to cultural and biological diversity. With Illich, Noam Chomsky (1987, p. 37) and Felix Guattari (Elkaim, Prigogine, Guattari, Stengers, & Denenbourgh, 1982, p. 67) decry the professional guild mentality's repression of the boundaries of inquiry by promulgating the internalization of the political presuppositions of the status quo. Many indigenous people and ecologists around the world are increasingly vocal against professional experts whose engineered solutions of re-engineering the ecology of the earth boomerang back with insulting destruction (Mooney, 1979); Woodhouse, 1987; D'Souza, 1990). Further as this essay emphasizes, recent scientific analyses in both biology and thermodynamics have dismantled determinism.

Sheldrake: Genetic Morphogenesis Is Dead

Rupert Sheldrake (1981, 1988) firmly establishes the failure of the consensual atomistic attempt to explain the forms of life in terms of genetic determinism. This is relevant to social workers who labor in pathological model-environments abounding with linear or cybernetic explanations of, for example, the genetic basis or predisposition for alcoholism, schizophrenia, or physical disease. The implications of his theorizing extends conceptions

of what an ecosystem is as well as the very presuppositions of science. His work resonates with the thermodynamic work of Nobel Laureate, Ilya Prigogine; both conclude that the so-called laws of nature are evolving and both emphasize the self-organizing principles of natural phenomena. Mechanistic interpretations of professionalism in the name of eco-systemic ideas will be addressed in light of the theories of Sheldrake and Prigogine.

Morphogenesis means the coming into being (genesis) of form (morpho). Explaining morphogenesis has been at the crux of Western biological, philosophical, religious and systems thought. In the 20th century, the prevailing belief of professional biologists has been genetic determinism; genes cause the shape, color, size, etc. of your body within the constraints of the environment. The genotype is the template for the phenotype in a one way casual relationship. In somewhat more technical terms, Sheldrake calls this the central dogma of biology: "genetic material acts as a template for the synthesis of proteins, but never the reverse" (1988, p. 80). Over most of this century it was heresy to challenge this view. However, in the last decade many biologists have come to the firm conclusion that genes or gene programs explain very little of morphogenesis.

Materialist versus Vitalist Philosophy and Science

Sheldrake discusses the evolution of morphogenetic theory as a dialectic between materialist and vitalist philosophy. The dominant modality of science is materialist: life processes can be described in terms of machine models which are governed by the laws of nature. For example, the earth has a mass which is acted upon by gravity, producing movement which wouldn't exist in the absence of the gravitational field. The law of gravity is considered to be constant, eternal and independent of the earth's existence. At the molecular level there are gravitational, electromagnetic, and sub-atomic forces which determine chemical reactions. Natural selection, popularly considered a mechanistic biological law, makes an offer that can't be refused to each particular genetic configuration. The deterministic, mechanistic assumption is that the behavior of larger organisms will be explained in terms of cellular, biochemical, genetic, and ultimately

sub-atomic forces once the details are sufficiently articulated through physics and chemistry.

Sheldrake traces the philosophical roots of this mechanistic materialist view back to the dualism of Plato, who thought the real world to be a mere reflection of unchanging ideals; this parallels scientific changeless laws of nature (ideals) describing everything from the motion and changes of planets to the effects of human hormones. But this model is dualistic—built on a contradictory foundation. Changes (in nature) are described as derived from changeless laws (in archetypal or mathematical realm). In other words, hardcore materialists base their theories on purely transcendent, eternal laws; they are metaphysicians underneath.

Opposing the mechanistic mode is the vitalist tradition. Aristotle's concept of *entelechy* posits a soul which informs everything with a template of its destiny (including its form). Many indigenous tribal people held such a world view, sometimes known as Animism. This view foreshadows Lamarck's hypothesis that structure follows function. For example, giraffes grew long front legs and necks out of necessity in a environment with lots of high food and little low food; future generations of giraffes could inherit those traits. Darwin couldn't escape this completely; he postulated a *nivus formativus*, an inner creative force for change. However, he opted to dismiss the degree of its creative potential in comparison to natural selection. Sheldrake documents the whole history of the struggle between the two world views and demonstrates the inadequacy of the materialistic explanations. Though much empirical evidence supported this intuitively appealing model throughout this century, the functionalist view lost favor in the Western Hemisphere where a Platonic template, as a commitment to control nature, dominated not only biology but all scientific methodologies and, perhaps, the ecosystem of the entire earth.

Historically, the idea that genes could determine morphogenesis ran into trouble. "What genes are known to do is to code information for the sequence of chemical building blocks in RNA and protein molecules. Thus they help to provide a detailed understanding of the way in which organisms inherit their biochemical potentialities. What they are not known

to do is to code for morphogenesis for inherited patterns of behavior" (Sheldrake, 1988, p. 88). Sheldrake quotes Brenner: "At the beginning it was said that the answer to the understanding of development was going to come from a knowledge of the molecular mechanisms of gene control. I doubt whether anyone believes that any more. The molecular mechanisms look boringly simple, and they don't tell us what we want to know. We have to try to discover the principles of organization" (p. 94).

To remedy the insufficiently complex gene, the concepts of selfish genes and gene program were invoked. Biologists went on a search to decode the program with the promise of one day molding life itself. Genes were suddenly spoken of as competitive, selfish and ruthless. In this they followed Darwin who apologizes for personifying nature because it's "difficult to avoid this ambiguity" (Sheldrake, 1988, p. 272). A gene program was postulated to inhere in the sequencing of individual gene molecules. Numerous objections arose to this concept and many biologists recognized its inadequacy while continuing to propagate it. An international group of biologists concluded in 1981, that "studies of the development of the nervous system have shown that the notion of genetic programming is not only defective at the conceptual level but also represents a misinterpretation of the knowledge already available from developmental studies" (Gerhardt, et al., 1982, p. 112). For this paper's thesis, the paramount objection is that "program" is inconsistent with the mechanistic claims of a materialist world.

Programs are described as "instructions", "messages", and "information". The latter recalling the informing notion of entelechy. Underneath its hard science veneer, a genetic program has a heart—it is a vitalist idea. Normal science never left the metaphysical realm because it always depended on the ideal of eternal transcendent laws. In a materialist dominated context, it became embarrassing to inquire where the animistic program inhered. Sheldrake proposes an alternative synthesis sketched below.

The presence or absence of particular genes will strongly correlate with differences in form. For instance in *Drosophila*, a

fruit fly, the presence of a certain gene may result in a double set of wings which do not appear with statistical regularity without that gene. This does not prove genetic causality.

To see the force of this point, consider the analogy of a radio set. A mutation in one of its transistors might cause the sounds that it is producing to become distorted; and a mutation in one of the components in its turning circuit might cause the set to pick up another radio station; an entirely different series of sounds would come out of the loudspeakers. But the fact that mutations in the set's components can cause differences in the sounds the set produces does not prove that these sounds are determined or programmed by the components of the set. These are necessary for the reception of the program, but the sounds are in fact coming from radio stations and are transmitted through the electro-magnetic field. **The mutant component is not a component "for" a particular program or type of sound** [emphasis added] (Sheldrake, 1988, p. 90).

Sheldrake postulates an immaterial biologic field paralleling the electromagnetic radio field. The fields have morphogenetic potential. He suggests that biologic fields evolve—they are living; behavior of creatures is governed by the fields but is also formed by behavior over time. Fields evolve out of experience through repetition over time. Laws of nature are like learned habits. The more a pattern is repeated, the more likely it is to stabilize and recur, but they are living, changing fields. Of course, some patterns like relationships in sub-atomic particles have had trillions of trillions of repetitions and so they are likely to appear as absolute. Relatively new patterns like functional behaviors of animals are newer and thus less grooved. Sheldrake cites many examples which are consistent with his hypothesis. A few will be mentioned here not to advocate for his particular theory, but to underscore the inappropriateness of ignoring the contradictions in the consensual view.

There is an apocryphal version of morphic resonance called the hundredth monkey theory. The story goes that after one monkey learned to wash sandy tubers to be used as food then other monkeys quickly learned the same behavior. The real surprise is that when a critical number of monkeys learned the

behavior then monkeys on other isolated islands suddenly were able to wash tubers for food. Sheldrake explores this theme through many dimensions including animal behaviors in the wild and in the lab, human learning behaviors, evolution, and crystal formation. For example, an experimenter bred strains of rats into dull and bright strains selected by learning experiments. The current genetic model predicted that bright rats will beget relatively brighter rats and vice versa. This is exactly what did happen. However, succeeding generations of dull rats actually learned faster and faster. This experiment followed similar experiments performed at Harvard, Australia, and Scotland. Assuming well designed experiments, this evidences a potential contradiction in the genetic causality model. But according to "morphic resonance" theory, there is a learning field, a biologically sensitive field, which becomes more firmly "canalized" with repetition. a similar explanation is consistent with the formation of crystals, the behavior of birds, and experiments with human memory.

In this cursory consideration numerous alternative common sense objections may occur to the reader. There is no claim that there is sufficient evidence to elevate the morphic resonance hypothesis to a theory. Space does not permit a thorough review of Sheldrake's pragmatic and methodical approach in examining the existing and alternative models. A few points need to be stressed. Less stable fields are subject to more radical changes; they have a more responsive nature and thus are less predictable. Thus descriptions of fruit fly behaviors are less likely to maintain over time than descriptions of gravity. Experiments in fields subject to more rapid changes over time are less subject to the (usually assumed) experimental criteria of repeatability.

The implications are obvious for contemporary society characterized by instability and change. In no way, can it be proven that human or biological ecosystems are in equilibrium presently. Sheldrake cites the work of Nobel Laureate Illya Prigogine in the self-organizing principles of non-equilibrium thermodynamics in developing his hypothesis.

Prigogine: Atomistic Determinism is Dead

Classical physics wrote a set of prescriptions (laws) which applied over all time and, thus, emphasized stability and permanence. Prigogine points out that there was no room in these formulations for non-cyclic changes over time—evolution. Rather, than viewing the world as subjected to sovereign laws of nature cut from an external template, Prigogine was able to model out innate self-organizing principles in chemical reactions, ecosystems, regulatory cellular processes, and traffic patterns among many other applications. His work draws on an examination of the history of philosophical and scientific thought (Prigogine & Stengers, 1984) and highly technical mathematical and chemical investigation (Nicolis & Prigogine, 1977). The self-organization of systems in contrast to an external Platonic and deterministic organizational template is the main aspect of his work that I wish to emphasize. Prigogine demonstrated that change towards increased complexity (decreased entropy) takes place in far from equilibrium conditions. This occurs when fluctuations or errors in random activity are amplified and grow into viable “dissipative structures”. The growth of a town along a river is a simple example of a dissipative structure, a configuration which is propelled to greater complexity through a continuous flow of energy. Suppose that a town comes into being for an industrial purpose. A town maintaining at equilibrium for years, may experience economic or social changes so that while the town may be continue to appear stable, under the surface turmoil is brewing and it is far from equilibrium. Then, a very small stream of new energy may be incorporated such that the town takes a quantum leap or, conversely, a city may die quickly when a small, but critical, flow of energy is cut off.

In some localities, far from equilibrium conditions, instabilities trigger new structures. A phenomenon called the Benard’ convection cell illustrates this. Picture a glass casserole dish filled with water at room temperature. There are trillions of molecules bumping into each other and exchanging energy in an amorphous pattern of random collisions. If you put your finger on the side of the dish, some nearby molecules pick up the body heat and move faster with more energy. However, the extra

energy of any particular molecule is instantly redistributed—at high atomic speeds there are so many collisions per micro-second that the energy of the body heat is virtually instantly diffused through the whole system. Under the old atomistic assumption, the behavior of a small group of molecules must conform to the dictates of the overall system norms—temperature, pressure, volume, and random movement patterns. But this isn't so.

Now, imagine that heat energy is applied to the bottom of the dish. At a critical temperature, cellular patterns, called Benard' convection cells, appear in the water. The width of these cells is almost a centimeter, 10,000,000 times the distance of molecular forces—deterministic molecular forces can't explain the patterns which are self-organizing phenomenon on a different logical level than molecular forces. While the molecules of one convection cell rotate to the right, in the adjacent cell rotation goes to the left. Interestingly, the direction of rotation can never be predicted—it is indeterminate.

The importance of the non-equilibrium vector is crucial. Consider, the moment just before the critical temperature is reached. The water has more energy; the molecules move much faster though their movement is still amorphyously chaotic, imagine something like snow on a TV screen. Though the system exhibits the same structural properties, it is now far from equilibrium; then, a finger to the side of the dish though providing a minute amount of energy is a sufficient amplification to set off the new inherent structure-convection cells—which can accommodate more energy. Other experimental designs using water and the infusion of energy demonstrate a sequence of structural development: One structural configuration remains stable while accommodating increasing energy flows until, at a critical point, a turbulent period ensues followed by a reorganization to greater complexity which accommodates more energy (Swinney & Gollub, 1978).

These self-organizing and indeterminate features in far from equilibrium conditions can be demonstrated in many other more complex phenomena in both organic and inorganic activity. Hoffman (1981) and Elkaim (1985) have both proposed this notion from Prigogine's work for a theory of family therapy. In

processes far more complex than convection cells, the dissipation of energy may amplify initial instabilities to favor further instabilities which may result in new evolutionary structures. Ferguson (1979, p. 165) summarizes:

The more complex or coherent a structure, the greater the next level of complexity. Each transformation makes the next one likelier. Each new level is even more integrated and connected than the one before, requiring a greater flow of energy for maintenance, and, is, therefore, less stable. To put it another way, flexibility begets flexibility. As Prigogine said at a higher level of complexity "the nature of the laws of nature changes".

In traditional thermodynamic explanation, the statistical chances were virtually zero for a small sub-system of billions of molecules to behave coherently beyond the macro statistical laws governing the behavior of those molecules. That was the thermodynamic version of determinism. But systems demonstrate spontaneous creative organization which is not predictable (Nicolis & Prigogine, 1989). While Sheldrake's work is more explicitly organic in allowing for the innate "intelligence" of systems, Prigogine describes creative self organization through random processes which defy prediction.

Implicit Theory of Institutional Structure

In contrast to Allen-Meaures and Lane's (1980) deterministic ecosystems approach for social workers, Prigogine (1989, p. 399) is explicitly non-deterministic: "The notion of instability has in some way been ideologically suppressed for the phenomenon of instability leads naturally to very serious problems. . . . The world of unstable phenomena is not a world we can control, any more than we can control human society in the sense that extrapolation in classical physics led us to believe." He comments that there are no risks or ethical dilemmas in a deterministic world.

In a dialogue with Prigogine about family therapy and non-equilibrium thermodynamics, Guattari (Elkaim, et al., 1982, p. 65) interprets Prigogine's work in opposition to "the strengthening of power groups that are interested in a policy of standardization". Guattari characterizes those policies as effected

by a professional "scientific" superego which imports external constraints on local systems. Of course, such standards are the primary focus of social work institutions. Referring to the Council on Social Work Education, Bernard (1987, p. 330) writes, "the council carries out its purpose through accreditation and other standard-setting activities". Similarly, the National Association of Social Workers focuses on standardization. Battle (1987, p. 333) summarizes: "The association works to advance and unify the profession, to develop and institutionalize professional standards".

Countering the professional chauvinism that imposes external standards, Illich (1976, p. 16) calls this the "Age of the Disabling Professions". His work extends Marx's notion of alienation from the means of production to the alienation from the "very ability to do and to make". He defines an institutional spectrum by reframing the political categories of left and right which apply both to capitalist and socialist countries. Right wing institutions impose a predigested program on others, organize production, and rely on unwilling or trained consumption of their products and services. At the left end of the spectrum, institutions facilitate activity defined by the user (self-organizing) and offer relatively spontaneous use (indeterminate); their few regulations are geared to prevent the abuse of general accessibility—not to enforce use. Law enforcement and the military/defense complex are obvious right institutions, but more profound is the insidious oppression of the educational system. Schools are compulsory at lower levels yet closed at upper levels to those who don't consistently advance their credentialed status. The telephone network (not the corporate structure) offers an alternative; the phone system can be used by virtually everyone—it is inexpensive to make an individual call; it can be used virtually anytime of the day or night; it can be used by anyone (including the hearing impaired to a lesser extent). The postal system demonstrates similar access and constraints. A typical restriction of these institutions is a law to stop harassing phone calls or junk mail, not a requirement to use. Parks and hotels are other examples towards the left of the spectrum. The medical industry, with social work at its side, tends toward the right.

In *Medical Nemesis*, Illich (1976) makes the case that the commodity intrusiveness of medicine has expropriated the cultural imagoes of healing, the ability of people to creatively suffer and care for themselves. Birth and death have become medicalized with enforced consumption of treatment. It is impossible to make the case in this brief space given the pervasiveness of the myth of modern medicine. Only a few examples can be discussed. Most of the total decline in the death rate due to scarlet fever, diphtheria, whooping cough and measles occurred before the introduction of antibiotics or immunization. The vast majority of successful drug interventions involve a few dozen drugs which do not require a doctor to administer except by laws requiring doctors. Most of the reduction in infant mortality was due to sterile procedures. One out of five children admitted to a research hospital emerge with an iatrogenic disease.

Specific iatrogenic disease isn't the target of this critique, rather cultural theft is—political orthodoxy masquerading as scientific truth! Medicine “reinforces a morbid society that encourages people to become consumers”; this yields a cultural iatrogenesis which “consists in the paralysis of healthy response to suffering, impairment, and death” (Illich, 1976, p. 33). Licensing requirements, whether in education, construction, or psychotherapy, constitute a systems boundary which neglects the healing aspect for people in actively self-organizing one's healing which is, de facto, characterized as passive consumption. Under the auspices of a Platonic professionalism, accreditation and licensing standards perpetrate this type of iatrogenesis which is not only racist but at the core of alienation in the modern world.

Professionalism versus Self-determinism and Self-Organization

In Germain's (1980) discussion of professionalism in health care settings from an “ecological perspective” her primary concern is the social worker's professional status vis a vis the medical profession: “With competence and identity well in hand, a hospital's social work staff and individual social workers are in a position to gain professional autonomy” (Germain,

1980, p. 1). By autonomy she is "referring to a fully accountable and responsible practice through mechanisms for quality assurance, peer review, and consumer evaluation" (Germain, 1980, p. 1). Resonating with most historical social work analysis, Germain acknowledges "concern for reducing social distance and power differences between worker and client" and dutifully qualifies it by affirming a "commitment to mutuality and reciprocity between client and practitioner to the degree permitted by the client's age, physical condition, capacities, and life style" (Germain, 1980, p. 6). Are we to assume that professional expertise will define the "degree permitted"? Unlike Sheldrake and Prigogine, Germain doesn't discuss the philosophical or historical premises underlying the concepts of accountable or professional. The assumption is that health is appropriate adaptation to the environmental norm but environment is then defined in terms of professionalism. For example, of 15 factors describing "environmental needs", second on the list compiled by Hepworth and Larsen (1990, p. 248) is "access to specialized health care services (e.g. physicians, dentists, physical therapists, hospitals, nursing homes)". Germain implies that the institutional structure of medical settings is scientifically consistent with the client's best interest.

Crediting Germain as a major contributor in the evolution of social work's use of systems theory, Martin and O'Connor (1989, p. 76) flail against the tyranny of an outdated conception of the Second Law of Thermodynamics (1989, p. 51). They are direct in confronting the facts that professionals often have the power to "determine the standards and procedures by which deviants (or people with problems) are recognized" (Martin & O'Connor, 1989, p. 97). Though careful to warn against reductionist tendencies ascribing ulterior motives to helping agents, they echo Germain's definition of professional autonomy; in their discussion of professional-client relationships, they conclude that "social workers' legitimacy rests on their education, licensure, and employment credentials but particularly on their employing organization" (Martin & O'Connor, p. 104). But the vectors of "education", "licensure", and "employing agency" do not reside in the client except as the client is an extension of those institutions. Claims that the client issues the legitimacy

as tax payer or voter is a distorted equation leading back to the client as the legitimate source of society's inequities.

In stark contrast, Illich views the heteronomous aspect of that "legitimacy" as the cutting edge of exploitation and racism. I propose that education and licensure are stultifying institutional boundaries and bias, which, by their nature, squelch self-organization with the claims of expertise in a deterministic and objectifying engineering technology. Graduate schools supposedly scramble to find faculty candidates from political minorities, but there wouldn't be a scramble if those schools didn't give priority in hiring policies to doctoral degrees even as devotion to "cultural competency" is claimed. A community mental health center in a minority neighborhood hires a white MSW to work with children who, the center claims, would do better with a role model from their own culture and race. However, the white person is hired because the MSW is given higher priority over cultural resonance and knowledge.

Further Implications for Intervention

The CSWE and the entire accrediting-licensing nexus fits Illich's (1971) institutional spectrum model. The set, called scope of responsibility that can be assumed in society, is defined by elements like post graduate degrees which are expensive and require previous and culturally specific schooling—unless you show a receipt for a B.S.W., you may not have the opportunity to purchase an M.S.W. permitting legal participation in healing at that level. Social Work schools proudly attempt to more efficiently recruit political minorities who are only insufficient to heal by virtue of the schools' participation in institutionally racist standardization claims. I am not opposing politically expedient "cultural competency" requirements or affirmative action hiring policies but rather placing them in the context of standardization policies. In systems imagery, "technical and managerial measures taken on any level to avoid damaging the patient by his treatment tends to engender a self-reinforcing iatrogenic loop [feedback] . . . analogous to the escalating destruction generated by the polluting procedures used as antipollution devices" (Illich, 1976, p. 34). I imagine an alternative graduate

school in which groups of 12 to 24 students are supported to make a creative response to social conditions. Their response, judged by specific facts rather than an *a priori* template, would meet the response of local conditions. Certainly, many groups wouldn't produce in their terms or those of potential employers, but others would flourish in creative self-organizing expression that is currently cast in the shadow of the CSWE's brand of the professional persona.

The organizational structures of Alcoholics Anonymous and its many offshoots fit Illich's model of a left institution: everyone is invited, it's accessible, and a minimum of rules (e.g., no cross talk) prevents abuse of the common forum for listening and speaking. Ironically, professionals find it necessary to refer their clients to such free groups which provide a powerful healing forum according to millions. Carl Jung, whose work evokes Sheldrake and Prigogine, is credited with the inspiration for AA by its founder (Lovern, 1985); Jung directed a client to a spiritual journey for which the client was substituting alcoholic spirits. Without demonstrating an isomorphic relationship between the structure of AA and the philosophy which inspired it, I believe the following examination of Jungian thought suggests potential for incorporating principles of Prigoginian self-organization into institutional interventions.

Jung's psychology referenced vast system boundaries calling for an examination of specific empirical data whether in mythology or clinical cases—the "extraordinary diversity of individual life necessitates constant modifications of theory" (Jung, 1954, Vol. 16, p. 41). In contrast to Freud's Newtonian template (Grof, 1984) of sexuality as the deepest repression, Jung saw God as the deepest repression; that is, God, not as an orthodox belief, but as an empirical fact of the human psyche as evidenced in the historical data of literature and art. The psyche emanates from the collective unconscious with boundaries so vast that indeterminacy rules—spirit is marked first by "the principle of spontaneous movement and activity" (Jung, 1958, p. 67). Sheldrake (1988, p. 253) concludes that Jung's archetypes are innate psychic structures or energy configuring patterns corresponding to morphic resonant structures. Like Prigoginian dissipative structures, Jung describes individuation

as the development of increasingly refined awareness through the progressive integration of different archetypal psychic structures, each of which holds more energy from the unconscious than the previous constellation. If successful, that process culminates in the integration of the archetypal energies of the Self which is the name that he gives to the energy configuring pattern which can accommodate the collective energies of lesser archetypal structures. The Self has greater access to the energy of the collective unconscious, a psychic commons which defies engineering or conscious control by virtue of its vastness if nothing else.

Lovern (1985) links AA and Jung to the clinical work of Milton Erickson. Though not developed here, with several authors (Hoffman, 1990; Elkaim, 1985) I wish to underscore the implications of Prigogine's work for strategic clinical interventions, particularly as developed by Erickson. Paralleling other analyses (Rossi, 1985; Gordon and Meyers-Anderson, 1981), Stern (1985) calls Erickson's approach the "theory of no-theory" suggesting Jung's or Prigogine's caveat about distorting the particular with general theory. Offering specific examples of Prigogine's work adapted to therapy, Elkaim (1985) explores the amplification of small fluctuations and indeterminacy to strategic interventions with families. I suggest that elaboration through the filter of dissipative structures will reveal structural family therapy as a temporal subset of strategic therapy and numerous powerful therapeutic techniques will be elucidated.

Conclusion

Much of social work literature about ecosystems perspective hasn't examined the philosophical and scientific roots of its assertions. I maintain that the unexamined premises and absurd conclusion of a mechanistic "eco-systems" philosophy stems from the political orthodoxy of institutional power relations and momentum—certainly not in empirical data. Prigogine's work has been offered (Elkaim, et al., 1982) as a refutation of scientific rationales for deterministic "ecosystems perspective" as well as institutional structures. I do not claim proof of the viability of alternatives but, with Sheldrake, I reject professional

experts' muddled materialist science, which serves as "legitimacy" for current institutional mandates, and, with Illich, I assert my right to offer other institutional proposals. While it is too great a leap to insist that Prigogine's work fully corroborates Illich's institutional analysis, there are unmistakably correlating themes. In any case, the failure of engineered "solutions" like the green revolution and, indeed, the ecological crises of our times calls for a reexamination of the scientific seal of approval on the deterministic or engineering orientation of eco-systems perspective as presented in social work literature.

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Social Work, Social Science and the Disease Concept: New Directions for Addiction Treatment

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The perception of alcoholism and other substance abuse disorders as disease entities is a view ardently defended not only among chemical dependency professionals but, increasingly, by the general public as well. Over the past two decades, this perspective has also become so ensconced within the addiction treatment industry that alternative interventions are almost nonexistent even though evidence of their effectiveness is available (Miller & Hester, 1989). And yet, "no leading research authorities accept the classic disease concept" (Fingarette, 1988, p. 3). Competing views are generally characterized as irresponsible, and their sponsors summarily dismissed as dangerously uninformed by disease view proponents or accused of being in "denial" themselves (Kasl, 1992, Peele, 1989; Trimpey, 1989). In addition, public polls have revealed that Americans have increasingly subscribed to the addictive disease theory over the years. In the 1946–1955 Gallup polls, 20% indicated that alcoholism was a disease. By 1982, that response had risen to 80% (Gallup, 1987).

The professions have also been influenced by disease notions. In research conducted by the author, 520 social workers were surveyed in regard to their views about alcoholism and its treatment. In response to the query "Do you believe that alcoholism is a disease?" 74.2% of the respondents answered in the affirmative, 6.7% answered in the negative and 14% were unsure. Of the respondents 58.5% said that they believe alcoholism is a primary disorder, while 25% believe that it is symptomatic of an underlying disorder. When asked the choice of the most appropriate intervention for sufferers of alcoholism, 50% of the sample deferred to Alcoholics Anonymous (AA), with the remaining half mentioning a range of other interventions.

While this may mean the respondents are relatively unfamiliar with other approaches, the findings may also suggest that social workers embrace the disease view at both the theoretical and the operational level as indicated by the preference for AA, an intervention rooted in the disease model.

Public policy is also heavily influenced by disease notions. Most public efforts at remediation of substance abuse problems, aside from drug interdiction, are directed towards treatment and prevention (disease concepts) rather than toward broader macro or systemic approaches. This "medicalization" of social ills is consistent with the national tendency toward "reductionistic" approaches to social problems. Unfortunately, the transformation of complex issues into typifications and simplified causal models is at the root of many of our most ambiguous social policies.

While social workers in some quarters verbalize support for more enlightened policy, current social work practice seems to be converging with the methodology derived from the disease model, which has dominated the treatment scene for a number of years. According to Miller (1987), there have been virtually no substantive changes in American residential treatment in over twenty years despite the advances made during the same time period in the refinement of newer interventions. Once the disease model and its accompanying medical treatments took root in the treatment community, conflicting empirical research generated within the social sciences was disregarded (Peele, 1989).

Social Work and the Disease Model

If social workers are incorporating the disease viewpoint wholesale into their theory base, some troubling paradoxes emerge. For instance, how does a profession which has historically assessed individuals from a contextual point of view reconcile the disease notion that behavior is "determined" by unalterable biogenetic forces beyond the sufferers' control. Furthermore, how do clinicians account for differential manifestations of chemical dependency problems if the disease notion explicitly defines the malady as a unitary syndrome (Vaillant, 1983)? And finally, what unique social work perspective is

brought to bear on addictive disorders if its practitioners only mimic the efforts of paraprofessional counselors?

Possibly, social workers' changing view of substance abuse parallels the development of the profession (Cocozzelli & Hudson, 1989). In the early years of social work, alcoholism, along with other social maladies, was seen as a somewhat natural consequence of conditions created by immigration and urbanization, the exploitation of workers, and inner city squalor. For many years, social workers seemed to accept the fact that drug and alcohol abuse were a product of set and setting and that intervention necessarily involved addressing a range of issues, especially family functioning (NASW, 1965). The shift in thinking, however, is evident even as recently as two decades ago. A social work authority on alcoholism states "my basic premise is that alcoholism is primarily a *social problem* with medical complications rather than primarily a medical problem" (Krimmel, 1971, p. 7). Krimmel, however, makes this assertion in the introduction to his text, published by the Council on Social Work Education, and then goes on to describe micro-level, disease-disease-oriented treatments in detail. Quite possibly, social work rhetoric and practice have become disjointed.

In the pre-professional period of social work, during the Charity Organization Societies era, social work "visitors" frequently assumed a judgmental attitude toward drug and alcohol addiction, a condition considered to be symptomatic of the larger social pathology that was the plight of the poor (Pumphrey and Pumphrey, 1961). As the development and adoption of scientific principles propelled the advancement of professionalism, this view gave way to a perspective more consonant with theories of social disorganization (Abbott, 1931). Other enlightened perspectives were forwarded through the settlement houses, particularly in the cross fertilization of the ideas of Jane Addams of Hull House and of the University of Chicago sociologists (Deegan, 1988). Social reform was influenced by perspectives flourishing in the Chicago School, such as symbolic interactionism and critical pragmatism, debates over which Addams had varying degrees of influence.

In these contexts, the problematic drinking and drug taking behaviors displayed by clients were considered important, but

so were the broader mezzo and macro environmental conditions that impacted specific sufferers and wider target groups of sufferers. Social workers in those years were concerned not only with providing services to "inebriates," but also with changing the conditions that gave rise to the identified "social problem" of intemperance and inebriety (Kane, 1979). But, as independent clinical practice and proprietary hospital-based program settings have become the practice standard for addressing substance abuse problems, with their attendant need for patient classification, a treatable disease entity appears to serve those interests more than does a social problem. The opportunism of many social workers aspiring to private practice also helps to reinforce notions of "diseases" that respond to paid professional service rather than to structural changes in the economic and political life of the nation. Additionally, medical perspectives appeal to the general public at a time when coping with intractable social ills appears all but hopeless.

Social workers must be wary of incorporating purist applications of the disease concept. As in other fields of practice, the profession is relinquishing its own traditions in favor of accepting a methodology and knowledge-base that may challenge the very core beliefs on which social work is founded.

Addiction as a Disease

Interestingly, as the problems of addiction grow more complex and troubling, public and private views move toward the more simplistic. Unfortunately, reliance on disease interpretations and remedies leaves little room for a broadened understanding of addictive behavior. While the tenets of the disease theory seem to fit the gamma alcoholic or the hard core addict (loss of control, craving) there are many other situational, or problem, drinkers and drug users who do not fit that mold. Medical views of addiction frequently ignore ecological or anthropological considerations of behavior. Unfortunately, when an ecological perspective is absent, the causes of addiction are limited to a single element that ignores the varied range of human experience; furthermore, ignoring anthropological considerations discounts the meanings with which people endow their

experiences and life choices, particularly in regard to chemicals. Not only are such narrow approaches anathema to social work's knowledge base and values, they lack the empirical support which would justify the extensive treatment network in place in the United States.

Disease concepts are derived from a set of normative assumptions about human behavior, which see addiction as a biopsychosocial deviation which manifests in a unitary fashion, (that either one has the disease or does not), which is predictable in its progression and prognosis, and which has only one cure—abstinence through the principles of the 12 steps of AA. This set of assumptions is frequently linked to the belief in medical treatment for chemical addiction based on the cookie-cutter approach of the Minnesota model of 28 days of inpatient treatment. This model, developed at the Hazelden Corporation in the 1960s, consists primarily of detoxification, addictive disease indoctrination and AA immersion.

Nevertheless, the disease model continues to make important contributions to the treatment of addictive disease. These contributions include the de-stigmatization of substance abuse for sufferers and their families, the provision of solace and hope to those who may have felt condemned by a society prone to moralize against what it does not understand, and the establishment of a common language which has facilitated communication among those interested in addressing the problem of chemical dependency. The less desirable outgrowths of the disease perspective are what is at issue here. These secondary consequences include separatism attributable to the white mainstream value approach of most treatment facilities, the prescription of universal solutions that are effective only with certain individuals (treatment matching based on availability rather than the most appropriate treatment), and the "individualization" of a social problem. These manifestations would appear to be in conflict with traditional social work values.

While interventions promulgated under the disease model have helped a number of individuals, there is little evidence that when applied across a treatment population, these approaches are any more effective than natural remission (Fingarette, 1988; Peele, 1989). The most rigorous studies of treatment outcome

indicate that long-term drug and alcohol abstinence rates obtained through current medical model treatments rarely exceed 10% at follow-up (For reviews see Emrick and Hansen, 1983; Peele, 1989; Vaillant, 1983). Program representatives, however, often make "success" claims far in excess of these figures in marketing approaches. In addition, social science poses challenges to other elements of disease model treatments. There is clinical research demonstrating the efficacy of techniques aimed at moderating problem drinking among specific groups and documenting controlled drug use that suggests that addicts' usage patterns may deviate from the "loss of control" model. (For a review see Peele, 1989). Additionally, studies of the natural course of alcoholism and addiction indicate that alcohol and drug abusers will self-moderate their chemical use at a natural remission rate that often exceeds current treatment outcomes. (Vaillant, 1983; Fingarette 1988; Peele, 1989). These studies seem to contradict main tenets of the disease theory, which is less a "theory" than a loosely connected set of precepts derived mainly from poorly conducted research and speculation.

The articulation of the disease concept originated with Dr. Benjamin Rush late in the colonial period (Ray, 1983). Rush believed that alcohol itself was the culprit in the formation of the undesirable symptoms of addiction. The modern disease concept encompasses a shift in emphasis from the substance to individual vulnerability. Whereas the 19th-century version of the disease theory suggested that anyone who drank regularly or immoderately would become afflicted, the modern version emphasizes that only a small group of habitual inebriates actually have the "disease" of alcoholism. This group is characterized by an allergy to alcohol (and now drugs) that cause craving and loss of control once drinking commences. Jellinek's (1960) typological classification of alcoholism in the 1950s, though based on a very small sample, appeared to lend empirical support to this hypothesis. When the disease view was endorsed by the American Medical Association in 1956, it was given biomedical legitimacy and began its unchallenged reign as a guiding theory for most treatment and prevention efforts in the United States.

The "labeling" and "medicalization" of social problems has become a fairly widespread practice in the United States. From crime to mental illness, a host of social maladies have been redefined in light of medical "science" and have been relegated to psychiatry instead of to more traditional social control mechanisms. Conrad (1981) believes the medicalization of deviant behavior produces some positive outcomes but that its destructive impacts are formidable, including the problems of expert control, medical social control, the individualization of social problems, and the "depoliticization" of deviant behavior.

Expert control and medical social control are a particularly insidious threat not only to professional social work practice, but to our individual liberties as well. The elevation of medical "science" and its treatments from an entrepreneurial activity to a "religion" driving public policy has relegated many lifestyle choices and personal decisions to the realm of "medicine." Only a few years ago, the *Diagnostic and Statistical Manual* (DSM) of the American Psychiatric Association still listed homosexuality as a mental disorder, a condition many consider a status independent of choice. Substance abuse is still considered "pathology" from a psychiatric standpoint, however, it is unlikely to be removed from the DSM in the near future.

Medical social control ultimately manifests itself in a range of treatments (both chemical and behavioral) that put the "addict" in a secondary status. The promotional efforts of the anti-drug forces have left drug users without advocacy and at the mercy of the proliferation of laws, treatments, and restrictions that would "remake" them in a socially acceptable image or would lose them altogether. Individualization of social problems orients the focus on the intrapsychic functioning of the individual. This "blaming the victim" approach articulated by Ryan (1971) removes culpability for social inequities and institutionalized oppression, and affixes the remedy at the level of individual intervention. Once the mandate for social change has been sidestepped, the issue has been depoliticized.

Szaz (1985) has commented extensively on the medicalization of mental illness and drug abuse. He views drug abusers as classic scapegoats, employing the analogy that scapegoaters

view the drug offender much the same way that the Nazis viewed Jews during the second World War—i.e., as the source of most national ills. Hence, the best way to purge the nation is to identify the offenders (label them) and then control them (or kill them in the case of the Third Reich). Szasz charges that this view ignores the reality that substance use fulfills a crucial function in the user's life and is not destructive to society in and of itself. Only when "addiction" gets labeled and substances prohibited does society experience social and personal upheaval to the degree now present in the United States.

A further elaboration by Becker (1963) observes that the drug user (marijuana users in Becker's study) moves away from social controls in order to assume a drug-using lifestyle. The subgroup of which he becomes a part is at odds with the larger society, and the individual user takes solace in subgroup status. Typically, forces within the larger social system attack the deviant subculture and behavior through a "moral crusade." In Becker's formulation, these "moral entrepreneurs" redefine drug abuse as a medical and health issue, thereby placing it in the province of psychiatry and the helping professions. Becker stops short of analyzing the entrepreneurial motive, but, in carrying his analytical scheme further, one is forced to consider the possibility that moral entrepreneurship is reinforced by proprietary interests. Once the vested opposition group places addiction in the medical realm and disease proponents assume positions as professionals and managers in the sector charged with administering "help," then a powerful self-interest keeps the moral entrepreneur from ever questioning his or her own assumptions. The addiction treatment industry has developed in much that fashion in the United States.

Other social scientists see the development of drug prohibition and medicalization as an imposition of morality by those who have the power and will to impose it on the larger society. Gusfield (1963), working from the value-conflict perspective, analyzed the American temperance movement as a clash of lifestyles between "wets" and "drys" that saw a policy swing between the two positions in a relatively short period of time. During that span, "deviance" shifted from being associated with drinking to becoming synonymous with abstinence. Using

Gusfield's analysis to understand current events, one cannot avoid the conclusion that the rules and controls imposed on drug users derive from a moral stance that is neither superior to nor qualitatively different from that of the drug users, but, nevertheless, is supported by the power of law. The use of moral symbolism, and vilification of the opposition, serves to galvanize the public in support of prohibitive social controls.

Also consistent with the value-conflict perspective are views of the disease model and 12-step approaches derived from the feminist critique. Much of this literature considers addiction and codependency, at least among women and minorities, as a result of power differentials and value clashes between traditionally dominant white males and their perceived inferiors within the american class structure. Some commentators see the resultant manifestations, particularly codependency, as a social reconstruction mythologizing women's experience and recasting it in light of pathology (Krestan and Bepko, 1991). Kasl (1992) views addictive diseases as artifacts of internalized oppression generated by inequities in american social structures; accordingly, "patriarchy, hierarchy, and capitalism create, encourage, maintain, and perpetuate addiction and dependency" (p. 53). Schaef (1987) takes this view even further in her conceptualization of the United States as an "addictive society" which is not only oppressive to women and minorities, but to men as well. Kasl, while no separatist herself, reacts to traditional addiction treatment by rewriting the 12 steps from an "empowerment" perspective and removing any references to powerlessness, surrender, and a patriarchal God.

While impugning disease notions and their accompanying treatments cause reactionary sentiment among adherents to these approaches, it is imperative that social workers begin to think more critically about this issue as they attempt to provide what will truly offer the best help available for their clients. The challenge of the helping professions, and society at large, is to begin formulating solutions to substance abuse that can render significant change in the way society experiences its consequences. On this point, the collective failures are well documented. Policymakers and professionals must move beyond current guiding theories if meaningful progress is to be made.

Social workers hopefully can begin moving toward a more enlightened view of addiction, a perspective that can incorporate the various elements which contribute to an integrated and proscriptive model of prevention and remediation. Much progress has been made in identifying the range of factors that influence the development and maintenance of addiction. However, to address this continuum, strategies and solutions will have to be multidimensional. A more ecologically oriented model of interventions could address a fuller spectrum of the important etiological and cultural factors that drive substance abuse problems.

At the macro level, a policy approach of a much wider scope is needed. The policy agenda envisioned here would include a perspective that views structural issues as key components in the development of the social program that is labeled as addiction. This shift entails attention to poverty and opportunity access, issues which have been neatly sidestepped in contemporary views. In recent history, a very narrow view of the problem focusing solely on the supply reduction of illicit drugs has come into vogue. This view must give way to a focus on demand reduction, a concept barely articulated at the national level and not implemented in any meaningful way. Concerned social workers should enter the policy debate over drug strategy at the local and national level. The National Association of Social Workers should formulate a coherent and integrated social welfare policy agenda for Congress and the administration which includes attention to institutional supports for addiction and impediments to recovery. Under President Clinton's leadership, much of this agenda is already well under way.

At the level of the individual, treatment and prevention approaches must take a view broader than that constrained by the disease model. Most clients are currently served within an extremely narrow range of options, with the same treatment often prescribed for all those seeking services rather than making available different modalities for clients with different needs. Similarly, the same level of intensity of care is often prescribed rather than determining the most appropriate level

for individual sufferers. Treatment technologies implemented and evaluated outside the disease model community are frequently dismissed out of hand by treatment specialists. A number of methods tested extensively in Veteran's Administration and other public settings show tremendous promise, but remain virtually unknown, even though the data is readily available (Miller, 1987). By the same token, a continuum of care matching approach is not available in most communities even though excellent models for matching currently exist (Gottheil et al., 1981).

If scientific practice is once again to become the hallmark of the profession, then social workers should begin to embrace interventions and treatment approaches that have been empirically justified as being the most efficacious available. Optimizing treatment outcome is the primary goal of an effective matching scheme, as it should be the goal of professional social work practice. Leading researchers in the substance abuse field have been urging treatment networks to adopt strategies based on the matching hypothesis (Annis, 1988; Gottheil et al., 1981). The centerpiece of the hypothesis is that while one treatment is not preferable over another for all patients, the documentation of selective improvement for certain clients under certain conditions is well on its way (Miller & Hester, 1989).

The development and implementation of a matching approach should be consistent with experimentally derived indicators that suggest the most efficacious modalities for special populations or for clients with a particular profile. This approach is compatible with an ecological view of chemical dependency that incorporates consideration of a range of factors, both individual and environmental, in making intervention decisions. Annis (1988) suggests that client variables, treatment variables, and substance abuse variables are all factors that may differentiate clients for purposes of treatment matching. Thus, the offerings of treatment regimens should more closely match individual deficits and needs rather than attempt to view institutional structure as a flexible response (i.e., extending length of stay), although these factors need to be considered.

The current impediment to this model in many areas is the lack of differentiation among treatment settings. While many

urbanized or traditionally well funded states can boast a comprehensive treatment network serving diverse populations, many large catchment areas are fortunate if they have one publicly funded chemical dependency treatment center. Multiple treatment setting types, such as methadone maintenance, drug-free outpatient, short-term detoxification, and therapeutic communities, may simply not be available. Another problem pointed out by Miller and Hester (1989) is that program staff tend to recommend the particular service they provide without regard to differential diagnostic characteristics of the client. Hence, under this shortsightedness, establishing treatment matching reliant on outside settings becomes more problematic. It will likely be necessary for social workers to network among existing providers as well as implement multi-modality approaches within existing programs in order to establish a range of treatment options sufficient for the establishment of credible matching schemes.

Moos and his Stanford group have made substantial contributions to the understanding of the benefits of patient-treatment matching (Finney & Moos, 1979). In their extensive studies, up to 33% of variance in treatment outcome is due to unique program-treatment effect, but up to 40% is explained through patient-treatment interactions. Additionally, 28% to 72% of the patient variable effects are shared in interaction with treatment variables. While these indicators suggest a need to make appropriate treatment assignments if outcomes are to be maximized, it is important that the particular treatment options in the model are shown to be efficacious for addressing specific client issues.

Miller and Hester (1989), in a comprehensive comparison of evaluated alcohol abuse treatment approaches, find evidence that social skills training, outpatient psychotherapy, and community reinforcement approaches are promising alternatives to the traditional methods producing enhanced outcomes in major client life-functioning areas. These three approaches share an emphasis on effecting positive client adaptations for functioning in the larger community, but they represent a mix of conceptually different treatment orientations including both intrapsychic approaches and environmental manipulation (Luborsky, 1984; Miller & Hester, 1989; Mallams et al. 1982). With the exception

of community reinforcement, these approaches have also been utilized with drug abusers (Hawkins et al. 1986; Marlatt and Gordon, 1985).

Psychotherapy should be employed in substance abuse treatment as a method to ferret out the individual emotional, cognitive, or behavioral blocks to recovery. Studies have indicated that psychotherapy – either supportive expressive psychoanalytically oriented (Luborsky, 1984) or cognitive-behavioral (Beck, et al. 1979) when added to drug counseling can produce significantly better outcomes than drug counseling alone. In a treatment outcome review of programs using psychotherapy with opiate addicts, Rousanville and Kleber (1985) found that the approach beneficial to certain individuals across programs. Litt (1992) compared psychotherapy with skills training and found that personality-disordered alcoholics benefitted more from psychotherapy while other alcoholic types benefitted more from skills training.

While the use of psychotherapy in various settings may be suggestive of the view that treatment is individualized, its use in many public drug treatment facilities is solely for the purpose of addressing diagnosed psychiatric problems. Psychotherapy is frequently assigned based more on therapist availability, cost considerations, and clients' willingness to cooperate, than on a comprehensive strategy of meeting assessed client need. The gains derived from psychotherapy as an adjunct to drug counseling appear to derive less from the theoretical orientation of the therapist than on the strength of the therapeutic relationship (O'Brien, Woody, and McLellan, 1984). Psychotherapeutic interventions in drug and alcohol treatment may be an area where social workers could bring considerable skill and experience to the task of implementing this component in existing programs.

Social skills training and community reinforcement are premised on the assumption that functional life skills and supports can be modified and positively enhanced through the application of interventions specific to each (For a review see Miller & Hester, 1989). While the theoretical premise of social skills and community reinforcement are similar, they are dissimilar in the way they are operationalized. Social skills attempts to provide concrete skills for the client to more successfully

respond to specific life stressors, an individual change approach, while community reinforcement relies more on providing a means for client alteration of certain stressors in the family and on the job and on providing positive lifestyle environmental supports. Interestingly, both of these modalities operate on a premise similar to case management, an ecosystems perspective that emphasizes the multidimensionality of significant life problems.

Social skills training is the teaching of adaptive coping skills and substance refusal responses to individuals who typically exhibit maladaptive responses to events that are high stress, anxiety-provoking, or substance abuse triggers. Marlatt & Gordon's (1985) studies of relapse found that at least a third of relapsers do so in response to anger and frustration. Consequently, the authors see social skills training as essential for those lacking adequate coping skills. Research on skills training provides evidence that clients assigned to skills training groups showed greater improvement in handling difficult tasks and drank less during follow-up than the alternate treatment and control group subjects (Chaney, 1978; Intagliata, 1978). Social skills training interventions were also found to be better predictors of improvement than drinking history or any other demographic variable. Studies of drug abusers showed improved social skill acquisition among subjects following systematic skills training as well as reduced drug-taking among certain classes of drugs (Callner & Ross, 1978; Hawkins, 1989).

The community reinforcement approach (CRA) has been studied almost exclusively within the alcoholism treatment field. CRA relies on the components of job skills training, family behavior therapy, community social supports and social/recreational counseling as essentials in the intervention package. A study comparing outpatient clients assigned to either CRA or to the regular treatment regimen found that those in the experimental group drank significantly less, frequented drinking environments less, and showed less behavioral impairment than the controls (Mallams et al., 1982). The strongest evidence for the efficacy of community reinforcement comes from studies conducted in the Veterans Administration system in which there are multiple treatment components available (For a review

see Miller & Hester, 1989). These results bode well for those localities that are restricted in the number of treatment options available.

More traditional modalities should be reconsidered as well. For instance, therapeutic communities (TCS), whose early evaluations appeared discouraging, were sometimes dismissed as ineffectual based on the logic that aggregate outcomes should be more encouraging if these programs were worthwhile. Instead, one should ask, which client groups are helped by these programs. A recent study found that half of a TC program's graduates were abstinent at the 10-year follow-up, but, the percent of graduates that could be located and interviewed constituted only a fraction of the total group (Charvuvastara, 1989). One study of an innovative TC that uses a shorter program and intensive reentry programming found that successful outcomes were achieved in 60% of cases at one-year follow-up (Winick, 1990). Another study found that outcomes were improved where continued systematic aftercare was a part of the TC program approach (De Leon, 1991). While these findings are mixed, they suggest that TCs probably serve as a vital link in the treatment network. It may be that for cocaine addicts, who seem to benefit from longer, more intense treatment stays, that TCs will become the modality of choice (Rawson, Obert, and McCann, 1991). Social workers can be of immense help in identifying client groups that can benefit most from the TC approach.

Other program approaches speak to the needs of special populations and should be a part of any comprehensive approach to meeting individualized needs. For instance, social workers have generally recognized that female addicts and alcoholics have special needs, although the treatment community has only recently begun to make meaningful changes in the way women are served. Several communities now offer programs that serve women only and include options for pregnant women and facilities for small children (Kasl, 1992). Many of these programs work from an empowerment model sorely lacking in traditional treatment. Other programs and models are incorporating ethnic-sensitivity in their approach, and specialized programs for Hispanics and Native Americans are starting to appear (Lawson and Lawson, 1989; Kasl, 1992). Although these

programs are too recent to have generated research on their relative merits, anecdotal data and common sense alone suggest that using them will yield results as favorable as those achieved in traditional programs (Bepko, 1991; Kasl, 1992).

A number of self-help alternatives to AA have been developed, of which social workers and others in the helping professions should be aware. Each of these were started by people who left AA and discovered that there were others like themselves who, for a variety of reasons, could not benefit from that program. Jean Kirkpatrick started Women for Sobriety when she felt alienated by sexist language and remarks in AA and by the patriarchal approach that was not sensitive to the needs of women (Kirkpatrick, 1976). Secular Organizations for Sobriety was begun by people who couldn't tolerate the religious/spiritual notions of AA (Christopher, 1988). Rational Recovery was developed by Jack Trimpey, based on the rational-emotive therapy of Albert Ellis, who was put off by the ideas of powerlessness and the notion that one should experience "ego deflation at depth" as is suggested to newcomers at AA (Trimpey, 1989). While each of these organizations uses a somewhat different programmatic format, they collectively adhere to the central theme of abstinence as a priority in recovery. Although these organizations appear to be attracting a following, unfortunately there is no research comparing the approaches to AA or each other in terms of their relative effectiveness in helping people achieve abstinence.

A caveat is in order following this discussion of treatments and effectiveness research. Social workers should be cautious in their choice and interpretation of outcome measures. In traditional disease model treatments, outcome measures have been customarily restricted to focus only on abstinence, but researchers suggest that a broader range of dimensions should be examined as a better descriptor of progress in recovery (Wells et al., 1988). Additionally, working from a competency perspective, it is appropriate that social workers in particular look at indicators which provide feedback related to the value base of the profession, such as empowerment, in addition to more discrete indicators of post-treatment performance (Frans, 1993).

The tenets of the disease view should be continually challenged and reevaluated, being especially mindful of current research and social work's unique mission. It is this author's view that an ecological approach may be social work's unique contribution to addressing drug and alcohol abuse. Such an approach actually fits well with the emergent "new paradigm" in social work that, according to one theorist, is returning the profession to a holistically oriented enterprise (Orcutt, 1990). Those social workers ascribing to such a notion should eschew simplistic and reductionistic notions, and, while possibly focusing their efforts at one particular level of intervention, they should continue to recognize their role within a broader multidisciplinary and multidimensional solution. Rather than totally reject the disease model, social workers should begin to develop a new ecological paradigm which can incorporate it appropriately in a broader vision for the future.

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Client-Driven Advocacy and Psychiatric Disability: A Model for Social Work Practice

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This paper presents an innovative advocacy model designed to assist people coping with psychiatric disabilities to fulfill their basic living needs. The model emphasizes the importance of clients defining their own needs for advocacy and then, with the support and assistance of an advocate, taking direct action to fulfill these needs. The model is elaborated in terms of its basic attributes, the interlocking roles of both clients and advocates, the importance of the advocacy relationship, and seven core processes of advocacy. The authors conclude with a discussion of possible effects of introducing the model into social work practice in mental health settings.

Many social workers agree on the importance of client advocacy as a critical function of mental health practice whether in case work, in case management, or in family work (Gerhart, 1990; Moxley, 1989; Rapp & Hansen, 1988). However, much of the emphasis placed on the importance of advocacy by the profession is rhetorical. It encourages social workers who otherwise identify themselves as clinicians and therapists to address environmental and institutional factors that prevent the fulfillment of clients' basic living needs. Yet we know that many social workers in the mental health field are more comfortable with office-based practice that places them in the roles of clinicians (Johnson & Rubin, 1983; Mowbray & Freddolino, 1986). These workers may view advocacy and related environmental

modification activities to be superficial extras in addressing the "real" needs and problems of people with psychiatric disabilities which the workers define more in terms of psychological and psychodynamic processes than in terms of environmental and structural factors (Johnson & Rubin, 1983).

Alternatively, social workers may view advocacy as more of a paraprofessional function, easily done by workers without professional training. Social work clinicians may be reluctant to embrace roles that thrust them into conflictual arenas within community settings where they may not be able to use effectively the skills of collaboration and consensus-building which are so fundamental to our profession's traditional approach to problem-solving.

The relative inattention paid to advocacy by social workers practicing in mental health may be compounded by the failure to achieve consensus within the profession on what constitutes this intervention (McGowan, 1987). Does advocacy mean assisting clients in gaining access to services or entitlements, with the functions of brokering and linkage being the most important (Moxley, 1989)? Does it mean protecting the substantive rights of clients, thereby requiring the social worker to invoke legal processes (Raider, 1982)? Does it mean working in the client's "best interests" despite the possibility that the client may not agree with the aims of the social worker (Gerhart, 1990)? Or does it involve a partisan perspective in which the social worker only acts on those goals or issues that clients want to achieve for themselves (McGowan, 1987; Moxley & Freddolino, 1990)? Each of these definitions suggests a different type of advocacy activity.

Given this extensive diversity in the definition of advocacy as used in mental health contexts, the concept and related interventions can mean different things to different practitioners. It is not surprising, therefore, that the profession does not have clear and compelling *practice models* that guide our provision of client advocacy. This paper is based on the authors' empirical research on advocacy which identified a high prevalence of unmet basic living needs among consumers of mental health services (Freddolino, Moxley, & Fleishman, 1988; Moxley & Freddolino, 1991). This research also evaluated the impact of

an advocacy intervention in fulfilling these unmet needs using a consumer empowerment strategy. In the paper we articulate a basic model of advocacy practice that was actually field tested (Freddolino, Moxley, & Fleishman, 1989) and assess the relevance and practicality of this model for social work practice in mental health settings. The model is based on the fundamental view that advocacy must be grounded in the self-defined needs and desires of consumers, resulting in a client-driven approach to the provision of social work services.

The Relevance of an Advocacy Perspective

In the context of social work practice in mental health, is advocacy relevant to serving people coping with psychiatric disability? Indeed, several conditions underscore the importance of advocacy in the mental health arena (Moxley & Freddolino, 1990).

People labeled mentally ill constitute a vulnerable population, nowhere more visible than in the areas of housing, employment, and income maintenance (Moxley & Freddolino, 1991). People with severe mental impairment are at risk of homelessness (Torrey, 1989). Anywhere from one-third to two-fifths of homeless individuals may be coping with significant mental impairment (Lamb, 1984). Because they do not control many housing placements, mental health agencies have not been able to respond to this explosion in the need for housing, and they have also found it difficult to coordinate their services with public housing authorities reluctant or even hostile to serving people with psychiatric disabilities (Mechanic, 1987). In the face of this, advocacy strategies may offer an alternative to front-line social workers that is much more consistent with the values of the profession—such as promoting self-determination (Moxley & Freddolino, 1990; Freddolino & Moxley, 1992)—than oppressive alternatives that reduce client autonomy (Belcher, 1988).

Many people coping with psychiatric disabilities experience considerable difficulty in obtaining gainful employment due to discrimination by employers, employment that pays an inadequate wage, and a reluctance by vocational rehabilitation agencies to serve people with psychiatric disabilities (Gallagher, 1987). An advocacy approach which emphasizes assisting clients

in addressing their self-defined needs may provide a concrete method for dealing with these situations instead of accepting the only currently-available alternatives such as a sheltered workshop designed for people coping with different disabilities (Malamud & McCrory, 1988).

In the area of income maintenance, the actions to strip many people with psychiatric disabilities of their social security disability benefits by the Reagan administration during the early 1980s illustrate the vulnerability of this population not only to the elimination of public income supports but also to the broader danger of bureaucratic manipulation (Goldman & Gattozzi, 1988). Through a narrow interpretation of administrative rules, the Reagan administration eliminated many people with mental disabilities from federal income supports and forced them onto public assistance or onto their own, often inadequate, means (Burt & Pittman, 1985). Both individual advocacy (dealing with specific people) and systemic advocacy (dealing with groups or classes of people and broad system-wide conditions) are certainly relevant strategies for addressing the relative lack of access to basic living resources experienced by many people coping with psychiatric disabilities. People labeled mentally ill are certainly not insulated from future administrative ploys to decrease or eliminate vital social benefits in the name of budget balancing or retrenchment.

Being labeled mentally ill can have negative social consequences, resulting in stigmatization leading to rejection, mislabeling by the media, and lack of motivation to provide essential services even by health care professionals (Gallagher, 1987). Advocacy in this context may need to address social and interpersonal processes that lead to gross misperceptions of people with psychiatric disabilities which in turn can prevent their integration into our communities.

The effects of stigmatization can be worsened by learned helplessness, involving a loss of motivation and reduced feelings of self-efficacy and resulting from important decisions, opportunities to make choices, and critical tasks of daily living being usurped by significant others or by mental health workers (Taylor, 1979). The resulting dependency may mean that individuals coping with psychiatric disabilities will be unwilling

to take autonomous action. Again, advocacy—in the form of assisting clients to address their self-defined needs—may be quite relevant.

Finally, some people coping with psychiatric disabilities may not see clinical services as having much utility for them. They may see relevant services as ones that assist them in obtaining housing, employment, income and other necessities of daily living—services that address basic resources and not the psyche. Rather than mental health services or in addition to clinical care these consumers may desire more pragmatic social supports that address their basic living needs and that assist them in achieving the goals that they themselves identify as most important (Anthony, Cohen, Farkas, & Cohen, 1988; Cohen & Anthony, 1988; Freddolino, Moxley, & Fleishman, 1988).

The Client Support and Representation Model

Five Attributes of Client-Driven Advocacy

The Client Support and Representation (CSR) model views individual (client specific) advocacy as a means of improving the well-being of people with psychiatric disabilities through a process of skill development and support leading ideally to empowerment (Rose and Black, 1985). At the core of this empowerment process are five attributes that give the model a client-driven character by emphasizing the values of self-determination and client control (Moxley & Freddolino, 1990).

First, this model of advocacy recognizes the legitimacy of clients defining their own wants and desires. Needs are not defined by the social worker or by others but by clients themselves. The role of the social worker, ideally, is to facilitate the identification and definition of the problem from the client's perspective. This process of self-definition is fundamental to the problem solving process that is used by CSR. Second, advocacy is not defined as a passive activity in which the advocate identifies systemic and environmental barriers and then takes action on behalf of clients. Alternatively, the clients', own problem-solving skills and resources are strengthened in relationship to attaining self-defined wants and desires, and in dealing effectively with barriers and constraints that prevent the fulfillment

of daily living needs. A third attribute is the importance of on-going social support and the role of the advocate as a strong source of support to clients. Advocates assist clients in defining problems, in establishing goals, and by providing on-going encouragement in the resolution of needs and desires. A fourth attribute is the need for clients to acquire knowledge about the broad range of community resources that exist within many of our communities. Knowledge is seen as a critical precursor to empowerment since clients need to know what exists (and what does not exist) in relationship to their own individualized wants and desires. The final attribute is the legitimization of clients', disputes and disagreements, including support for the right to express these disagreements and to seek either formal or informal hearings in order to resolve them.

The Client Support and Representation framework is based on a humanistic view of people coping with psychiatric disabilities. CSR advocacy assists clients in developing and strengthening their abilities to acquire knowledge, assertiveness, and problem-solving skills. Advocacy also is designed to assist clients in overcoming personal and environmental challenges that can stand as barriers to their obtaining what they want for themselves (Rapp & Wintersteen, 1989). Advocacy in this context becomes a form of personal self-assistance, based on self-identified needs, that unfolds within the context of a very supportive interpersonal relationship with an advocate. This approach is seen as appropriate for clients diagnosed with a broad range of psychiatric disabilities, similar to the target groups for case management services. It has been field-tested with clients labeled with schizophrenia, major affective disorders, and schizoaffective disorders (Freddolino, et al., 1989). But perhaps what is most important is the identification of those individuals who prefer an approach in which they struggle to make their own decisions and to select their own courses of action (Moxley & Freddolino, 1990).

Two core values are fundamental to all five of these CSR model attributes. The value of self-determination (Moxley & Freddolino, 1990) means that clients must understand their needs and define what action they want to take to fulfill them. The value of client control means that the advocacy process

involves direct action by clients to resolve their problems or to fulfill their desires. The value of client control, therefore, is a recognition that the purpose, aims, activities, and evaluation of advocacy must be formulated and implemented according to the perspectives of clients themselves (Moxley & Freddolino, 1990; Freddolino & Moxley, 1992).

The Roles of Clients in CSR

The values of self-determination and client control are further operationalized through the roles available to CSR clients. Four roles, all based on the idea that clients must take responsibility for operationalizing the process of advocacy through their own actions, are fundamental components of the field-tested model. These four roles are: initiator, implementer, evaluator, and educator.

As initiators, clients take responsibility for initiating the advocacy process by agreeing to become involved, by defining their own needs through a needs assessment process, and by determining the actual advocacy activities that will be employed to address these self-identified needs. As implementers, the CSR advocacy process requires clients first to implement action on their own behalf before any higher order level of intervention is undertaken-especially by the advocate. Within the CSR model emphasis is placed on self-help and direct action by clients while the advocate provides on-going technical assistance, support, and encouragement. As a result, clients are actors rather than passive recipients of services provided by the advocate.

Throughout the process of CSR, clients are involved as active evaluators of the process and outcome of advocacy. Clients are involved in monitoring which advocacy activities should continue, whether they are satisfied with the outcome of these activities, and whether advocacy activities should continue, be modified, or stop. Consequently, emphasis is placed on clients taking the role of active decision-makers.

Finally, clients are seen as educators of CSR advocates and others about their preferences, what they want to achieve for themselves, how they want to go about achieving what they have identified as important for themselves, and what they are willing to accept from mental health and other social welfare

systems. In this role, clients are seen as active agents who are increasing the understanding of advocates and others.

The Roles of Advocates in CSR

The CSR model identifies four roles of advocates that complement client roles: mentor, coach, supporter, and representative. The CSR advocacy model does not assume that clients will have all of the requisite skills to engage in proactive problem-solving. It is up to the advocate to be available to clients to mentor them through the learning of these skills and their application to specific situations. By modeling effective problem-solving, by teaching clients the essential skills involved in dealing with institutions and bureaucracies, and by suggesting to clients how to network and with whom to network, the advocate can promote problem-solving on the part of clients.

The role of coach is connected with that of mentor and is useful to teaching problem-solving skills directly. Here the advocate is much more explicit about teaching specific skills. This may involve task analysis, the provision of special knowledge concerning regulations, and the use of rehearsal to give clients opportunities to practice skills.

In operationalizing the role of supporter the advocate provides a range of supports including emotional, instrumental, and informational resources (Gottlieb, 1981). Attentive listening, empathic responding, and allowing the expression of anger and frustration are some of the ways that the CSR advocate provides ongoing support. In addition, support is provided even though the advocate may disagree with the course of action that clients have chosen. As a supporter, the advocate is available to assist clients in making these decisions and perhaps to reconcile any difficulties that may arise as a result of the choices made by clients. There is an inherent dignity in making choices about a course of action even though these choices can result in failure (Wolfensberger, 1972). CSR advocacy is consistent with psychiatric rehabilitation principles which emphasize that clients need opportunities for both success and failure since these opportunities are so fundamental to learning in real life situations (Farkas & Anthony, 1989). Finally, the CSR advocate is always prepared to serve as a representative of client wishes

and desires within institutional, bureaucratic, and community situations. CSR advocates do not fulfill this role based on their own assessment of the situation but take this role when advocates and clients agree that this is the preferred course of action. As representatives, advocates may attempt to resolve disputes through mediation and negotiation, or through more assertive actions such as administrative hearings or formal legal action.

The Importance of the CSR Advocacy Relationship

As with most effective human service technologies that use interpersonal techniques, CSR requires the development of an effective relationship between advocate and clients in order to integrate the roles of the two parties (Egan, 1985). Undergirding this relationship is mutual trust. This trust can be developed between advocate and clients when the advocate accepts the legitimacy of client perspectives and desires and, in turn, when clients are forthright in identifying what they want to gain from the advocacy effort. The only a priori limits on the types of clients for whom this approach may not be optimal are those with organic brain conditions and clients whose primary diagnosis is substance abuse.

Trust also is developed when clients articulate the actions they want advocates to engage in, and advocates take these actions and do not pursue their own agenda. In addition, the advocate sustains trust by asking, on a consistent basis, what clients want the advocate to undertake and then pursuing these activities. Again, the advocate avoids unilateral action or "action in the best interests of the client," leaving that approach to the other professionals in the mental health system. Fourth, clients and advocate sustain trust by "touching base" with one another, preferably on a regular basis, in order to inquire into how things are going, to identify new needs, and to evaluate whether agreed-upon actions should be continued.

Last, trust is sustained by advocates when they recognize that clients may want to drop in and out of involvement in CSR advocacy. This is recognized by both parties as legitimate action, and the advocate has faith in the ability of clients to recognize for themselves when they want to be involved and when they do not want such involvement. By addressing this

and all of the other aspects of relationship both the advocate and the client will be able to build and sustain a productive collaboration.

The Process of CSR Advocacy

CSR makes use of seven core processes which are based on casework and rehabilitation practices of demonstrated effectiveness including the use of tangible objectives, the task analysis of activities, contracting, homework, the development of client problem-solving skills, and the monitoring and evaluation of the implementation and effectiveness of advocacy activities (Anthony, 1979; Brown & Hughson, 1987).

The seven advocacy processes are:

1. **Engagement.** CSR services are offered to an identified group of clients or to all clients within an identified geographic service area. Advocates explain the services, and inquire into whether clients want to participate. These outreach and engagement activities are implemented to assure that clients who might otherwise not have the skills or resources to obtain the assistance on their own initiative if they want it will not be deprived of the opportunity to participate. For those clients who do not have any self-defined needs, the routine and unconditional offer of advocacy services increases their awareness of the service and offers the possibility of linkage with the program sometime in the future if they so desire.

2. **The Assessment of Advocacy Needs.** To assess the needs from the perspectives of clients themselves, an open-ended needs assessment instrument is employed that allows clients maximum opportunity to identify their self-perceived needs without the formal structure of either the program or the advocate being imposed upon them.

In order to give some focus to the interview process, the needs assessment instrument is structured so that nine daily living needs areas are covered. These areas are: housing; employment and training; income and benefits; health, mental health, and dental care; transportation; medication; legal problems; social, personal, and family issues; and conservatorship; An additional question is included to allow clients to identify needs that do not fall within these categories.

The practicality of the need areas within the instrument attests to CSR's concern for identifying issues pertaining to clients' self-perceived quality of life within the community rather than with the quality of their mental health care. The needs assessment process reinforces the client role as the initiator of advocacy activity. In addition, the process is designed so that clients can engage in the role of educators who teach the advocate what they need or desire.

3. *Setting Objectives and Identifying Tasks.* Following the identification of needs, clients and advocate work together in the formulation of client driven plans. The advocacy plan consists of mutually-agreed upon objectives for the issues clients defined based on their self-identified needs, problems, and barriers. Objectives are concrete statements of what clients want to achieve in order to reconcile their identified needs and problems. These objectives are then prioritized so that clients and advocates can address the issues that are most pressing from the perspectives of clients themselves.

Clients and advocates then collaboratively identify tasks that must be accomplished if the objectives are to be achieved. By the time tasks are specified both clients and advocate understand the responsibilities each must undertake in order to achieve a successful and desirable outcome.

A major bias of the CSR model revealed here is the emphasis on encouraging and supporting clients to take on as many specific tasks as they can handle in their own behalf. Except for emergency situations, the general advocacy principle guiding staff is not to do for clients what they can do for themselves even if it may take more time or demand more effort. The emphasis placed on self-initiation reinforces the client role of implementer, thus working toward overcoming learned helplessness. This emphasis also means that advocates are more likely to engage in coaching and mentoring rather than in direct action on behalf of clients.

4. *Maintaining Relationships Across Space and Time.* A fundamental principle of the CSR model is that weekly contact with clients is to be attempted no matter where the client is located. For the purpose of the CSR research demonstration, the contact area was defined as that space within a 50 mile radius

of the project office. Tracking the client so that there can be an on-going offer of CSR advocacy services means that advocates follow clients if they are committed to psychiatric facilities, move from one residential program to another, or if they are sentenced to jail. Client movement, therefore, does not mean that clients need to break with the advocacy services. Although clients can choose to stop receiving CSR services, advocates bear the responsibility for maintaining contact, offering assistance, and following-up with clients no matter what system-mental health, criminal justice, or medical-the client enters. By following the client, advocates seek to maintain continuity of the advocacy effort.

CSR calls for maintaining the offer of assistance across time. The intervention is seen as an on-going one during which clients can drop in and out of service based on their preferences. Treatment compliance is not incorporated into the model since continuing with the advocacy service is a choice made by clients.

5. Problem-Solving and On-Going Needs Assessment. Implementation of the advocacy plan typically begins with the advocate providing technical assistance and information on how to resolve each specific need or problem before any higher level of intervention is undertaken by either party. At the time of each weekly contact client and advocate discuss progress made toward the fulfillment of objectives. If technical assistance does not appear to be sufficiently effective for a specific need, the advocate can become more involved if the client requests such involvement. Advocates, for example, may represent clients at administrative hearings, at face-to-face negotiations with landlords, or in meetings with employers if clients request such action.

At this stage of the CSR process a short needs assessment is completed during each weekly contact. The advocate inquires into how things are going in specific areas of potential need, determines whether the client wants to address any other needs, and the two then update the advocacy plan accordingly. Frequent repetition of the brief needs assessment process allows the timely identification of newly emerging needs and reinforces for clients that an on-going source of support and representation is available to them.

6. **Monitoring of Problem Resolution.** Maintaining frequent communication between clients and advocates is an important aspect of the intervention process. Clients and advocates contract for both face-to-face and telephone contact with the purpose of discussing how things are going. Monitoring is not designed to assess whether the client is complying with the agreed-upon plan under threat of some punitive action for failing to do so. The purpose of monitoring is to determine if milestone tasks are relevant, if they are being achieved, and if adjustments in strategies need to be considered by the two parties. In addition, the monitoring contacts permit friendly visiting between the client and advocate, an activity that reinforces the on-going supportive nature of CSR services.

7. **Evaluation of Outcome.** The extent to which clients are satisfied with the resolution of their needs or problems is an important criterion used to evaluate the effectiveness of the CSR advocacy effort. Although this may seem rather simplistic, the use of client satisfaction is consistent with the "client driven" character of the CSR model. This approach to evaluation prioritizes the perceptions of the participants. It respects their status as independent decision-makers who have the capacity to determine when they have resolved a situation to their own liking, and it reinforces the importance of participant reflection on the attainment of their own preferences and desires.

Practice Implications

The Client Support and Representation model of advocacy is an interpersonal practice approach that can expand the repertoire of social workers practicing in mental health. In the past, social work practice in mental health has emphasized the case-work role of the social worker who worked with client and family coping with the onset of psychiatric illness and then in helping both client and family to adjust to the milieu of the institution. Practice has evolved into more of a case management approach in which the social worker practices at the boundary of the mental health program and the community. The social worker helps clients to identify the services that are necessary to meeting their needs in community-settings and then links them to these services. Advocacy in this context typically involves getting clients access to services.

The CSR model can complement this case management approach to mental health service delivery by expanding the advocacy function. The model promotes the values of self-determination and client control over intervention activities. Despite the fact that the profession espouses these values, it has been difficult to operationalize them in situations where social workers must represent the interests of the system or of agencies over those of the clients. Thus, social workers may find themselves in "people processing roles" rather than in roles that enable them to represent the desires and goals of clients (Cohen & Anthony, 1988). The adoption of CSR principles can assist social workers in working collaboratively with their clients in defining and acting on what they want to achieve for themselves. Perhaps social workers adopting this approach to practice will find themselves working on mental health issues under non-traditional auspices such as public interest law firms, consumer-operated services, and self-help alternatives.

Another implication for social work involves the practical focus of the CSR model, which addresses the basic needs and resources of clients from the perspectives of clients themselves. The focus of CSR is on whether clients, from their perspectives, are coping with major problems or issues that can prevent them from achieving the lifestyle that they wish for themselves. Clients' desires concerning housing, employment, legal issues, and medical care, for example, are much more important to the model than their diagnostic profile or their psychiatric histories. The latter are seen as potential barriers because of the way other people—mental health professionals and community residents alike—use these profiles and histories to make *a priori* decisions about clients' competencies and capabilities. By focusing on the needs that clients define as important the social worker is more of a generalist practitioner than a psychiatric professional. Perhaps this will mean that social workers practicing in mental health will take into consideration what the community as a whole has to offer clients and will not confine their attention only to those services that are readily available through the mental health service system.

Many approaches to interpersonal practice emphasize the importance of mobilizing the action of clients in resolving their

own problems and needs (Epstein, 1988; Germain & Gitterman, 1980). The CSR model operationalizes this principle of effective social work practice by emphasizing the need to formulate advocacy plans that identify the action taken by the client to address each prioritized need or issue and how the client and worker will collaborate in resolving the identified need or issue. Rather than indicating that clients are left to their own devices to help themselves, this means that the worker takes responsibility to assure that clients have every opportunity to exercise their own skills—or to develop new ones—so they can make a positive impact on their environment, a condition that is so essential to the realization of personal mastery and effectiveness (Wine, 1981).

An emphasis placed on mobilizing client action may also be useful in offsetting some of the motivational deficits induced by psychiatric disability. By identifying their own skills, by exercising these skills, by learning new skills, and by receiving support to use these skills, people coping with psychiatric disabilities may learn to sustain their motivation and to resolve other problems effectively in the future with less dependence on professionals.

Despite its focus on individual action, the CSR model also recognizes the role of environmental factors in preventing people from realizing their goals and desires. The model emphasized the importance of identifying any legal, institutional, societal, and bureaucratic processes that can prevent clients from meeting their needs. The advocacy process emphasizes the importance of resolving these environmental issues, which means that the social worker may have to represent clients in different forums. Thus, this model of advocacy requires the social worker to work with clients directly in augmenting their problem-solving skills, to work with the client collaboratively in addressing environmental issues, or to take action independently of the client when this is mutually agreed upon.

Finally, a fundamental aspect of the CSR model is the need for on-going support provided by the social worker during the course of advocacy. On-going support—whether it involves emotional sustenance, active listening, the provision of information, or simple encouragement—may be very important to clients who

have experienced considerable discouragement, frustrations, or oppression when trying to achieve their goals. The consistent provision of support may be a major tactic for propping up the motivation, problem solving, and autonomous action of clients.

Client Support and Representation encapsulates much of what the profession defines as good social work practice. The model complements and operationalizes the profession's historic commitment to meeting the basic needs of vulnerable client groups and to involving clients directly in the process of social work service delivery (Towle, 1987). CSR also is a practice model that is consistent with the profession's person-in-environment framework. Perhaps the incorporation of CSR into the repertoire of social workers practicing in mental health will further strengthen the leadership role of the profession in enhancing the lives of people coping with psychiatric disabilities (Wintersteen, 1986).

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A Marxian Review of Gerontological Literature

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A major concern for the sociology of aging and social gerontology is the lack of theoretical rigor. In particular, Birren and Bengtson (1988) describe all of social gerontology as "data-rich but theory-poor." In an effort to deal with the lack of theory, this essay reviews the general social gerontology literature from a Marxian perspective. The findings suggest that the Marxian framework can illuminate aspects of social gerontology hitherto left unexamined in both the academic and applied arenas.

In the light of recent events in Eastern Europe and the former Soviet Union, a reasonable question might be asked, "How relevant is a Marxist theoretical framework?" Sociologists such as Hollander (1990) are highly critical of the continued use of the Marxian framework in academic circles. Some contemporary Marxists feel they must respond to statements like: The Berlin Wall is no more. *Perestroika* will soon be included in English dictionaries. The "analytic Marxists" greet what has been called the "crisis of Marxism" with a zealous joy. Wright (1989a, p. 36) articulates his belief that Marxism is in a period of "theoretical transformation" and will emerge from this state with greater explanatory power. He also refers to this new emerging Marxism as "more politically relevant" suggesting that the framework will be an even more effective tool for community organization and advocacy. In his elegantly written essay, Bowles (1990, p. A56) notes that the slogans being used in Eastern Europe

come from neither the *Communist Manifesto*, nor from *Wealth of Nations*. There is a plea for citizens to be able to participate in the economic and political decision-making process. Contrary to the emphasis in most of the American press on markets and capitalistic institutions, Bowles interprets these Eastern European pamphlets as being similar to the "Declaration of the Rights of Man" and Tom Paine's "Common Sense." He states that the crowds in Prague and Moscow have nothing in common with the Bolsheviks but are more reminiscent of "Berkeley in 1964 or Paris in 1968." Marxists from the "analytic school" contend that it is time to fine tune and retest the perspective, not a time to bury it (Burawoy, 1990). Efforts to test and refine the Marxian perspective are likely to appear throughout the academic world in this decade. In this paper, we argue that the application of Marxian theory can illuminate aspects of social gerontology hitherto left unexamined.

Marx's program for overcoming oppression includes organizing the oppressed and engaging them in active struggles with their oppressors, all the while helping them to become aware of the contradictions inherent within the capitalist system and of the necessity of overthrowing the system itself. Literature in social gerontology that has utilized contributions from Marxian theory does not specifically question the relevance of Marxism's fundamental assumptions (Marson, 1991a). This paper fills this gap.

In order to apply the Marxian framework to social gerontology it is necessary to successfully accomplish three tasks. These include:

- Meeting theoretical prerequisites
- Fine tuning the framework to meet the need of gerontologists
- Applying the framework for advocacy

Theoretical Prerequisites

In order to effectively utilize the Marxian framework for social gerontology, three theoretical prerequisites must be met. They include:

- Conflict must exist
- Conflict must be materialistic in origin
- Conflict must occur between two opposing groups

Existence of Conflict

Conflict, in Marx's writing, is the very driving force behind social change. Demarcation lines are drawn between contending classes, capitalists and workers, with conflict emerging from struggles over the control of over the means of production. Conflict is well noted in the social gerontology literature. At least three scholarly bibliographies (Frazier and Hayes, 1991; Johnson, O'Brien, and Hudson, 1985; Marson, 1991b) and one scholarly journal (*The Journal of Elder Abuse and Neglect*) exclusively address this issue. Popular literature on aging also frequently addresses conflict (i.e., Clift and Hager, 1989; Dwyer, 1989; Moore, 1985; and Paulson and Goldwasser, 1989).

Materialistic Origin

In traditional Marxism, conflict is generated by the control over the means of production. Some—but not all—neo-Marxists have retained this view. Because of retirement, elderly people have little to no direct participation in economic productivity. Thus, in social gerontology, "control over the means of production" has little relevance.

Wright (1989b), a prominent figure in neo-Marxian analysis, has moved away from "control over the means of production" and toward to using "material interest" as the center-piece for Marxian analysis. It is extremely difficult to find a concise definition of *material interest* either within Marx's own writings, or those of his contemporary interpreters (Wright, 1989b, p. 205 in footnote). A new conceptual definition of material interest should be constructed for the sociology of aging. In the capitalist mode of production, just as in all other precommunist modes, material interest is the tie that binds people into society, while the strategies employed to pursue material interest are the ties that bind people into social class. Conflict emerges between social classes because *all* are pursuing the same material interest. Within each social class there are distinctive strategies. Thus, social classes can be identified on the basis of *relative* strategies

of pursuing material interest. The central goal for each strategy is to maximize wealth while minimizing the efforts needed to gain it. The classic strategy noted by Marx (1967) is to gain wealth by limiting the amount of potential wealth of another class—"less for you, more for me." As capitalism becomes more sophisticated with the flow of history, the various strategies employed become more difficult to identify and analyze even though their objectives remain the same. A detailed illustration of the historical development of these strategies is available (Marson, 1991a).

Existence of Social Groups

The issue of whether the aged constitute a real social group, rather than a mere aggregate, is complex, but it is of fundamental importance for the application of a Marxian framework to the study of aging. Marxists identify group (class) awareness as a fundamental prerequisite for collective struggle. In fact, any conflict theory requires that there be at least two opposing groups, aware of each other's presence and identity in order for conflict to take place. The problem in the sociology of aging is a lack of any clearly delineated opposing sides (Minkler, 1984).

Marxian inspired writing has addressed this concern by making polar opposite conclusions. Estes (1979) and Olson (1982) begin their independent analyses with the assumption that elderly people constitute a social group that separates them from younger people. The literature offers several illustrations of this phenomenon (Braddy and Gray, 1987; Love and Torrence, 1989; Marson, 1983). Whereas, Dowd (1980) and Phillipson (1982) begin their analyses with the assumption that elderly people constitute an aggregate—not a social group. Dowd (1980) and Phillipson (1982) independently contend that a Marxian analysis of conflict should occur within the context of social classes in which elderly people are included. The literature also supports the existence of this phenomenon (Calasanti, 1988; Stoller and Stoller, 1987).

The debate that emerges out of the work of Estes (1979), Olson (1982), Dowd (1980), and Phillipson (1982) forms a point of departure for our analysis since it illuminates how social gerontologists have found the Marxian framework fruitful for

making sense of their data. The issue of which side in this debate is "correct" is beside the point; however, the interested reader should consult Marson (1991a) for a detailed discussion. For our purposes, the debate facilitates the identification of at least three locations where Marxian analysis is appropriate. These locations include:

- subculture by age alone;
- age nesting within social class;
- age crossing social class.

The Three Conflict Locations

A *wide* variety of Marxian perspectives are available for general analysis.¹ Thus, it is not surprising that our discussion should include three mutually exclusive perspectives. The identification of three perspectives is meant to illustrate that Marxian analysis is rich with ideas that can illuminate the wide range of social gerontology literature—a literature that is theoretically barren (Birren and Bengtson, 1988; Lipman and Ehrlich, 1986; Maddox and Campbell, 1985; Marson, 1991a). Identifying which perspective is most fruitful is a testable research question. The purpose of this paper is layout ideas in order to be tested.

Subculture

Rose's (1965) work on subculture theory provides the foundation for the work of neo-Marxists in the sociology of aging.² Although not influenced by Marxian theory, he was the first to address the issue of elderly people as a social group when he suggested that a subculture of senior citizens will emerge whenever members of one category interact more among themselves than with people from other categories.

Both Estes (1979) and Olson (1982) concur with Rose's original idea when they begin their Marxian analysis with the assumption that elderly people constitute a social group with a unique consciousness that separates them from younger people. Estes focuses upon and reviews contemporary social and economic programs while Olson follows the historical explanation of the emergence of social programs for elderly people.

Bengtson *et. al.* (1985) strengthens the argument for the subculture perspective when they analyze the literature and suggest that elderly people are in a historical period of great social change. The social structure is moving from a period in which there was little or no collective consciousness among elderly people to a period in which there will be group cohesion. Bengtson and his associates contend that Rose's subculture theory was ahead of its time. There is little evidence of a subculture in the past; some evidence of it in the present; and stronger evidence that suggests that it will exist in the future. Two succeeding editions of a leading text book (Harris and Cole, 1980; Harris, 1990) show a trend supporting Bengtson. In the first edition, Harris and Cole (1980) are quite critical of Rose's theory of subculture. After ten years of research and literature review, Harris' (1990, p. 173) position changed.

From the subculture perspective, the cleavage is located between the young group and the old group. That is, the *Younger Cohorts* are in conflict with *Older Cohorts* because of material interest which oppose each other. The non-Marxian literature supports the existence of such conflict. Braddy and Gray (1987) demonstrate that younger job applicants are given preference, even though such a procedure is clearly illegal. Preston (1984) takes a different view when he addresses the potential conflict between young and old cohorts on the basis of "transferring resources to dependents." He suggests that with continuing limited resources, dependent children are more likely to go "wanting." Elderly people have more political clout. In Preston's (1984, p. 446) words, "children don't vote; and adults don't vote on behalf of their children. . . . If we passed through life backwards, adults would insist that conditions in childhood be far more appealing." McCall (1991) extends Preston's work by linking the transfer of resources to suicide rates. Although not in total agreement with Preston's analysis, she finds that rising suicide rates among the young are "associated with a deteriorating state of well-being for adolescents;" while the declining suicide rate for elderly people is associated with improved resources for them. Such studies support the argument that the conflict is between the cohorts. The cleavage between cohorts is the result of conflicting material interests.

Social Class Conflict

Dowd (1980) contends that elderly people cannot be perceived as a separate social entity even within a Marxian analysis. He points out that our capitalistic society divides elderly people into two social classes: the *haves* and the *have nots*. Phillipson (1982) argues that elderly people cannot form a true social group or subculture. She contends that social class forms the primary lines of social cleavage. She frequently quotes directly from Marx who insists that longevity is a characteristic of the "ruling class."

Riley (1985) supports the proposition that the study of conflict in social gerontology is based on social class interests of elderly people. Any variation of the class interest theme projected by an elderly person is the result of self interests. In more complex and more precise terms, Riley contends that the values and interests of each successive age cohort are founded on a unique encounter with history. From the history of the cohort emerges the potential for a group (or age) consciousness. Contrary to Rose's original position, Riley makes clear that most cohorts are not likely to develop a group consciousness founded on age. Even though there are shared experiences and values because of common history, there are many social factors which create division. Gender, race, and most importantly, socioeconomic factors create division among senior citizens that will impede a subculture as Rose hypothesizes.

Marxian analysis for social gerontology illuminates two different arenas for social class conflict. First, conflict can be nested within, rather than crossing class lines. That is, conflict emerges between two age cohorts within the same social class. Second, class conflict can be found among elderly people. That is, elderly people face conflict across class lines within their own age cohort. Both of these perspectives are appropriate points of departure for Marxian analysis.

Conflict Nested in Social Class When we speak of conflict nested in social class, we are referring to conflict over the material interest in which a younger generation competes with an elderly generation of the same social class. Little is written about this conflict, however, the line of division is most likely to

follow the demarcation between *core* and *peripheral* sectors of the dual economy. The *core* sectors consist of firms that are large, oligopolistic, highly profitable, unionized, and higher paying. The *peripheral* sectors consists of smaller, more competitive, marginally profitable, nonunion, and low paying firms. Mueller, Mutran, and Boyle (1989) offer an impressive work in the sociology of aging. They clearly demonstrate that aging workers in core sectors face the greatest amount of discrimination from younger workers who share the same social class. *Core sector* older workers have more to lose in their retirement benefits than *periphery sector* older workers. In the end, *core sector* workers face significantly greater age discrimination because they are a greater threat to younger workers of the same socioeconomic status. A proposition can be formed: The greater the material wealth possessed by older workers, the greater the efforts by younger workers to struggle over that wealth.

Conflict between Social Classes Conflict between social classes comfortably fits into traditional Marxian analysis. Crystal and Shea (1990) provide evidence for the existence of this cleavage when they report that the *have nots* (the poorest one-fifth of the elderly) receive 5.5% of the elderly's resources, whereas the *haves* (the richest one-fifth) receive 46%. Stoesz shows that money can buy the best health care. In concluding his analysis he (1989, p. 30) states, "the gray market is likely to divide into two clearly demarcated systems of eldercare: the affluent elderly enjoying the generous care of completely—some would say excessively—provisioned life care communities: the poor elderly dependent on the squalid institutions willing to accept government payment for care." However, the most convincing support for the existence of this phenomenon is found in recent news reports (Clift and Hager, 1989; Dwyer, 1989; and Paulson and Goldwasser, 1989). In 1988, Congress passed the *Medicare Catastrophic Coverage Act*. The intention of the Act was to avoid the financial losses and humiliation faced by elderly people who must sell all their life possessions and become welfare recipients when catastrophic illness strikes. The benefits were impressive. However, because of the huge national debt, a surcharge was attached. Middle and upper class elderly people were required to pay for the protection. The *National Committee*

to Preserve Social Security organized their 33 million members to demand an unprecedented repeal of the Act. The Act, of course, was repealed in 1989 and immediately thousands of elderly people were required to sell all their belongings and become welfare recipients. Critics of Congress (Clift and Hager, 1989) referred to the repeal as "government by those who yell the loudest." The wealthy were in battle with the less affluent, or from a Marxian perspective, cleavage could be located on the basis of material interests of social class.³

Application and Advocacy

At least three theoretical locations of conflict exist for the Marxian analysis of aging: a) subculture by age alone; b) age nesting within social class; c) age crossing social class. These locations would not have been identified without the use of the Marxian framework. Existence of each axis of conflict has empirical support and each deserves further analysis. Which of these axes of conflict becomes critical at any particular point in time may be dependent upon specific historical events and swings of public policy. Additional research is needed and must be based upon the identification of variables that are of interest to social gerontologists but which are also theoretically meaningful for the Marxian framework. Two variables that are particularly important include: health and life satisfaction.

Health

Scattered throughout the first volume of *Capital*, Marx makes reference to the linkage among health, exploitation and social class. "*Après moi le déluge!* is the watchword of every capitalist and of every capitalist nation. Hence capital is reckless of the health or length of life of the labourer, unless under compulsion from society" (Marx, 1967, p. 257). Because of the exploitation inherent in the capitalist economy, workers simply did not live long enough to be labeled "elderly." Gerontologists continually find that socioeconomic status predicts health (Bergner, 1985; Chapman *et. al.*, 1986; Ferrini and Ferrini, 1989; Hendricks and Hendricks, 1985; Lazarus, 1988; Seccombe, 1989).

An individual may be biochemically predestined to live to 90, but his working class status in an asbestos factory might cut off his life at 55. Schwalbe and Staples (1986) use a Marxian inspired class measure to effectively predict health effects for the working class. Health status is an integral part of the Marxian framework and offers a theoretical foundation in which level of health can be used as a variable in sociology of aging research. Marson (1991a) demonstrates that a Marxian inspired social class index uncovers a possible spurious relationship when the more mainstream SES [socioeconomic] measure is used to predict health level.

Life Satisfaction

Although life satisfaction may be the most widely studied phenomenon in social gerontology, it is a concept without a theory (Sauer and Warland, 1982). Okun (1987, p. 401) defines it as, "an abstract, superordinate construct entailing the affective reactions of individuals to their life experiences along a positive-negative continuum." Neugarten *et. al.* (1961) may have been the first to operationally define it as a self-report inventory and see it as the self-acceptance one projects upon reviewing one's life. The inherent attraction to life satisfaction in gerontological studies seems to emerge from the negative image younger people have of the aging process. What factors contribute to life satisfaction for an aggregate that is constantly confronted with physical, psychological and social losses?

Perhaps the most routine independent variables used by sociologists to predict life satisfaction are socioeconomic status and income level. Although most of the life satisfaction studies "lack the use of mainstream social science theories to guide research" (Okun, 1987), they tend to support the importance of material resources as a significant factor of prediction. This general tendency supports the Marxian perspective. Those who *have* are going to be more satisfied with their life circumstances than those who *have not*.

Level of health is another common independent variable that sociologists use to predict life satisfaction. Such research also has a tendency to be theoretically implicit. For example, Ferrini and Ferrini (1986) have written a comprehensive monograph that is intended for use in the social sciences. It includes

an entire chapter on "biologic theories" but does not include a conceptual framework that explicitly embraces the concept of health from a social science perspective. Kovar (1987, p. 302) notes that there is "no consensus" for a conceptual definition of health among social gerontologists. In social gerontology, health and life satisfaction share a common characteristic—they are both concepts in search of a theory. Notwithstanding the implicit theories from which these concepts may have emerged, they seem to fit well into the Marxian framework.

There is massive evidence that demonstrates a quantitative linkage between health and life satisfaction. Chatfield (1977) offers the simplest model when he suggests that health is an intervening variable. His model can be illustrated as:

INCOME —→ HEALTH —→ LIFE SATISFACTION

Chatfield among others (Fengler, Little & Danigelis, 1983; Liang, 1982; Mancini, 1981; Markides & Martin, 1979; Seleen, 1982; Spreitzer, Snyder & Larson, 1980; Tai, 1978) suggest that increased income affects level of health and, in turn, better health affects life satisfaction. From a traditional sociological perspective these authors are saying that the wealth associated with socioeconomic status offers greater opportunity to have access to the health care delivery system. In simple terms, money can buy good health. These authors fail to consider the enormous investment made by the state for health care of those who do not have sufficient funds to pay for such care. The state's efforts were made to equalize health so that income would not significantly predict level of health. Marx states that level of health is an effect of class. The exploitation and oppression of the working class limits its ability to have meaningful satisfaction in later life because its members are compelled to work in areas that undermine physical health. For example, Kogevinas (1990) demonstrates that poor people are more prone to cancer, and less likely to survive it.

Several factors enhance the use of life satisfaction as a dependent variable in sociology of aging research that is Marxian inspired. They can be divided into two general categories, philosophical and theoretical.

Philosophically, both Althusser (1969, p. 13) and Conway (1987, p. 30) state that Marx's earlier work was humanistically focused. Marx is preoccupied with human misery in relation to the capitalistic economy and believes that communism relieves misery and reinstitutes freedom and happiness among the proletariat. Marx's goal is to produce a society that promotes happiness among its citizens. Soper (1981, p. 11), for example, contends that Marx implicitly asserted that "'happiness' of human beings is a good thing." Structuralists will have problems with her highly humanistic interpretation of Marx's work. We do not think that Soper's interpretation is stretching the framework to its' breaking point. Using life satisfaction as a dependent variable seems appropriate.

Health as a variable holds together Marx's concept of social class and life satisfaction. As stated earlier, level of health is a major theme throughout the original writings of Marx. He sees the capitalist economy as having a major influence on the health of the working class. Health is also a major variable in the explanation of life satisfaction in the theory-free research in the sociology of aging. Marx provides the theoretical linkage between these two important variables for the sociology of aging.

As a Framework for Advocacy

The first popular recognition of the inherent contradictions between the capitalist economy and elderly people occurred under the critical eye of Maggie Kuhn. At age 65, she was forced to retire from her position as a social worker—a career she dearly loved. Retrospectively, she (Kuhn, 1987) describes herself as being "anxious and depressed" when the reality of decreased income was set into her consciousness. As a social worker, she had years of training and experience in organization and advocacy skills. Because of these experiences, she impulsively wrote a memo to friends who faced the same situation. They began to meet as a group. Maggie Kuhn (1987) writes, "We could take risks together in our own supportive community. We could reach out to others and organize for change. We could be risk takers with nothing to lose but our fears and isolation!" Kuhn's memo ushered in the birth of the *Gray Panthers*. This is

reminiscent of Marx and Engels' (1967) words, "The proletarians have nothing to lose but their chains. They have a world to win. Working men of all countries, unite!"

Kuhn (Kuhn and Sommers, 1981) is well known for her articles and speeches about advocacy for aging people. In one of her earliest articles, she (Kuhn, 1979) outline stages that senior citizens can follow to gain control of their own social and economic destiny. Her stages have a Marxian flavor with the possible exception of two themes. First, Kuhn realizes that a violent revolution cannot be considered and change has to be implemented through the democratic process. Second, Kuhn is also well-known for enlisting professionals by appealing to their ethical standards of practice. She (Kuhn, 1978) often outlines responsibilities that professional groups have for their elderly clients and obligates them to take action. Her efforts paid off. The Gray Panthers spearheaded efforts to end mandatory retirement and saw the fruits of their labor in the 1986 *Amendment to the Age Discrimination in Employment Act*.⁴ Hudson and Strate (1985) suggest that the Gray Panthers will cease to exist after major goals are accomplished. If the Gray Panthers' social concerns are limited to material interests of elderly constituents, Hudson and Strate probably will be correct in their prediction. However, the Gray Panthers articulate many concerns [i.e., the Viet Nam War] that facilitate unity among many oppressed groups.

Kuhn is well aware that merely organizing a group of people who were forced to retire does not produce sufficient power to facilitate change. Coalitions have to be established with central themes. Becoming "aged" is the only group that everyone is facing, thus many non-aged people are joining the ranks of the Gray Panthers. Maggie Kuhn and the Gray Panthers recognize that the economic structure that promotes the division of class is an extremely powerful force that will inhibit the development of a consciousness of kind among senior citizens. The strategies that are the centerpiece of the Gray Panthers' can be summarized as efforts to: 1) join with other oppressed groups who recognize their oppression under the economic structure; 2) demonstrate that most Americans will become elderly and therefore suffer economic oppression.

Kuhn apparently recognizes the handicap of using Marxism as an advocacy tool. Marxism has negative connotations because of the "popular" association between Marx and eastern communism. We will not read about the Marxian influence on the strategies employed by Maggie Kuhn. With training in social work, there is no doubt she is familiar with Marx's work. A combination of forces, including the ideological hegemony of this country's capitalist class, the Cold War, propaganda from religious groups, and even the historical predominance of the British cultural tradition of individualism have effectively convinced the masses of the inherent evils of Marxism. Marxism is connoted as being an oppressive and authoritarian system that leaves little room for individual free thought and expression. Current events in Eastern Europe reinforce this perspective. The Gray Panthers could have never successfully established a coalition by actively announcing their subscription to Marxian ideology. College students are often excited by Marx's theoretical framework—until they learn that Marx was the father of the perspective. Maggie Kuhn suggests that a Marxian framework has been successful in advocating for senior citizens as long as the strategies are not connected with the name *Karl Marx*.

Summary

It is not necessary to consider oneself a Marxist in order to find that the Marxian framework adds to the knowledge base for social gerontology. In particular, the framework facilitates the process of identifying at least three types of social groups among elderly populations:

- subculture by age alone;
- age nesting within social class;
- age crossing social class.

The social gerontology literature [which is, at best, theory-implicit] demonstrate sources of conflict for each group-type. This knowledge provide a guiding force for further study. The Marxian framework also seems to able to provide theoretical linkages for key concepts in gerontology, such as health and

life satisfaction. As such, it may be able to add theoretical sophistication to an otherwise "theory weak" literature.

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Notes

1. Ritzer (1983) identifies a minimum of six schools of neo-Marxian thought with "irreconcilable differences among them."
2. It is interesting to note that Giddens (1975) uses many of these same criteria as the foundation for the emergence of class consciousness among the proletariat.
3. Ironically, forecasters are already projecting that the repeal of the *Medicare Catastrophic Coverage Act of 1988* will affect the more affluent elderly. The premiums for private health insurance will soon skyrocket. It is likely that the projected surcharge for the government insurance would have been less expensive than the increase of private insurance premiums (Kosterlitz, 1989).
4. The 1967 *Age Discrimination in Employment Act* prohibited job discrimination of employees between the ages 40 to 65. Workers over the age of 65 were not covered. It was this legislation that forced Maggie Kuhn to retire. In 1978, the *Act* was amended to include protection for those 70 and younger. The Gray Panthers successfully lobbied for the passage of the amendment. The 1986 amendment protected employees from forced retirement at any age.

With a Little Help from Our Friends: Social Support as a Source of Well-being and of Coping with Stress

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The relationship between one's psycho-emotional and physiological health has long been of interest to social scientists. While many factors have been examined for their impact on causation and prevention, over the past two decades the concepts of social support, stress and well-being have undergone much scrutiny. In this article the authors provide empirical data to enhance our understanding of the interrelatedness of these three concepts.

Based on the findings from a study of stress and health in organizations, a model is proposed which elucidates some of the conditions under which social support networks mediate the impact of stress on psychological well-being.

Human beings are radically social by nature. We live in families and communities, work in organizations large or small, engage in groups of all kinds ubiquitously, and enter into multiple social transactions virtually everyday of our lives. Our identities have their roots in social relations and groupings. Our very existence is caught up in a complex network of interdependencies such that very few human needs can be met save through the mediation of others. Yet we Americans live in a strongly individualistic culture and prize autonomy perhaps more than relationships. Idealizing "strong, silent types" who

never call on others for help, we often face high degrees of stress and put up with its psychological and somatic symptoms and attendant erosion of quality of life.

The central focus of this study is on the role of supportive social relationships in the promotion of personal well-being and as a source for effective coping with stress. Based on the findings of a three year study, in this paper we report on research conducted within a larger study of health and stress.

Theories of Social Support and Stress

The research literature on social support and stress has approached the measurement of social relations from a variety of perspectives from family relationships (e.g., Cook & Weigel, 1983; Pilisuk & Parks, 1983; Robles, 1983), organizational membership (e.g., Bromet, Dew, Parkinson, & Schulberg, 1988; Cooper & Smith, 1985; Martin & Wall, 1989), the enhancement of one's well-being (e.g., Thoits, 1986; Tracy, 1990), to well developed instruments gauging the number and strengths of those significant relationships (Caplan, Cobb, French, Harrison, & Pinneau, 1975; Sarason, Levine, Basham, & Sarason, 1983). Cohen and Wills (1985) classify social support measures as *structural* (the extent to which one engages in relationships or groups) versus *functional* (the degree to which such relationships provide identified functions for the person, e.g., companionship or nurturance). They also differentiate specificity versus globality of scale—the extent to which the measure specifies particular functions or contexts or combines a number of them into a largely undifferentiated global index.

In general, social relationships serve a variety of human needs, many of them subsumed under general terms such as love, belonging, or social companionship. The stress literature focuses on relationships as support for the person, and suggests a tripartite classification: *socioemotional support*, behaviors that reflect empathy and understanding and enhance a sense of acceptance, worth, self-esteem; *informational support*, the provision of perspective, guidance, and advice to assist the person in coping and problem solving; and *instrumental support*, the provision of resources and services to help resolve problems

or maintain other life functions (House, 1981; Jacobson, 1986; Leavy, 1983; Thoits, 1986; Cohen & Wills, 1985).

A key difference among these groups of functions is that informational and instrumental support enhance mechanisms for coping while socio-emotional support and companionship go beyond coping and directly enhance the quality of one's life. Regardless of the source or functions, amiable and supportive relations have frequently been cited as factors which increase personal well-being and curtail distress.

Stress has been the subject of investigation for some decades and intensively so in recent years, spawning a growing business in stress management training and consulting. Much of the research has focused on the individual—the consequences of stress on health and well-being—and on the emotional experiences and coping responses. But a growing body of literature address the conjoint impact of stress and social support on well-being.

Hans Selye (1956) was among the first to study stress, which he defined as a non-specific response of the body to any environmental demand. He was particularly concerned with the physiological and biochemical responses to unexpected or excessive environmental demands. He identified and described the General Adaptation Syndrome (GAS) mobilizing one for flight or fight in the face of external threat. He also linked GAS to the formation of various symptoms and the onset of certain diseases.

In an early social psychological study of stress in organizations, Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964) investigated the effects of role conflicts, ambiguity and overload as frequent stresses which generate tension, anxiety and dissatisfaction at work and which tax the adaptive capacities of managers and workers. In a unique research design, they derived measures of environmental stresses from interviews with the subject's role senders and hence independently of the subject's experience of or response to the stress. Their study was also among the first to report that quality of relationships at work mediate or buffer the effects of stress.

However, most research on stress relies on the subject to report on the degree and kinds of stress he or she is facing.

Generally this coincides with conceptions which define stress as psycho-socio-emotional or physiological responses in the person to threatening situations. The stress is in one's experience although the threat may come from the environment. We believe it is important to distinguish environmental stressors (the source of stress) from the experience of stress, although most research on stress focuses on the latter.

Two approaches to stress have gained currency, both using the subject as informant on the stressors. The first, represented by Holmes and Rahe (1967), Brown and Harris (1978), and Naismith (1975), presents a list of troubling *events* (e.g., death of spouse, loss of job) and asks whether the event occurred or not. The second approach focuses on *chronic conditions* (e.g., noise, conflict, overload) in the home, community or workplace with which people often find difficulty in coping (Adams, 1981; Pearlin, 1983).

Using either stressful events or conditions, researchers conceive of stress as stemming from three different situations—needs, transactions, and transitions. Caplan (1964) and Thoits (1985) see stress as threats to or disruption of one's efforts to meet one's needs, and hence as a source of frustration and deprivation. Others (e.g., Lazarus & Folkman, 1984) have put forth a transactions model in which demands on the person exceed one's resources and thus over-tax one's adaptive and work capacities producing a decline in well-being. Still others (Arnold & McKenry, 1986; Parkes, 1971) have focused on the stress of life transitions and on the re-adjustments required by changes positive or negative.

All of these approaches imply a general model in which events or conditions in the environment (stressors) lead to the experience of stress. This stress may lead to successful coping but often results in symptom formation and a decline in one's sense of well-being.

Cohen and Wills (1985) have presented a rather complete review of the literature on stress and social relations and an important classification of the role social support plays in maintaining well-being and managing stress. They suggest two general hypotheses. The *main effects hypothesis* states that social

support has a significant linear effect promoting positive indicators of well-being and inhibiting negative indicators. In simple terms, one's quality of life is enhanced by the presence of caring and supportive relationships. Research by Bell, LeRoy and Stephenson (1982), Friedland and McColl (1987) and Williams, Ware, and Donald (1981) represent studies that support the main effects hypothesis.

The second hypotheses addresses the ways in which relationships protect one from the adverse effects of stress, and this they call the *buffering hypothesis*. If the primary role of social support is buffering, there should be little difference in well-being for those with or without social support in the absence of stress. But as stress increases, well-being should decrease for those who lack social support but not for those who are well supported. Alloway and Bebbington (1987), Eaton (1978), Kessler and Essex (1982), and Kahn, Wolfe, Quinn, Snoek, and Rosenthal (1964) are among those reporting a buffering effect.

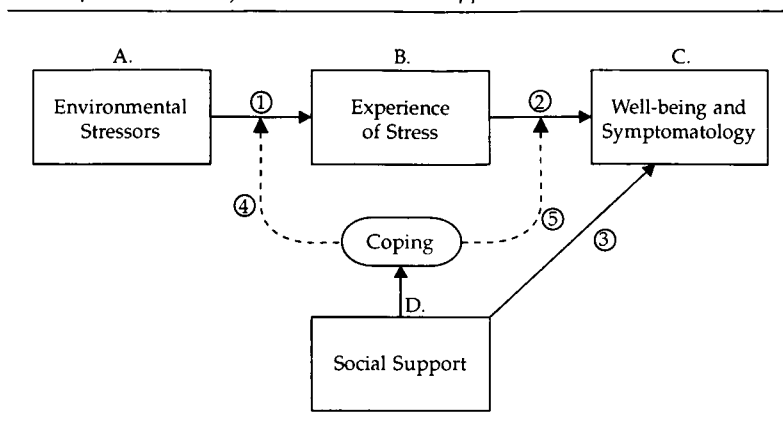
There exists some literature which critiques the buffering model. Barrera (1988) suggests other models that might link stress and social support to psychological well-being. The major alternative in most studies remains the main effects model.

Cohen and Wills (1985) suggest that the use of structural measures of social support yield largely main effects, while buffering effects are observed when the support functions that are measured are appropriate and relevant to the stressors present. They also indicate in their review that it's often hard to tell whether an instrument is primarily structural or functional and, if the latter, what support functions are being measured. In any case, if buffering is present, it is presumably because the stressors are responded to and coped with in different ways with and without the social support.

A Composite Model

The model guiding the present study, entitled a Composite Model, is presented in Figure 1. The main stress hypothesis is that A, environmental stressors (i.e., conditions and events in one's immediate environment), generate B, an experience

Figure 1.

A Composite Model of Stress and Social Support

of stress which undermines C, ones' sense of well-being and produces various symptoms of distress (i.e., anxiety, depression, somatic complaints, etc.). The main effects social support hypothesis is represented by arrow 3, namely that D, social support enhances well-being and reduces symptomatology.

The buffering hypothesis holds that social support enhances coping which mediates either the stressor-experience of stress association (arrow 4) or the stress-well-being association (arrow 5) or both. In particular, the mediation is such that increasing levels of objective or experienced stress yield pronounced effects for those lacking in social support but modest or nil effects for those with strong supportive relationships. In the Composite Model the main effects and buffering hypotheses are not viewed as alternative explanations but as different social psychological dynamics which may both operate at the same time to enhance coping with stress and thus limiting the distressing effects of stress.

The central questions addressed in the analyses reported here are: 1) what are the effects of different kinds of stress in life or work on various indicators of well-being and symptom formation, 2) what are the direct effects of different measures of social support on well-being and symptom formation and 3) in

what ways do different measures of social support mediate the effects of different kinds of stress on the dependent variables?

Methods

The data for this analysis were gathered in a three year study of stress, health and health promotion programs in two organizations, a health insurance company with some 1400 employees and a manufacturing company with about 350. The larger study included a initial questionnaire survey of stress and health and a second survey 1 1/2 to 2 years later to enable an evaluation of various health promotion activities. The data reported here are all drawn from the questionnaire surveys.

Sample

The surveys were offered to all employees in the smaller company and to the major divisions (some 70% of employees) of the health insurance company. Participation was voluntary and strongly encouraged in both organizations. Questionnaires were completed on company time. Time-1 survey involved 839 completed returns. Time-2 yielded 757 of whom 404 were also involved in time-1. The second survey offered a opportunity to approach measurement of social support in a different way (see below). For some parts of the analysis reported here, the total N is 1192. Other parts are limited to the time-1 or time-2 samples alone. In either cases, the sample size was more than adequate, substantially larger than most previous studies.

Two thirds of the sample were female, and 29% minorities, ranging in age from 19 to 71 years (average age 35). As a whole, the respondents are in white collar jobs (professional, technical and lower to middle management) with less than 10% in blue collar assignments.

Measures

Research concepts were operationalized into three sets of variables: stressors (as the independent variables), social support (as the moderating and mediating variable), and well-being and symptomatology or strain outcomes (as the dependent variables).

Stressors included two measures focusing on one's work setting (work events and work conditions) and two measures of

general life stress (life events and life conditions). Stressful life and work events were measured by the life Events Inventory (Cochrane & Robertson, 1973) with 40 events and the Events at Work Inventory (Naismith, 1975) with 30 events. Both inventories asked participants to indicate if an event did or did not happen over the preceding twelve months. The listed events from both instruments have been found to elicit stress reactions and to require people to exert adaptive behaviors (e.g., two items of the Life Events Inventory referred to personal long term illness or hospitalization, three items concerned miscarriage, abortion, or pregnancy). Based on previous research, the events in both inventories are weighted by the degree of stress imposed on the person; the individual's score equals the sum of the weights he or she reported as having occurred.

Respondents were asked to rate the frequency of occurrence of 19 stressful conditions (such as "concern over values/behaviors of family," "chronic worry or guilt"). These items summed, constitute the Life Conditions variable. Similarly, participants were asked to rate 26 chronic conditions in the work environment (such as "lack confidence in management," "I feel overqualified for the work I actually do") and these items became the Work Conditions variable. Adams (1981) developed both of these instruments and used a 5-point scale anchored by "rarely or never" and "always".

Social Support. In the initial survey, social support was measured by an instrument developed by Sarason, et.al. (1983). Respondents were asked to identify (with initials) the people in their environment (home, work, etc. unspecified) who provide them with caring and support (such as "Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?"). The scale, referred herein as *Numbers of Caring Relationships*, is the total numbers of people identified across all such items.

The time-2 survey substituted an instrument developed by Caplan, et.al. (1975) which looked at support at home and at work (i.e., from supervisor and co-workers). A series of items (e.g., "How much can each of these people be relied on when things get rough at work?") elicited a separate rating-scale response for each source of support.

Well-being and Symptomatology were measured by the following instruments:

The Quality of Life measure (Datamation, 1980) asks participants to rate their level of comfort and satisfaction with self, relations with others, ability to meet life demands, and ability to enjoy things. This inventory used 24 items anchored by a 7-point scale from "low or poor" to "high or good."

Strain was measured by the Adams (1981) 26-item instrument. Depression, Anxiety, and Somatic Complaints were strain variables that were identified through a factor analysis of this instrument. The participants were asked to respond to these questions used a 5-point scale from "rarely or never" to "quite frequently."

The affect Rating Scale (Sipprelle, Gilbert & Ascough, 1976) consisted of thirty words (e.g., elated, bashful, secure, etc.) that participants were asked to rate on a 7-point scale (from "not at all" to "very much") to describe how they generally felt. Positive affect, negative effect, and tranquility were the variables that were identified through a factor analysis of this instrument.

Job Satisfaction (Manring, 1979) was measured by asking participants to rate ten items (e.g., the quality of supervision, the nature of the task, etc.) on a 7-point scale from "dissatisfied" to "satisfied."

Job Related Tensions (Kahn, Wolfe, Quinn, Snoek & Rosenthal, 1964) were measured by an 18-item instrument that listed situations that sometimes bother people about their jobs (e.g., "Feeling that you're not fully qualified to handle your job"). Participants were asked to indicate how frequently they felt bothered by each item using a 7-point scale anchored by "never" to "nearly all the time." All of the measures used in this analysis have been reported in previous studies and have demonstrated acceptable validity and reliability. Most have been widely used.

Findings

Direct Effects of Stress

Table 1 presents the correlations between four measures of stress (stressful events in life and in work and chronic stressful

Table 1

Correlations between Stress Measures and Indicators of Well-being

Indicies of Well-being & Symptomatology	Stress Measures			
	Life Events	Work Events	Life Conditions	Work Conditions
Quality of Life	-.16***	-.15***	-.32***	-.39***
Strain	.37***	.33***	.55***	.48***
Depression	.32***	.29***	.49***	.48***
Anxiety	.35***	.26***	.48***	.40***
Somatic	.29***	.30***	.43***	.37***
Positive Affect	-.08*	-.00	-.16***	-.20***
Negative Affect	.30***	.24***	.48***	.43***
Tranquility	-.21***	-.18***	-.35***	-.37***
Job Satisfaction	-.22***	-.29***	-.35***	-.65***
Job Related Tensions	.22***	.44***	.41***	.79***

*** = $p < .001$ ** = $p < .01$ * = $p < .05$

conditions in life and at work) and ten measures of well-being and symptomatology.

With two exceptions all four measures of stress show highly significant relationships with each of the dependent variables in the expected directions. That is, increasing stress is associated with decreases in quality of life, positive affect, tranquility, and job satisfaction and with increases in strain and its three sub-scales (depression, anxiety, and somatic complaints), negative affect, and job related tensions. Positive affect is undermined modestly by stressful life events ($p < .02$) and not at all by stressful work events.

The other notable pattern in Table 1 is that chronic stressful conditions in life or at work show persistently stronger relationships with the dependent variables than are found with the episodic stressful events in life or work. The chronic life conditions instrument asks the respondent to indicate "how

often you experience stress as a result of that condition." Similarly, the chronic work conditions measure asks how often various troublesome experiences (conflict, ambiguity, overload, etc.) are "true for you." These are clearly direct measures of Experienced Stress—box 2 in Figure 1. In the life and work events instruments, the respondent merely reports whether or not various stressful events occurred. This approach is generally viewed as more objective, i.e., as a direct measure of environmental stressors—box 1 in Figure 1. Not surprisingly, experienced stress is more closely associated with diminished well-being than are the environmental stressors.

The two dependent variables focused on well-being at work (job satisfaction and job related tensions), show very strong correlations with chronic stressful work conditions, and are more closely associated with stressful work events than stressful life events. Specificity with regard to source of stress and dimension of well-being strengthens the relationship.

While we view the life and work conditions measures as tapping into the subjective experience of stress, and the events measures as more closely reflecting environmental stressors, we do not draw one-to-one links between them. The life conditions instrument does not ask the respondent about his or her experience of the particular events checked in the life events instrument. Similarly, while the life conditions instrument alludes to conditions in one's environment, those conditions are not reflected in the list of stressful life events. The same holds true with regards to stressful work conditions and events. The two sets of measures differ not only in relative objectivity-subjectivity but also in terms of episodes versus chronic factors. The four instruments are addressing different sources of stress measured in different ways.

Direct Effects of Social Relations

Table 2 presents the correlations between three measures of social support—Numbers of Caring Relations, Home Support (from spouse, family and friends) and Work Support (from supervisor and coworkers)—and ten indicators of psychological well-being. All but one are highly significant and all are in the expected direction, i.e., the stronger the social support, the

higher one's quality of life, positive affect, tranquility, and job satisfaction and the lower one's strain, depression, anxiety, somatic complaints, negative affect, and job related tensions. The only non-significant correlation is between numbers of caring relationships and job related tensions.

Cohen and Wills (1985) would classify Numbers of Caring Relationships as a structural measure and Home Support and Work Support as functional in that the latter two variables address ways that one might be helped during difficult times. The main effects of the two functional measures of support on the dependent variables are consistently stronger than are those of the structural variable. While the presence of such relationships in one's life promotes a high quality of life and inhibits strain, etc., the perception of those relationships as helpful during times of trouble strengthen the associations. This holds particularly with regard to support at work in relation to job satisfaction and job related tensions.

Table 2

Correlations between Social Support Measures and Indicators of Well-being

Indicies of Well-being & Symptomatology	Social Support		
	No. Caring Relationships	Home Support	Work Support
Quality of Life	.19***	.46***	.36**
Strain	-.15***	-.31***	-.31***
Depression	-.15***	-.31***	-.32***
Anxiety	-.17***	-.33***	-.34***
Somatic	-.09**	-.18***	-.23***
Positive Affect	.21***	.32***	.27***
Negative Affect	-.22***	-.38***	-.35***
Tranquility	.14***	.30***	.32***
Job Satisfaction	.12**	.28***	.56***
Job Related Tension	-.04	-.22***	-.50***

*** = $p < .001$

** = $p < .01$

* = $p < .05$

Support for the main effects hypothesis is robust and systematic. The pattern is fully consistent with the solid arrows in the model present in Figure 1.

Social Support & Coping: The Buffering Hypothesis

The results presented above underscore the importance of social relationships as a direct source of human fulfillment and well-being. Let us turn now to the more central question of the extent to which social support protects or buffers one from the debilitating effects of stress. Does the strength of support from others mediate the relationships between different measures of stress and various indicators of well-being and symptomatology?

For this analysis, we have divided each of the support measures into strong, moderate and weak degrees of social support. This permits a two-way analysis of variance in which the *interaction* term serves as a test of significance.

Figure 2 presents the relationships between each of the four stress measures (plots A through D) and quality of life for strong (N=133), moderate (N=179) and weak (N=404) levels of Caring Relationships. Quality of life declines with increasing scores on stressful life events for those with moderate or weak relational networks, but in fact increases slightly for those with six or more caring relationships. The interaction term is significant at the .028 level. A similar pattern is found with regards to stressful work events, with an interaction significant at .013.

Plots B and D on the right hand side of Figure 2, showing the effects of stressful life and work conditions, respectively, demonstrate a quite different pattern. In these, the main effects of both stress and support are evident, but the slopes of these lines are virtually parallel. Here we find no evidence of buffering, and the interaction terms are, of course, not significant.

Figure 3 presents the same analysis using the strain index as the dependent variable. Once again, those with strong support show little increase in strain with increases in stressful life events (p. of interaction = .018) or stressful work events (p. of interaction = .076). Stressful life and work conditions increase strain comparably for all three levels of support.

Figure 2.

Quality of Life by Stress for Strong, Moderate & Weak Social Relations

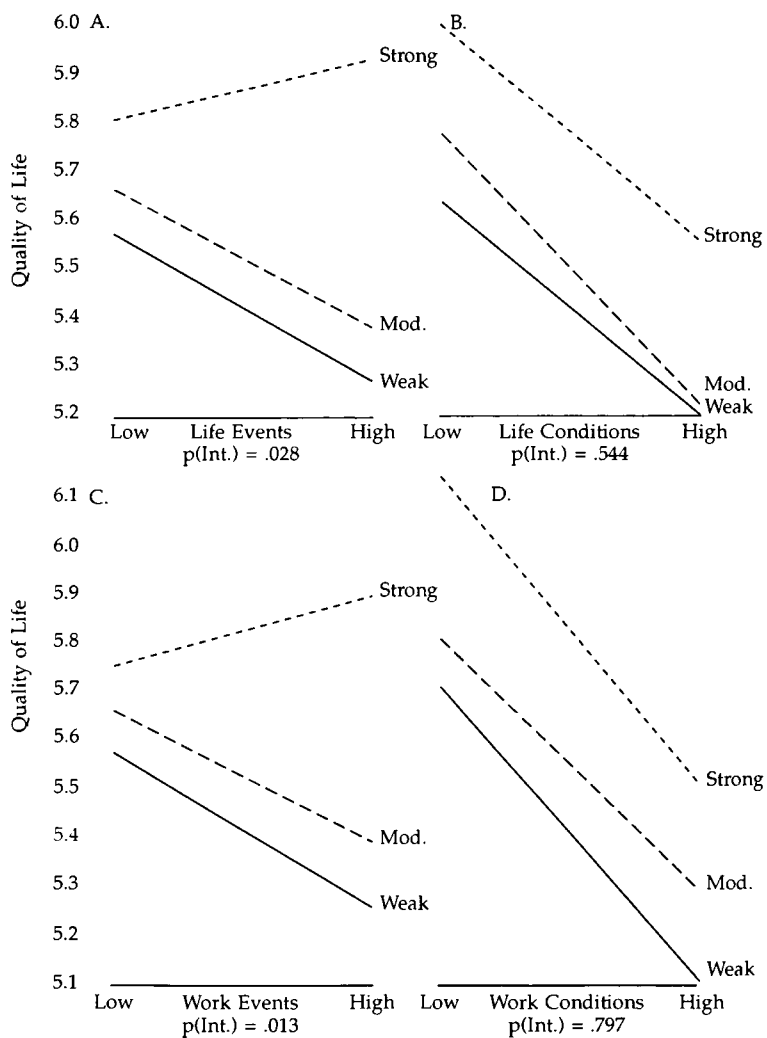
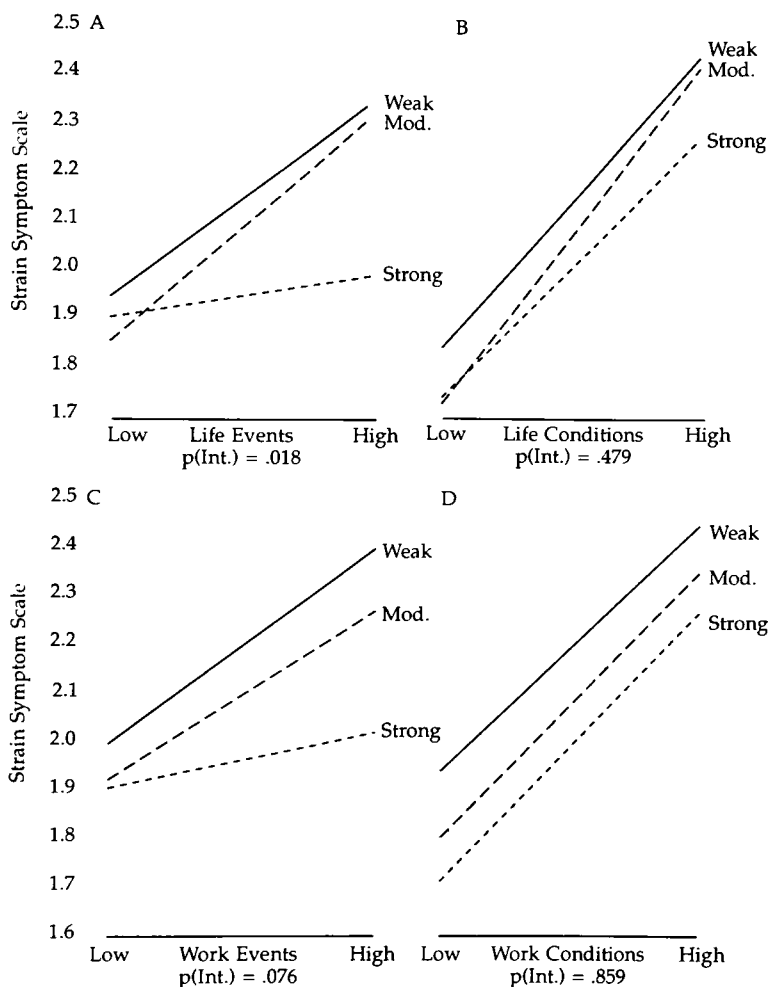


Figure 3.

Strain Symptom Scale by Stress for Strong, Moderate & Weak Social Relations



This analysis was repeated for all dependent variables separately for each of the measures of social support. In no case did we find evidence of buffering when the stress measure focused on chronic conditions in life or at work. There are two potential explanations for this. First, when stress is episodic, when a disturbing event occurs, that is precisely when caring friends and loved ones step in to offer help, emotional support, and resources—the caring is expressed through aid in coping with the threat, loss, or change. With little or moderate support, the stress takes its toll.

However, when the stress is chronic, say from racism, economic inequities or work overload, there is not much that others can do but provide sympathy and companionship. That is, for some kinds of stress, supportive others may offer little in the way of coping in spite of their contribution to one's general quality of life.

A second interpretation must also be considered. We noted above that the events measures may be taken as representing environmental stressors (box A in figure 1) but that the chronic conditions measures clearly represent experienced stress (box B). The question is, does the mediation of social support occur between the environmental stressor and the experience of stress or between the experience and the consequences for well-being?

It may be that those with strong social support don't find difficult events as debilitating because of the active presence of caring friends—their equilibrium is maintained in spite of the troubles and, hence face the difficulty with less emotional upheaval. Consequently, there are fewer symptoms that arise and little or no decline in quality of life.

If the presence of strong supportive relationships does mediate one's experience of the environment, then objective chronic conditions *in the environment* would have already been buffered when one experiences those conditions as stressful or not. Given the same objective conditions, one with strong support would report them as less stressful than those without such support. But once it is experienced as stressful it leads to the same symptom formation or decline in well-being as occurs for others who are less well supported.

Let us turn now to the mediating effects of the more situation specific sources of support. Figure 4 portrays the effects of stressful life (A&B) and work (C&D) events on the strain index for those strong (N=264), moderate (N=261) and weak (N=153) in home support (i.e., from spouse, family and friends) (A&C) and strong (N=93), moderate (N=178) and weak (N=130) in work support (from supervisor and co-workers) (B&D).

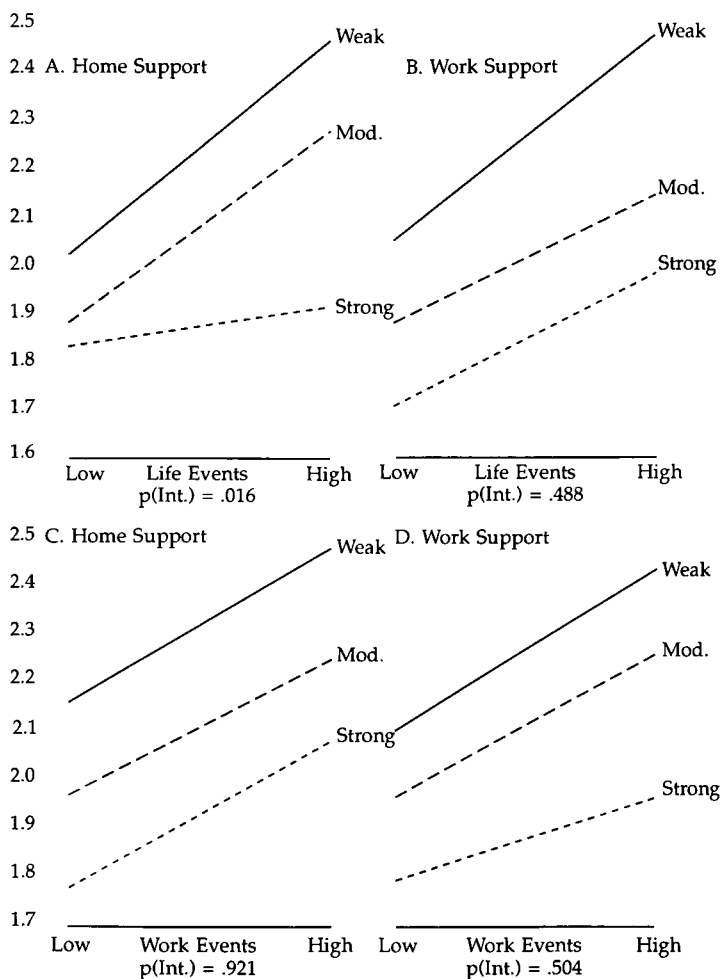
The buffering effect is clearly evident in plot A of Figure 4. Increasing levels of stressful life events increases strain for those weak or moderate in home support but not for those with strong home support (interaction = .016). But home support does not buffer the effects of stressful work events. The pattern of Plot D—strain by stressful work events with work support as the moderating variable—hints at some buffering effect, but falls far short of a significant interaction.

Figure 5 portrays the comparable analysis using job satisfaction as the dependent variable. The pattern of plot A—life events mediated by home support—is fully consistent with the buffering hypothesis, although the *p*. value of the interaction term is only .135. Home support does not moderate the effects of stressful work events.

The strong main effects of work support are evident in plots B and D. Regardless of stress level, the more supportive the work group, the greater one's job satisfaction. A significant interaction effect ($p=.034$) is also found in D. With strong support from supervisors and colleagues, increasing work stress does not undermine job satisfaction. The pattern in B, in spite of an interaction term approaching significance, does not reflect the buffering hypothesis. It is only in the moderate support group that life events fail to erode job satisfaction.

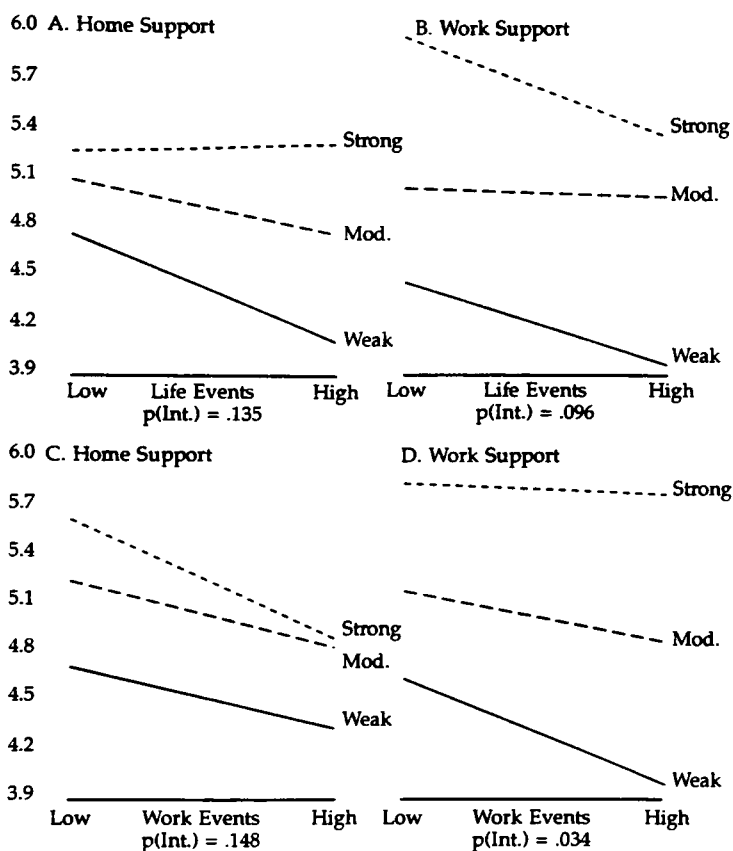
The pattern for a pure buffering effect would show no differences in the dependent variable across levels of support under low stress, but marked differences under high stress. Plots A and C of Figure 3 illustrate this well. Most of our analyses indicate some main effect of level of social support even under low stress, but stronger effects under high stress. The buffering hypothesis and main effects hypothesis are *not* antithetical to one another, but, rather, represent different dynamics which

Figure 4.

Strain by Life Events, Work Events by Degree of Home, Work Support

may, and often do, operate in combination. Even where main effects are very pronounced (as in Figure 5, plot D) the presence of strong support may protect one from the adverse effects

Figure 5.

Job Satisfaction by Life Events, Work Events by Home & Work Support

of increased stress, presumably because that support enhances more effective coping responses.

Table 3 presents a summary of evidence for the buffering hypothesis for each indicator of well-being or symptomatology by stressful events in life and work for each of the measures of social support. An asterisk indicates a pattern of buffering (less effect of stress for those with strong social support than

Table 3

Support for the Buffering Hypothesis

Stress Index	Social Support Measure					
	No. Caring Relationships		Home Support		Work Support	
	Life Events	Work Events	Life Events	Work Events	Life Events	Work Events
<i>Well-being Indicators</i>						
Quality of Life	*	*	+			•
Strain	*	+	*			•
Depression	*	*	*			+
Anxiety	+	+	+			+
Somatic Complaints	+	+	*			•
Positive Affect	+	*				
Negative Affect	*	+	*			+
Tranquility	+	*	+			•
Job Satisfaction	+		+			*
Job Related Tensions	*		+			+

for those with moderate or weak support) and an interaction term significant at the $p < .05$ level. A + represents the buffering pattern approaching significance; a • indicates the pattern is present but well short of significance.

The presence of caring relationships (people who offer love, trust, acceptance, and feedback for improvement) provides the strongest evidence for the buffering hypothesis. It is only where the stress occurs at work and the dependent variables are job related tensions or job satisfaction that such relationships do not enhance coping.

Home support (spouse, family or friends who make life easier, are easy to talk with, can be relied on when things get tough, and will listen to personal problems) shows consistent evidence of buffering for stressful life events but not at all for stressful work events. Such relationships help one cope with stress at home or in the community but not at work.

The buffering effects of work support (supervisor and colleagues who make life easier, are easy to talk with, can be relied on when things get tough, and are willing to listen to personal problems) are less pronounced. Work support does little to buffer one against the effects of stressful life events. The pattern is generally right for buffering against stress at work, but achieves significance only for job satisfaction and approaches significance only for job related tensions, negative affect, depression, and anxiety.

Part of the reason for less marked evidence for work support than for home support is the relative rarity of truly strong support at work. Thirty-nine percent of the sample fell into the strong home support category, and they were all at the top of the scale of the instrument. Of the 25% who made up the strong work support group, only a fifth were at the top of the scale. Thus, the test of the buffering hypothesis is less powerful for this group.

Discussion and Implications

In general, the findings suggest that life events and work events have similar effects on one's well-being; both place significance demands on one's adaptive capacity. However, the opportunities for coping may be somewhat different. Support at work enhances coping at work, but not away from work. Support at home and from friends enhances coping away from work but not at work.

These results above would concur with recent literature and suggest a situation specific character to the buffering hypothesis. However, with the more generic quality of the numbers of caring relationships measure, buffering is found against both work and non-work stress. Perhaps those with many caring relationships usually include some from the workplace as well as family and friends.

Persistently throughout these analyses, it is only with quite strong support that we find evidence of buffering. While a few supportive relationships may enhance quality of life over none at all, a few are not sufficient to protect one from the adverse effects of stress. It is quite likely that if one is limited to two

or three supportive relationships and the stress centers on them (e.g., marital discord) those relationships are unlikely to enhance coping. But if one has a larger network to draw on, the relevant help may be forthcoming.

Similarly, a generally supportive supervisor who is central to a stressful work event may offer little protection while a larger supportive work group can. Even one very strong relationship may provide the requisite emotional support and instrumental help if he or she is sufficiently knowledgeable about their stress situation and also not the source of the stress.

In any event, simple linear models will not be sufficient for understanding the relationships among social support, stress, and well-being. The buffering effect, while clearly supported by our data, is not a monotonic function.

With one exception, the Composite Model in Figure 1 is well supported by the data. The main effects relationships (arrows 1, 2 & 3) are generally clear and strong. The buffering effects for stressful events (arrow 4) are generally supported although successful coping may be fairly situation specific. We fail to find evidence for buffering between the experience of stress and measures of well-being (arrow 5). It may be that experienced stress takes its toll regardless of level of social support, but that environmental stressors are less apt to be experienced as stressful in the presence of strong social support. But it may also be that supportive relationships enhance coping with episodic stress, even when it is experienced strongly, but not with chronic stress. There is no reason to doubt that strong supportive relationships often become more active during times of intense distress.

In sum, the components that make up the Composite Model are not new to the world of behavioral science as evidenced by our overview of the literature. However, this model serves to pull together the many studies that focus on either home or work support and stress, where the latter is either long standing or episodic. In addition to the specific findings from the data described above, the Composite Model underscores the complexity of this thing we call social support as it refers to the type and amount of support available to an individual,

which is further complicated when we factor in the context in which the support and the stress occur.

The Composite Model attempts to bridge home and work support and stress as they exist under both chronic and acute conditions. The literature on the use of support networks maps takes us in a similar direction (e.g., Wolfe, D.M., O'Connor, D., & Crary, L.M., 1990; Tracy, E., 1990).

This model also has implications for addressing the trends emerging both internal and external to our organizations. One such trend is in the rapidly increasing multiculturalization of the workplace. As ethnicities, ages, lifestyles, and languages at work become more diversified organizations must go beyond helping employees recognize the potential benefits of such changes to actively attending to the inevitable stressors. The Composite Model underscores the argument that employers must facilitate the creation and maintenance of the multiple support groups to which their workers identify. Ethnic support groups, for example, would not only serve to strengthen the buffering of some work-related stress but have been found to increase worker (and therefore organizational) productivity (Cox, T., Lobel, S., & McLeod, P., 1991).

Similarly, the findings of the Composite Model are applicable to interorganizational arrangements. The increased number of community-level and international social service alliances to maximize resources and service delivery, "borderless" organization (Bennis, 1992), and "PALS" (as the pooling, allying, and linking of resources across corporate boundaries) as coined by Kanter, (1989) bring with them stressors that are just beginning to be realized. As our organizations attempt to succeed in a global economy, organizational leaders and policy makers must recognize the imperative to create strong support systems which tie into the various contexts in which stress occurs. Administrators need to invest more organizational resources in the training of others in social relations and organizational development skills. The findings of this study provide a strong rationale for organizations more aggressively meeting the need for socio-emotional as well as instrumental support.

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Foundation Grantmaking in the 1980s: How Three Human Service Fields Fared

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Analyzing three recent reports on grantmaking trends that use the Foundation (Center's grants database, at picture emerges of how three human service fields—aging, substance abuse, and crime and justice—fared in terms of foundation grantmaking during the turbulent period from 1983 to 1987 when federal support was reduced. Despite a sizeable increase in foundation dollars to each field which outpaced overall foundation giving, the authors caution that this increase may not indicate greater foundation commitment to human services.

In the past ten years, human service agencies have shown a heightened interest in obtaining foundation grants for their programs even though foundation support is relatively small compared to revenues from government and individual contributions. Foundation dollars from the nation's independent, community, and corporate grantmakers accounted for only about ten percent of all philanthropic giving in 1989 (Renz, 1991). The impact of foundation giving on the human services, however, goes far beyond the amount of dollars actually allocated. Grants are often essential to starting new projects and continuing existing programs. Demonstration and research initiatives frequently depend upon foundation dollars in their early stages of development. Foundation support can legitimize controversial programs, promote less traditional or alternative agencies, and focus national attention on emerging concerns. Foundation grants can help agencies build a base for future financial support or for a shift in agency goals. Moreover, as happened during the 1980s, when the reduction in federal support diminished agencies' capacities to provide services, foundation

funding can be used to help offset gaps left by cuts in federal funding.

How well did the human services do during the turbulent 1980s when federal support was drastically reduced, and there was greater need and hope for greater foundation support? This paper examines how three human service fields—aging, substance abuse, and crime and justice—fared from the perspective of foundation giving during the period from 1983 to 1987. Looking at the grantmaking trends in each field and comparing trends across fields provide not only a snapshot of how foundations allocated funds in three critical human service areas but a barometer of what human service agencies may anticipate from future grantmaking.

Methodology

This paper uses data from three separate reports on grantmaking trends recently published by the Foundation Center as part of its benchmark studies series (Renz, 1989, Greenberg, et.al., 1991, Jacobs & Somers, 1991). Each study analyzes the allocation of foundation resources within the field from 1983 to 1987 using the Foundation Center's grants database. The Foundation Center's grants database includes grants of \$5,000 or more, numbering around 40,000 a year. These grants are published in the Foundation Center's Grants Index which is compiled from grant reporting forms submitted voluntarily by foundations. Despite some limitations, the Index is the most complete source of information about foundation giving.

The Aging study is based on 4,869 grants in aging totaling \$293.2 million from 1983–1987. The Alcohol and Drug Abuse study is based on 1,814 grants totaling \$87 million over the five years. The Crime and Justice study is based on 3,794 grants totaling \$150.9 million in the same period. All data in this paper come from the three reports. Because comparable data are not available from other human service fields, the analysis is limited to these three.

Findings

These three human service fields together garnered just over half a billion dollars in foundation monies for more than 10,000

grants during the five years under study. Table 1. illustrates the five year trend in increased foundation giving in all three fields. Funding for aging increased from \$39 million in 1983 to \$68 million in 1987, up 75%. Aging's share of overall foundation funding in this period ranged from just over 2 to 3.4%. The number of grants in aging rose by 44% from 762 in 1983 to 1096 in 1987. Foundation support for alcohol and drug abuse programs more than doubled from almost \$10 million in 1983 to \$26 million in 1987. As a share of all foundation funding, alcohol and drug abuse giving doubled during the period, up to one percent in 1987. The number of grants awarded annually nearly doubled from 258 in 1983 to 490 in 1987. Funding for crime and justice doubled from nearly \$21 million in 1983 to \$43 million in 1987. The overall share of foundation support for crime and justice projects reached 1.7% in 1987, a small rise from 1983. The number of grants rose by 56% from 578 in 1983 to 903 in 1987.

Although alcohol and drug abuse programs received the greatest percentage increase in foundation dollars over the five years, even with this sizeable increase, as well as a doubling of its share of overall foundation allocations, the field never obtained more than one percent of total foundation giving. Crime and justice dollars doubled in the five year period, but its share of overall foundation giving hovered around 1.5% and

Table 1.

Grantmaking Trends: 1983-1987

	Aging			Alcohol & Drug Abuse			Crime & Justice		
	Grant \$	Share ¹ %	Grant #	Grant \$	Share ¹ %	Grant #	Grant \$	Share ¹ %	Grant #
1983	38.96	2.2	762	9.71	.5	258	20.72	1.2	578
1984	53.58	3.3	919	9.39	.6	289	20.49	1.2	586
1985	55.92	2.8	978	17.77	.9	368	29.61	1.5	889
1986	76.47	3.4	1114	23.84	1.1	409	37.01	1.7	838
1987	68.23	2.6	1096	26.36	1.0	490	43.09	1.7	903

¹ Percent of overall foundation giving.

Note: Dollar figures in millions.

never reached 2%. While the percentage of foundation dollars to the field of aging did not increase as dramatically as the other two fields, it was the only field that increased its proportion of total foundation giving to climb over 3% in 1986, a proportion never realized again. Nevertheless, the field of aging remained far ahead, leading the three in the amount of dollars received and in the share of overall foundation giving.

To further understand foundation giving between 1983 and 1987, we examined how grants and dollars were allocated—what kinds of organizations received grants, and what types of activities grants supported. We also looked at the distribution of dollars and grants in each of the field's major program categories. Table 2. presents the distribution of grant dollars by type of support. Foundations supported very different activities in the three fields during this period. Program development garnered over half of foundation funding in aging (53%), far more than the 30% allocated for the development of alcohol and drug abuse programs and the 16% for crime and justice programs. Grants to maintain agency operations or organizational infrastructure as well as grants to maintain services or staffing of ongoing programs comprised almost half of the grant dollars (47%) given to the field of crime and justice. In contrast, only 24% of funding for alcohol and drug abuse and 27% in aging was given for these continuing and general operating costs. Unlike the other two fields, the largest percentage of foundation dollars for alcohol and drug abuse, one third, went to capital support which includes funds for buildings, purchase of land or equipment.

Direct service agencies are the primary recipients in all three fields. Hospitals and medical facilities received a fifth of foundation dollars in the field of aging and one-third in alcohol and drug abuse, confirming the strong link between health and both of the fields.

Colleges, universities, and graduate schools obtained a sizeable amount of foundation dollars only in the field of aging (24%) reflecting strong foundation interest in supporting specialized graduate training in gerontology and geriatrics through fellowships, and the establishment of university-based aging research and policy centers.

Table 2.

Type of Support¹ Allocated Foundation Dollars: 1983–1987

	Aging	Alcohol & Drug Abuse	Crime & Justice
Capital	17.1%	32.5%	9.7%
General/Ongoing	26.6%	23.9%	46.5%
Program Development	53.1%	29.5%	16.2%
Research	17.2%	11.5%	6.4%
Other ²	13.9%	18.2%	21.0%

¹ Due to double coding of multipurpose grants, each category is analyzed as a percentage of the total grant dollars to that field for that period. Percentages do not add up to 100%.

²The major portion of this category is endowment.

In the field of aging, health programs ranging from acute care to education of health personnel received the largest share of funding, 55%. Welfare, including community based programs such as transportation, home care, and senior centers, social services, ranked second. Together, health and welfare claimed 84% of foundation dollars in aging. Intervention programs such as counseling or residential and treatment programs received the largest share of funding for alcohol and drug abuse during this period. Prevention, the fastest growing area in the field, was second. Together, the two accounted for 85% of foundation giving. The three top program priorities among crime and justice grants were domestic violence, crime prevention, and rehabilitation. These three garnered 51% of foundation support.

Summary and Conclusions

During the mid-1980s, when human service agencies were feeling the impact of Reaganomics and were threatened by a loss of federal support, foundations demonstrated a commitment to support programs in the three fields examined here—aging, substance abuse, and crime and justice. Foundations did so despite the fact that they were increasingly hard pressed during these years to respond to society's growing needs and stepped up requests for additional monies by agencies serving

a range of purposes. Funding for each of these three fields far outpaced overall foundation funding of 44% during this period. Increased foundation commitment to the human services in the 1980s contrasts with foundation support given to other fields such as cultural activities, education, health, science and social science which showed an average increase of only 18% from 1983 to 1987. Even with this considerable dollar increase to the three human service fields, there was little increase in their share of overall foundation giving. The human services' slice of the foundation pie remained so small as to grow from only 4 to 5% during the time of great need.

Foundation dollars in these three fields were dedicated primarily to programs that serve clients directly. Despite the general impression that foundations do not support existing programs, such a generalization is not entirely borne out by the data. Although it has been reported that general operating support from foundations diminished in the late eighties in keeping with a shift begun in the mid-seventies toward more targeted grantmaking (Seltzer & Cunningham, 1990), foundations continued to fund ongoing programs especially in the field of crime and justice. There are several possible reasons for this apparent commitment of grantmakers to ongoing programs. First, it may reflect foundation responsiveness to agency appeals in the face of impending federal budget cuts. Second, not all foundations see their role as underwriting new programs or funding demonstration projects that will influence public policy. Third, some foundation giving is based on ongoing relationships with agencies or their specific programs.

The picture emerging from this analysis may inspire optimism. We would like to point out, however, some possible areas of concern. During the 1980s there was tremendous growth in the number of new foundations. It is this growth that undoubtedly accounts for the growth in overall foundation giving during this period and is unlikely to occur again in the 1990s. The three human services reviewed here did not receive much more support from those foundations which supported them prior to 1983. Rather, the fields gained as beneficiaries of new foundations. Had the human services counted on their prior supporters for assistance when federal support was withdrawn,

it is unlikely the three fields would have garnered as much additional foundation monies.

The increase in foundation dollars given in each field is less dramatic than it first appears. When the amount allocated is adjusted for inflation, each field's increase is not as great. Because the number of grants also rose each year, and at a greater pace than the rise in dollars, the growth in each field was due primarily to the funding of a larger number of grants. Therefore, there was little real dollar increase to individual programs.

In addition, this analysis of grantmaking trends did not focus upon the year to year fluctuations and thus ignores anomalies in any one year. Total dollar amounts, numbers of grants, percentage of overall giving, and average grant size fluctuated. Each field experienced uneven growth in funding characterized by a surge in funds in one year along with gradual increases in other years. Although inconsistent funding patterns may not signal an increase or decrease in overall foundation commitment to any of the fields, it does suggest that in any one year some fields will do better while others will do worse.

Finally, the increase in human services funding observed here does not necessarily mean that those agencies experiencing federal cuts received foundation monies. It is possible that foundation support during the 1980s went to new and different programs and agencies. Grants may reflect more of foundation interests and priorities than agency needs. Because there is no way of knowing how many more agencies appealed for foundation support and how many more proposals were submitted in this period than previous years, we do not even know if proportionately more requests were funded during these hard times. We do know that foundations never intended to offset reductions in federal spending, and although they appear to have responded, their increased support during the 1980s did not compensate for federal reductions (Salamon & Abramson, 1988).

Foundations will continue to be viewed as a critical source of support in the 1990s by human service agencies despite the relatively few dollars they have to give. However, the economic climate is likely to affect foundation assets and thus limit the amount they will allocate. New foundations are not expected;

some foundations are actually winding down. Human service fields will again be competing with one another for a small share of foundation support. They will also be competing with the other fields that have traditionally been favored by grant-makers as they too are faced with decreased public support and government dollars. It is likely that human services will retain a similar proportion of overall foundation funding. Continued fluctuations in foundation support characterized by good and bad years for different human service fields are likely. As long as the proportion of foundation funding to the human services remains relatively constant, any growth of the field around new problems or populations in need, is likely to affect how foundation dollars to human services will be distributed each year.

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Book Reviews

Ann Braden Johnson. *Out of Bedlam: The Truth about Deinstitutionalization*. New York: Basic Books, 1990. \$13.00 paperback.

Ann Braden Johnson provides a passionate and engaging account of the evolution of the mental health system in America. She speaks from an experienced practitioner's perspective about the detrimental (often devastating) impact of the structure of the system on the very people it is said to be designed to help. She comprehensively reviews the political and social factors commonly associated with deinstitutionalization and vividly portrays the consequences of the "policy" for the lives of people with serious mental illness. Unlike other authors, however, Johnson takes the stand that the introduction of psychotropic medications (especially), Federal legislation, case law, and even the philosophical changes that occurred in the 50s, 60s and 70s were relatively minor influences. Instead she argues throughout the book that the profit motive was and is the key force shaping the system. She says: "I learned—the hard way—that a program's client is *never* the patient but *always* the funding source, no matter what the program's mission statement says" (p. xii); "What's more, (deinstitutionalization) had *nothing* to do with what patients did or didn't need, and everything to do with money" (p. xiv) (emphases in original). This position puts her at risk of being accused of being reductionist in her analysis, but neither objectivity nor balance ever seemed to be the goal.

There is much to applaud in the Johnson book. The book is a well-documented, scholarly account, yet manages to be firmly grounded in the author's own practice experience. According to Dr. Johnson, it was written as her way of "making sense of it all". Her use of both personal case examples as well as the integration of well-chosen quotes from the literature serve as an effective combination for drawing the reader into the "story" of deinstitutionalization and its aftermath.

Dr. Johnson admittedly addresses many points on the topic which are covered by other authors. For example, we all know

that the community mental health movement was oversold and underplanned. We all know the system is fragmented and that the players lack clear responsibility and authority. However, Johnson is successful in broadening our perspective by providing rich, sometimes overlooked information about these failures which are rarely gathered in one place. I appreciated, for example, her inclusion of the role of John Maurice Grimes, an physician member of the AMA in the 1930s whose critical report on the conditions in hospitals was originally silenced. I was also very interested in the discussion of the role of Council of State Governments as well as Smith, Kline and French, the manufacturer of Thorazine, in the 1950s, and the role of SROs in the 60s on deinstitutionalization. She does things such as describe the growth of adult homes for the mentally ill as "our pact with the devil" (p. 124), boldly asks "What ever happens to successful pilot projects?", and brings sterilization of the mentally ill and retarded out of the closet. Perhaps the point that she makes most convincingly is that our habit of "divorcing policy from practice" has had high costs for people with mental illness. She articulately and convincingly challenges the tendency of mental health practitioners to avoid involvement in policy issues.

Johnson has no problem with fixing blame for the failures of the past century. She puts it firmly at the feet of the bureaucrats, administrators, auditors, and policy makers who were responsible, in her view, for trying to make it right. In fact, even the actions and motives of clinic staff and her colleagues are sometimes defined as emerging from vested self interest and not the best interest of clients (even hers?). She is most condemning, however, of the psychiatric profession for abandoning the the field of "mental illness" in favor of "mental health" and for overreliance on "chemical control". She seems also to be somewhat anti-scientific, often blasting research and the "use of numbers" in policy and planning (not to mention the "people whose job it is to manipulate them", p. xiii). In her conclusion, I was surprised that she refused to offer her own thoughts about how to "fix it", saying that there were too many ideas about that and not enough folks willing to do the work. This seems to me to contradict her earlier (and very powerful) complaint about the division between practice and policy. After 259 pages with

"her", I wanted to know what she thought we should do about it all.

In spite of these few drawbacks, I remain attracted to the book's comprehensiveness and rich detail, and especially to its passion and clear social work perspective. Even though I am more optimistic about the potential of creating a rational and responsive mental health system, I believe Dr. Johnson's voice is an important one and should be heard . . . over and over again.

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Charlene E. Depner and James H. Bray (Eds). *Nonresidential Parenting*. Newbury Park, CA: Sage Publications, 1993. \$23.95 papercover.

E. Maccoby and Robert H. Mnookin with Charlene E. Depner and H. Elizabeth Peters. *Dividing the Child: Social and Legal Dilemmas of Custody*. Cambridge, MA: Harvard University Press, 1992. \$39.95 hardcover.

Both of these books deal in a scholarly way with issues related to parenting and custody, using different approaches to examine how parents perform the parenting role outside the traditional two-parent marital family. Each recognizes and attempts to document changes that are occurring in this area, for example, the trend toward joint custody in divorce cases. Together the books are a valuable resource. There are important differences between them, however.

Depner and Bray present a collection of edited pieces with reviews of the literature. Part I describes the demographics of the issue, with particular attention to differences among ethnic groups. Part II is a hodge-podge of issues that purports to deal with the contributions of social science to the question but is more a collection of interesting, but loosely connected, issues.

The descriptive information in Part I is well presented and informative, and in particular deals with ethnic differences that are not well addressed elsewhere. Unfortunately, the authors do not discuss how differences in social class, education, and

income may account for some of these ethnic differences; in areas such as health and family functioning, the effects of these variables are significant. Moreover, I was dissatisfied with the thin policy sections in Part I. Policies regarding custody and parenting are developing out of both legislation and court decisions at the state level, and I regret that the authors did not attempt to provide an overview and some suggestions for enlightened changes.

Part II contains some information that is critical to understanding this issue, for example the economics of two-household families, but lacks cohesiveness. The disparate topics contained in this section could have been enhanced by an overall framework that brings them together and relates them to the material in Part I more clearly. The last chapter, which aims to discuss "Multidimensional Approaches in Research, Policy, and Practice" makes an effort to do this but falls a bit short, again particularly in the discussions of policy.

Maccoby and Mnookin use data from an original study of over 1,000 divorcing families to address issues related to custody and parenting in cases of divorce, placing it within the context of California's family law system. They examine the parents', parenting behaviors longitudinally over a three-year span and demonstrate clearly that such arrangements as the division of child-rearing responsibilities, contribution to economic support, type of custody, visitation, and co-parenting change over time. A particularly interesting chapter discusses the effects of conflict between the parents on custody and economic issues. The final chapter provides a more comprehensive and critical discussion of policy questions than the Depner and Bray volume.

There is a subtle difference between the tone of the two books. Depner and Bray attempt to use a neutral tone regarding "nonresidential parents" that is akin to the "best interests of the child" principle; that is, they appear to presume that it is possible to address these issues in ways that will not harm the children involved. In fact, they struggle with neutral terms, eschewing terms such as "absent parent" as too pejorative. Their efforts seem overdone. It is clearly a reality that

the demographics of the American family have changed, that millions of American children live in one-parent households, and that parents often simply cannot live together in the same household with their children. The reality of this unfortunate situation does not make it advantageous for children, however, and taking pains to describe the phenomenon in neutral terms cannot change that reality. Maccoby and Mnookin deal with this issue more realistically; even their title recognizes that any time parents must divide their households it involves pain and other kinds of harm (such as financial) to the children. The essential question for professionals, and for parents alike, is how that harm can be minimized.

Terri Combs-Orme
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Orr, Alberta L., *Vision and Aging: Crossroads for Service Delivery*. New York: American Foundation for the Blind. 1992. \$29.95 papercover.

"Increasing numbers of older persons will experience vision loss each year through at least the first three decades of the 21st century. Older blind and visually impaired persons will number nearly 6 million by the year 2030, doubling the number documented in 1990." So begins the forward by Carl R. Augusto, President and Executive Director of the American Foundation for the Blind. As an insightful and practical response to this burgeoning trend, Orr's book gives aging specialists and other human service providers an overview of the challenges that the loss of vision creates for aging adults. The book outlines the structure of both aging and blindness service delivery systems and describes the resources available. Orr's insights into necessary collaborative planning and mutual empowerment between the two fields will be of interest to blindness professionals as well as generalists.

Orr begins by documenting the current demographics of the visually-impaired older population. She defines types and degrees of vision loss, and she uses case studies to explore the

psychosocial aspects of aging and vision loss. Additionally, she itemizes the needs she believes require professional attention and advocacy.

Orr's book examines the "nature of aging", considering both the physiological changes that occur with aging and their functional implications. The book describes changes in the nervous system and structural degeneration which could interfere with cognition, memory, learning, and the control of sensory input. In addition to descriptions of various eye diseases, the author does a nice job of examining age-related changes which occur in visual functioning such as from changes in optical and neural functions, and changes in depth perception. It is also helpful that Orr includes a look at how another common correlate of aging—hearing loss—interacts with aging and blindness. Rather than dwelling on ear physiology, the discussion focuses on the more immediate concern of hearing impairment as a limiting factor in communicating with older adults. The chapter discusses problems such as Tinnitus and disequilibrium and their psychological and practical consequences for persons who are visually impaired. The reader is given a variety of helpful guidelines for effectively communicating with someone with a hearing impairment such as moving away from background noise when talking with that person.

Consistent with its overview approach, the book then examines the social context of aging and vision loss, considering their influence on quality of life, economic circumstances, family and social interactions, and living arrangements. A chapter on psychological aspects of aging and vision loss explores age-related differences in cognitive abilities (e.g., intelligence and memory), and discusses theories of personality development. However, unlike many psychology chapters in gerontology books, which often focus on declining mental functioning, this chapter offers a perspective balanced between declining capacity and continued development during the lifespan.

The mid-section of the book examines service delivery. An overview of the national network on aging is presented with attention to service provision from both the public and private sectors. Also included is a brief discussion of the role of linkages between Area Agencies on Aging and blindness agencies.

The author argues that these agencies can and should work to provide more effective services to seniors such as encouraging senior centers to provide vision screening and urging transportation systems to extend their services to visually impaired riders.

The text also examines the diversity of services to elderly including financial assistance, outreach programs, and housing options to name a few. It then deals with specific blind rehabilitation services. A chapter on low vision describes low vision services and discusses how optical devices such as telescopes can enhance the visual functioning of visually impaired older adults. The author suggests that low vision services should be multidisciplinary in nature and consider the financial, psychological, medical, and social problems experienced by the low vision person.

In another chapter the reader is introduced to the profession of rehabilitation teaching to the cadre of skills that can be taught to improve the daily living skills of older visually impaired adults. These skills include personal and home management, communication, leisure skills, and indoor orientation skills. In a case study, the authors illustrate how simple low tech adaptations such as large print checks, or using a white coffee cup can enhance a client's independence and self-esteem.

The chapter on orientation and mobility (O&M) discusses the importance of O&M services to the visually impaired older person. Such services may include orienting individuals to their home environment, travel training with a white cane to allow the individual to travel independently in his or her neighborhood, or giving instruction in the use of public transportation for grocery shopping. A strength of this chapter is its step-by-step description of sighted guide techniques which can be used in providing travel assistance to a visually impaired person.

The last section of the book presents challenges that policy makers and personnel in the fields of aging and blindness must address including: "1) recognizing the limitations of currently fragmented and poorly funded programs; 2) collaborating in the empowerment of previously dependent clients; 3) coordinating community resources and the efforts of service providers and

of older persons with disabilities; and 4) initiating new legislation and regulations reflecting all these changes" (p.327). The remainder of the chapter fleshes out how these challenges can be addressed.

In the final chapter, Orr looks to the future of collaborative planning and service delivery between the aging and blindness systems, and discusses the barriers to collaboration as well as implementation strategies. Necessarily, Orr examines the impact of funding on implementation.

What are the weaknesses of the text? Perhaps only that it is a good general overview. Those readers seeking detailed topical information or service strategies will need to review the references listed after each chapter and/or contact the resource organizations listed at the end of the book. The strength of this text is that it may initiate and inform a critical discussion of the service demands of the large aging/blind population of the coming decades.

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Ralph J. DiClemente. *Adolescents and AIDS*. Newbury Park, CA: Sage, 1992. \$17.95 papercover.

DiClemente has assembled a renowned group of researchers and behavioral scientists to develop and disseminate information on effective HIV/AIDS prevention programs for youth. HIV/AIDS will continue to take its toll, especially among those who do not have the knowledge, skills, and resources to protect themselves. The National Research Council's 1989 analysis of AIDS prevention called for systematic evaluation of education and prevention programs. This call was again recently (1991) reiterated by the National Commission on AIDS. *Adolescents and AIDS* documents findings from evaluations of prevention programs. It broadly affirms that data can be collected, programs can be evaluated, and that programs can impact the outcome of this epidemic upon youth.

In the absence of vaccines and cures, and with no breakthroughs immediately apparent, prevention is essential. This

book reports on empirical evidence of how programs can achieve good outcomes in HIV/AIDS prevention among adolescents. Adolescent risk has only recently been analyzed, in part because of the long incubation period between time of infection and the onset of symptoms, often in young adulthood. Developmental issues enhance risk—of adolescence being a period of growth, experimentation, and change, of being characterized by struggles for autonomy and change, and of social issues related to sexual development and drug use. This book examines risks, ways of confronting risks, and documents effective prevention interventions.

DiClemente's objective in this edited work was to bridge the chasm between epidemiology, behavior change theory, prevention research, and public policy. The knowledge from these four areas were brought together with skill, clarity and timeliness.

The initial section of *Adolescents and AIDS* reviewed and examined current epidemiology information on adolescent HIV/AIDS. What vividly permeates the analyses of these five chapters is the link between risk behaviors and the course of the epidemic. General levels of risk were examined and certain adolescents were noted to be at greater risk. In a notable attempt to broaden the discussion beyond behavioral change, one author, when speaking of incarcerated and homeless adolescents, discussed the forces shaping risk behaviors emanating from failures of systems serving adolescents. Building on the valuable discussions of prevention efforts, the development of accessible and culturally competent community based comprehensive adolescent services with links to health care and social service delivery systems are urgently needed.

The seven chapters on prevention examine the development, implementation, and evaluation of intervention strategies for adoption and maintenance of HIV-prevention behaviors. These analyses covered a wide spectrum on intervention strategies, with implications for therapeutic, educational, and multimedia endeavors. The examples from community based prevention approach afforded salient discussion of social and cultural dynamics shaping the paths of this pandemic.

The concluding chapters discussed selected policy implications affecting adolescents and AIDS. Policies related to

programs, education, and health care access were outlined, raising many insights and challenges. DiClemente emphasized that a generation is in dire jeopardy, and that interventions can be effective in confronting this challenge.

These seminal analyses widen the discussion of AIDS and adolescents. Those youth at greatest risk are those most maligned and excluded from comprehensive social supports necessary for successful thriving. Evidence supports conclusions that programs and policies can be effective and that behaviors can be changed. However, the emphasis need not be limited to individual behavioral change but needs also to adequately address the larger social systems shaping behaviors in their environmental contexts.

The larger sociopolitical focus also needs meticulous and credible analyses. At risk adolescents are not just vulnerable to AIDS, but AIDS is one more life threatening force in their lives. Risks mount with the growing poverty of children and adolescents. With the ongoing impact of racism, some youth face persistent risk. The authors repeatedly acknowledged risk to gay male youth, yet did not credibly nor concretely address their unique and widespread needs. In August of 1992, the Center for Disease Control reported that the majority of adolescent AIDS cases remained a gay related concern. Yet this is not where programs spend their money, nor where research is directed. Prevention needs to encompass community development. DiClemente brought together a respected group of analysts who have both heightened the level of discussion and challenged new thinking.

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John R. Wolfe. *The Coming Health Crisis: Who Will Pay for Care for the Aged in the 21st Century*. Chicago, University of Chicago Press, 1993. \$22.50 hardcover.

Eric R. Kingson and Edward D. Berkowitz. *Social Security and Medicare: A Policy Primer*. Westport, CT: Auburn House, 1993. \$59.95 hardcover, \$18.95 papercover.

John B. Williamson and Fred C. Pampel. *Old Age Security in Comparative Perspective*. New York: Oxford University Press, 1993. \$49.95 hardcover.

The development of social insurance as an instrument of social protection for the elderly is widely regarded as one of the major achievements of the modern welfare state. Throughout the industrial world today, elderly people have access to health care, income maintenance, and other social services that significantly enhance the quality of their lives.

In recent years, however, social insurance protection for the elderly has been criticized. It has been claimed that social insurance cannot continue to meet the needs of the elderly in societies where the population is aging rapidly. Some have argued that the burden of supporting an increasingly large elderly population unfairly taxes the young and has a detrimental impact on economic growth. As social insurance funds are depleted, the present working population contemplates a future without adequate social protection. Some experts have called for the abolition of social insurance and its replacement with alternative approaches.

John Wolfe, an economist at Michigan State University, examines these arguments with reference to health care for the elderly. Wolfe claims that without drastic policy changes, medicare funding will be exhausted by the year 2005 leaving millions of Americans without adequate access to health services. Unless steps are taken to remedy the situation, those who currently meet the costs of medicare will have no access to health services when they themselves retire.

In an interesting review of alternative policy options, Wolfe advocates a mix of approaches in which fully funded insurance provisions are supplemented by private insurance, greater cost sharing, more careful rationing of services, the introduction of mandatory insurance for long term care, and the involvement of relatives in the care of the elderly. In addition, Wolfe discusses recent innovations in the field such as Social Health Maintenance Organizations which offer prepaid medical services designed to maintain elderly people in their own homes and Continuing Retirement Communities where elderly people

live in semi-sheltered accommodation supported by adequate health programs. Although these innovations do not offer simple solutions, Wolfe makes a major contribution to the debate by summarizing the current situation and examining alternative policy options.

Kingson and Berkowitz deal with these issues in a more general way seeking not only to provide an overview of the field but to deal in specific detail with some of the challenges facing social insurance in the United States. The book begins with an historical overview of social security and medicare, and offers a detailed description of these programs. The authors proceed to discuss some of the criticisms which have been leveled at these programs. These include the ability of social insurance to offer adequate social protection, its financial stability, its long term viability and the issue of equity. Their conclusions counter the current tendency to claim that social security and medicare are no longer useful social policy mechanisms, and that they need to be replaced by private provisions. Kingson and Berkowitz are convincing not only because of their cogent logic and effective use of empirical data, but because of the compassion which permeates their writing. Their obvious commitment to protecting a highly vulnerable group of citizens persuasively supports the argument that social insurance is currently the best mechanism for meeting this goal.

In their study of social security programs for the elderly, Williamson and Pampel examine the historical development of these programs in seven countries not primarily for policy but for academic purposes. For almost forty years, sociologists and political scientists have undertaken research into the factors which fostered the emergence of modern social security programs and several competing theoretical explanations of the dynamics of welfare systems have been formulated. In an attempt to test these theories, Williamson and Pampel provide a detailed analysis of the historical determinants of social security. In contrast to most other studies which have attributed the emergence of social security to one factor, Williamson and Pampel suggest that different factors are responsible for the evolution of social security in different countries. In Sweden, for example, the role of the labor movement and social democratic politics is significant while in highly democratic societies such

as the United States, theories based on pluralist notions offer more useful insights.

While Williamson and Pampel make an obvious contribution to the academic literature, the claim that their research is breaking new ground is disputable. The literature on the subject is now very extensive and while many will agree that Williamson and Pampel have undertaken a detailed and systematic study, some will question the need for yet another analysis of this kind. Similarly, while the inclusion of three developing countries in the study is lauded as a major innovation, the authors appear to be unaware of a substantial body of previous literature on the subject. Nevertheless, this is a sophisticated study which will shed light into the origins of modern day social security programs in different societies.

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Nancy Feyl Chavkin (Ed). *Families and Schools in a Pluralistic Society*. Albany, NY: State University of New York Press, 1993. \$59.50 hardcover; \$19.95 papercover.

For centuries, parents have been involved with the education of children. While parental involvement is not touted as a panacea for the problems encountered in educating a wide variety of populations, it has come to be recognized as an important aspect of educational policy, program, and practice. Parental participation in elementary and secondary education, and parental involvement in decision-making on behalf of handicapped children, is mandated by federal legislation.

Utilizing an ecological perspective, this book shows how the major socializing institutions of families and schools can be brought closer together through parent involvement programs. This book focuses upon the participation of ethnic, racial, and language minorities, poor people, and persons with low levels of education in effectively obtaining adequate school-based education for their children.

The first of the four main parts of the book consists of an overview chapter on collaboration between schools and disadvantaged parents which traces the long history of parents'

involvement in the education and schooling of their children. Surveys cited show the low level of school contact, which has sometimes been mistaken for a lack of interest, of lower SES parents in comparison with more affluent parents.

The second part, current research, which consists of five chapters, reports on the use of a variety of research strategies, with an emphasis upon large sample survey research, to explicate the relationships between minority parent involvement and children's school success. Among the many research findings which advance knowledge are those that examine the relationship between parental educational achievement and that of their children. One study shows the considerable concern of minority parents with the education of their youth, with levels of parental comfort with teachers and schools varying between minority groups.

The third part, practice perspectives, consists of six chapters, several of which contain data as a way of combining research with practice. Useful information for practitioners consisting of specific strategies for improving disadvantaged children's education through linking parents' and children's skills, and educational practices, such as parenting skills focused upon children's homework, are discussed. Also present is material on working with underserved populations, including an essay chapter on the cultural backgrounds of Asian-American immigrant parents, and another chapter about the cultural components, structure, and traditional teachings of American-Indian families. An international perspective is provided in a chapter which reports a convergence in findings about low-income parental involvement in children's schooling in England, Portugal, and the USA.

The fourth part, opportunities ahead, consists of three chapters which focus upon the future of parents and families. The chapters present a model of parental involvement, describe new programs, and include a systematic plan for helping minority parents. The final chapter raises and begins to answer several exploratory questions, and provides a useful critique of the context of research on parental involvement.

This book, which cites the available professional and research literature on parent involvement, examines recent and

current educational and social issues, such as school choice. As a compilation of writings that describe and evaluate many parent involvement intervention research programs, this book is positively recommended as a welcome contribution to the literature. Although the book is devoted to issues of program, practice and evaluation research, those interested in policy development will find useful material included from which to base a review of and plan selected social aspects of educational policy. The programmatic bases of a framework for understanding and improving parental involvement can be found throughout this edited collection of writings.

The intermediate level of the book makes it suitable for readers that have a background in concepts and practice related to social issues in education. This book will serve as a resource for applied social scientists who conduct research on minority parental involvement in schooling. It will be valuable to those who wish to gain a practical understanding of the direct operations of parent involvement programs, and will be useful as a resource for pupil personnel in providing material on the cultures of populations-at-risk in school settings, information about innovative programming, and ideas about practical strategies for helping parents who wish to further their children's education.

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Robert L. Rubinstein, Janet E. Killbride and Sharon Nagy. *Elders Living Alone: Frailty and the Perception of Choice*. Hawthorne: NY: Aldine de Gruyter, 1992. \$35.95 hardcover; \$18.95 papercover.

The dominant values of individualism and independence among American elderly are well known, if not well understood, throughout the world. Indeed, the American penchant for independence in old age is quite incomprehensible to many persons from societies where the idea of an elderly individual living alone is truly unthinkable.

This insightful book uses case illustrations to explore a sample of the American experience of independent living through

the lives of selected frail elderly persons in Philadelphia that are profoundly shaped by their fervent desire to stay in their own homes and residences even under extremely adverse conditions. The analysis focuses on whether or not individualistic frail elderly who live alone can age successfully despite limitations of health, support systems, and environment. The discussion also examines successful aging, defined as continued personal growth and development, in terms of the factors that make it possible.

Drawing on survey interviews of 52 persons age 65 and over who suffer from a variety of poor health conditions that limit their activities of daily living, case illustrations are used to demonstrate that even in circumstances where housing conditions are minimal and substandard most frail elderly to choose independent living. Clearly, what is most threatening about aging among the interviewees is the loss of independence which is equated with removal from their home environment. This is true even when the home is located in a neighborhood that has been so altered that the elderly person is virtually isolated from normal social contacts and interactions.

The study is a penetrating attempt to help us understand the attitudes of frail elderly persons who live alone with the intent of providing information that will assist relatives and social service agencies in creating more viable and acceptable choices and options. The survey shows that it is not just the presence or lack of community services, extended families, or income support systems, that keeps most unattached elderly in their homes. While these are important factors, it is the culture of independence and autonomy that plays the most critical role. A loss of independence is perceived as a loss of freedom.

Freedom means control over decisions of daily functions and the freedom of choice even when choices are very limited. As choices become more constrained due to health and other circumstances, the personal value of choice increases. When big choices are reduced the importance of small choices increases. Space is reduced but there is more control over it. This is described as a miniaturization of satisfaction or ethos of freedom in the small.

In addition to the value of independence, people prefer to live alone in their own homes so as not to be a burden on family or friends, having privacy when in pain or exhaustion, being their own boss, and not having to adjust to the needs of others. Another important contributing feature is the interviewees', long-term residence in one place. After living 20, 30, 40, or more years in the same house, there is a close association between person and place. There is ease, comfort, and an interconnectedness between the individual and the living space that is often very profound. Moreover, it is easier to live with familiar fears and discomforts than to face new ones that relocation would entail.

The case interviews stress the impact of the reduction of community life and support for the elderly who live alone. In many cases, the reduced mobility of individuals severely impacts their ability to shop and socialize. This is further compounded by social and economic changes in their neighborhood which often excludes them from the mainstream of community life.

It is not just the abiding desire for independence that is examined, but also the individual's ability to age successfully. In this regard, several structural constraints come into play, including, access to health care, low income, and deteriorating conditions of house and neighborhood. Not surprisingly, those who age the most successfully are people who have an adequate income that gives them the freedom to make choices and allows them to purchase goods and services that nourish their minds as well as feeding their bodies. These are also individuals who have prepared themselves for living independently by cultivating skills in the activities of daily living, including household management, hobbies and intellectual pursuits. The most successful have a history of continuity in personal habits and of malleability under extenuating circumstances. They are also more likely to have an emotional support network and be aware of social services that might be available to them.

The book is an illuminating study in the conflicting nature of individualism and collective responsibility. It raises meaningful questions about the burden of specific aspects of American

culture and the lack of social and income support for the frail elderly. The analytical approach is relatively easy to follow, although it tends to be somewhat erudite in the beginning chapters. The case studies are particularly captivating reading. This book is certainly recommended for anyone interested in gaining a better understanding of the characteristics of frail elderly who live alone and their needs.

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BOOK NOTES

Janis Tyler Johnson. *Mothers of Incest Survivors: Another Side of the Story*. Bloomington: University of Indiana Press, 1992. \$20 hardcover.

It is difficult to examine familial sexual abuse scientifically not only because it is an emotionally laden subject but because it is a secret subject. Johnson's in depth ethnographic study of six mothers whose daughters were victimized is, therefore, an important one. She reports on the experiences of these mothers, using their own words, and describes how they discovered the secret of incest, how they responded and why they kept it secret. Johnson challenges the belief that most mothers collude to aid and abet the father's sexual abuse of the daughter. She shows how complicated the dynamics of incest are and urges professionals to listen to the different ways of 'knowing' about incest that a mother may have. She shows professionals how to be truly responsive to the mother's experiences and to provide meaningful help.

John Swain, Vic Finkelstein, Sally French and Mike Oliver (Eds). *Disabling Barriers: Enabling Environments*. London: Sage Publications, 1993. \$22.95 papercover.

This edited book is intended to serve as a textbook for Britain's Open University. Unlike many other textbooks, it does not survey the field of physical disability but instead examines the way disabled people themselves are taking control over their own affairs. The majority of chapters are written by disabled people and this, the editors point out, is compatible with the book's primary objective which is to demonstrate that disabled people are playing a much more active role in formulating policies and designing services to meet their own needs.

The book illustrates how the barriers which society has created for the disabled can be overcome through an attitude which emphasizes the enabling environments which disabled people are creating for themselves. Those who work in the field of disability need to understand this new dynamic. To make a positive contribution, they must see the world from the

perspective of disabled people and support disabled people as they seek to change the social, structural and economic barriers which impede their attainment of full citizenship.

Christopher Bagley with Loretta Young and Anne Scully. *International and Transracial Adoptions*. Aldershot, England: Avebury, 1993. \$66.95 hardcover. (Distributed in the United States by Ashgate Publishing Co. Brookfield, VT).

In Western countries today, adoption practice is changing very rapidly indeed. The conventional mode of adoption in which childless white middle class families adopt children born outside marriage to young white women is fast disappearing. Consequently, childless couples are engaging in new forms of adoption of which international and transracial adoptions are becoming much more prominent.

The authors report that the outcomes for children in international and transracial adoptions can be extremely positive. Based on extensive empirical studies, they show that the majority of children who are placed make healthy adjustments and do well in the longer term. The authors do not deny that a minority of children do not succeed, and they do not fail to recognize that some adoptive parents experience difficulty in rearing and children of different cultural backgrounds. Nor do they avoid the complex controversies that attend international and transracial adoptions. Nevertheless, they believe that if the current trend towards truly open adoptions continues and if the cultural identity of the child is sustained, transracial and international adoptions offer a positive means of meeting the needs of abandoned and neglected children around the world.

Alice S. Baum and Donald W. Burnes, *A Nation in Denial: The Truth About Homelessness*. Boulder, CO: Westview Press, 1993. \$49.95 hardcover; \$16.95 papercover.

Most experts agree that the problem of homelessness has become more visible during the last fifteen years. However, there is less agreement about its causes and about the steps needed to address the problem. While much academic research points to the role of economic and social factors in the etiology of

homelessness, many ordinary citizens believe that the homeless have no-one to blame for their condition except themselves.

In this provocative book, Baum and Burnes argue that the truth about homelessness is not widely known. They claim that the vast majority of homeless people are homeless because of mental illness, drugs and alcoholism. Challenging currently accepted explanations of the causes of homelessness, they are particularly scathing of social scientists who attribute homelessness to poverty and social structural factors and who urge solutions that require significant social and economic change. The solution to the problem of homelessness, they argue, can be found in programs that treat mental illness and substance abuse and not in ambiguous appeals to policy makers to deal with wider social issues such as poverty, injustice and access to affordable housing.

David Clark. *Partners in Care: Hospices and Health Authorities*. Aldershot, England: Avebury, 1993. \$58.95 hardcover. (Distributed in the United States by Ashgate Publishing Co. Brookfield, VT).

The hospice movement has grown rapidly in recent times filling a gap which conventional health care providers cannot meet. In caring for the terminally ill, hospices have enjoyed considerable support and many have benefited from generous public contributions. However, there is a danger that public sympathy for hospices will foster the haphazard growth of new facilities and that no attempt will be made to coordinate programs, prevent duplication and match services with need. If the hospice movement is to be viable, it will need to enter into an effective partnership with the community in which its programs are properly planned and adequately supported.

The question of forging an effective partnership between hospices and communities is examined in this book by David Clark, an English author who has extensive knowledge of the field. Clark focuses on two English hospices and shows how they evolved, raised funds and established relationships with local health authorities. He offers eleven recommendations that will be helpful in establishing programs that effectively combine local initiative with public services. The English experience

of hospices has already informed developments in the United States. As the Clinton health care reforms are currently being debated, Clark's book will be of particular relevance to those engaged in this important field of service.

Brian Corby. *Child Abuse: Towards a Knowledge Base*. Buckingham, England: Open University Press, 1993. \$32.50 papercover. (Distributed in the United States by Taylor and Francis, 1900 Frost Road, Bristol, PA 19007).

The problem of child abuse has generated a great deal of research in recent times and there is a need to draw the findings of this research together. Corby has succeeded admirably in doing so. His book covers important topics such as the definition of child abuse, the history of child abuse, etiology, the consequences of abuse and the nature of the abuser. A final chapter summarizes the limited research which has been undertaken into child protective social work services.

This is a well written, comprehensive and informative book. Although dealing primarily with developments in England, extensive references are also made to research findings in the United States. The book is not only of value to American readers who are interested in developments in Britain, but it effectively summarizes key findings pertaining to this country as well.

Frances K. Goldscheider and Calvin Goldscheider. *Leaving Home Before Marriage: Ethnicity, Familism and Generational Relationships*. Madison, WI: University of Wisconsin Press, 1993. \$27.50 hardcover.

The Goldscheiders are sociologists at Brown University who have sought to investigate the decisions that young people and their families make about leaving the parental home. The Goldscheider's research findings are based on studies of some 60,000 young people who were tracked for six years after completing their high school education. In addition to studying the children, data about the parents and their attitudes were also collected.

While the research revealed complex patterns which are difficult to summarize, the study found that economic, cultural and religious factors played a significant role in determining when young people leave home. Economic independence was

a major determinant of independence as was culture. While Hispanic-Americans and Asian Americans seldom left home before marriage, this was not the case among white or African-Americans. Similarly, while fundamentalist protestants were unlikely to leave home, the vast majority of Jewish-American young people left home before marriage.

The study investigated many other aspects of young peoples' decisions such as the consequences of leaving home at an early age, the reactions of parents, the economic costs of independent living and the role of education in facilitating home leaving. As the authors suggest, the study offers useful insights which can help parents and their children cope more effectively with separation. It also offers useful insights into contemporary family dynamics and will be of interest to all sociologists studying the family today.

Wilbur J. Scott. *The Politics of Readjustment: Vietnam Veterans Since the War*. Hawthorne, NY: Aldine de Gruyter, 1993. \$47.95 hardcover, \$23.95 papercover.

Wilbur Scott is a sociologist at the University of Oklahoma who, as a Vietnam veteran himself, has a special interest in tracing the emergence of the Vietnam veteran's movement since the 1970s. Using sociological insights derived from the theory of social movements and the constructivist perspective, he shows how Veterans emerged from the demoralization of defeat to create an effective social movement which succeeded in having post-traumatic stress disorder included in the American Psychiatric Association's diagnostic manual, built the National Vietnam Veteran's Memorial, and began successfully to litigate on the damage caused through the use of Agent Orange by the military during the war.

Scott's book makes fascinating reading not only from a sociological perspective but from the way he tells his story. His own involvement in his subject matter informs the book and offers an incisive commentary on the lives of those who were once pushed to the margins of American society. For the social scientist, his narrative elucidates theory and demonstrates how theoretical perspectives enhance descriptive accounts.

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(Revised December, 1987)

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Reviewing normally takes 60 days but can take longer in the event of split recommendations. Things move more slowly at the end of semesters and during the summer. Authors should feel free to write or call the editor if they feel an undue amount of time has elapsed.

Preparation. Articles should be typed, doublespaced (including the abstract, indented material, footnotes, references, and tables) on 8 1/2 x 11 inch white bond paper with one inch margins on all sides.

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Style. Overall style should conform to that found in the *Publication Manual of the American Psychological Association*, Third Edition, 1983. Use in-text citations (Reich, 1983), (Reich, 1983, p.5). The use of footnotes in the text is discouraged. If footnotes are essential, include them on a separate sheet after the last page of the references. The use of italics or quotation marks for emphasis is discouraged. Words should be underlined only when it is intended that they be typeset in italics.

Gender and Disability Stereotypes. Please avoid gender restricting phrasing and unnecessary masculine pronouns. Use of plural pronouns and truly generic nouns ("labor force" instead of "manpower") will usually solve the problem without extra space or awkwardness. When dealing with disabilities, avoid making people synonymous with the disability they have ("employees with visual impairments" rather than "the blind"). Don't magnify the disabling condition ("wheelchair user" rather than "confined to a wheelchair"). For further suggestions see the *Publication Manual of the American Psychological Association* or *Guide to Non-Sexist Language and Visuals*, University of Wisconsin-Extension.

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