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THE CONCEPT OF EMPLOYMENT IN SOCIAL WELFARE PROGRAMS: THE NEED FOR CHANGE IN CONCEPT AND PRACTICE

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ABSTRACT

Social welfare and social work practice are based upon and limited by concepts concerning the role of work in society. These include coverage, vestedness, administration, and the wage-stop. As human labor becomes quantitatively less important in the technological society, and as attitudes toward work change, the role of social work should become proactive -- leading toward necessary and desirable changes, including new meanings of the concept work and new methods of distributing income, rather than continuing to attempt to shore up an increasingly outmoded systems of values and structures.

In examining the content of the major social work textbooks published in the United States during the 1970s, Ephross and Reisch (1982) identify the basic ideological positions of the authors, distinguishing between those that view social welfare and social work as concerned primarily with the socioeconomic system; those that deal mostly with individual differences; and those that attempt to do both. In none of these books, however,
including that of this author (Macarov, 1978), is the immanence of the concept of employment throughout welfare programs posited as a major determinant of the welfare systems and social work. It is the purpose of this paper, therefore, to point out the ubiquitoussness of the work/welfare link throughout social welfare programs, and to trace the deleterious results of that link in terms of the individual and social problems caused.

The work/welfare link

The connection between work and welfare expresses itself in a number of ways. When social insurance programs are adopted, the first such program undertaken is almost invariably workmen's compensation, which assures workers and potential workers that they can enter the labor force without fear of uncompensated injuries. Unemployment insurance, on the other hand, is usually the last such program to be adopted, since it is generally seen as helping or inducing people not to work. Workmen's compensation generally pays more than unemployment insurance, is easier to obtain, and is not limited as to duration. Surveys indicate that unemployment compensation has much less public support than has workmen's compensation and, indeed, than has any other social insurance program (Macarov, 1980).

The link between work and welfare can also be seen in terms of coverage, vestedness, administration, and the wage stop. From 72% to 100% of all social insurance programs in every country in the world limit coverage to workers, employees,
laborers, or some other designation of employed persons. People who do not work are simply not entitled to partake of these programs that are designed to protect people against the exigencies of life. Even Family or children's allowances are generally paid only to the families or children or workers (Social Security Programs . . . , 1977).

Being covered, however does not assure one of benefits. Almost all programs require a certain amount of prior work (termed "vestedness") to entitle the covered employee to benefits. The length of time worked and the salary received usually determine the number of payments made, and their amounts. Large numbers of workers are denied payments because they have not yet worked long enough to be eligible, despite the fact that they have paid in the necessary 'premiums' while they did work.

Then there are the administrative regulations designed to strengthen presumed incentives to work. These include a waiting period before drawing benefits (Griffiths, 1974); proof of continuing job search; personal appearances at the labor exchange; and taking almost any job offered, at any salary under any conditions. None of these requirements are attached to other types of programs, including maternity grants, invalidity, etc.

Finally, and perhaps most important, there is the factor known as the wage-stop. This is a direct outgrowth of the Elizabethan concept of less eligibility. The wage-stop, which is almost universal through all welfare programs, makes it virtually impossible to acquire from welfare as much as the person could acquire.
from working, or as much as other people acquire from working. This limitation also operates upon those people who cannot or should not work -- the aged, children, the disabled, single parents, etc. In thus linking welfare payments to salary levels rather than need, the work/welfare link dooms from 10% to 15% of the populations of every Western industrialized nation to poverty (Macarov, 1980).

But social insurance programs are not the only aspect of social welfare to be based upon the needs of the world of work. Social workers in their daily jobs spend enormous amounts of time inducing people to go to work and solving problems arising from work, viz., the burgeoning field of occupation social workers. Social workers seek child-care arrangements so that mothers can enter the labor market. Indeed, the recent enormous growth of child-care facilities did not spring from data or an ideology that such care was better for children than that of their parents, but rather from the phenomenon of women entering the labor force. Home-care service for the aged and the ill are arranged by social workers to allow family members who would otherwise have to stay home to go to work. In addition work is seen as both the goal and the method of treatment in rehabilitation efforts; sheltered workshops; in probation and parole; and in a myriad of other ways.

Attitudes toward work

At the heart of these efforts is the belief, shared by social workers, that full employment is not only possible, but a necessary and desirable goal for society; while work is viewed as good for individuals from points of view of their physical and mental health, their economic
situation, and self-actualization as happy, normal people. It is no surprise that social workers hold these views, as they are shared by the overwhelming majority of the population. Indeed, socialization for and into the world of work begins almost at infancy. Children learn on the see-saw that Jack shall have a new master, and that he shall get but a penny a day because he can't work any faster. Students are told to "work hard" at their "homework." Schools are criticized for not preparing graduates properly for their jobs. Religious teachings emphasize the Godliness, or at least the Biblical admonitions, concerning work, e.g., "Look to the ant, thou sluggard; consider his ways and be wise." Poems, songs, and fables, such as the grasshopper and the ant, or the hen who would not share her cake with any animal that had not helped bake it, re-emphasize work as the only acceptable basis for human existence. In fact, working -- and being considered a good worker -- has become a surrogate for being moral, religious, patriotic, and neighborly.

The internal contradiction in the situations described above is clear. On the one hand, work is posited as a normative, if not completely positive, activity, which people both need and enjoy; nevertheless, the fear that people will not work requires the most stringent positive and negative reinforcements. In short, while professing to believe in Theory Y, society acts according the Theory X (McGregor, 1960). The present structure of society, and the economic system in particular, makes this gap between values and behaviors both necessary and understandable.

Still, despite constant reinforcement
by all elements of society concerning the joy and usefulness of work, there is ample evidence -- ranging from the folk wisdom that nobody would work if they weren't pain for it to sophisticated studies of complex motivations -- to suggest that the great majority of people get little pleasure from their work. Generally speaking, the further one goes down the scale of occupations, the less the satisfaction found. It is indeed ironic that policy regarding work and welfare is made by those people with well-paid jobs that contain power and are ego-satisfying -- and these policy-makers cannot conceive, and do not believe, that other people do not get the same satisfaction from work that they do. For example, 93% of urban university professors would choose the same work again, while only 16% of unskilled autoworkers would; 43% of white-collar workers would choose the same work again, but only 24% of the blue-collar workers (Work in America, 1973).

In over three thousand studies of work patterns and attitudes conducted over the last fifty years, the phrases best used to describe attitudes to work are "fatalistic contentment" (Lasson, 1971) and "resigned acceptance" (Macarov, 1982), both of which are said to be arrived at by a "surrender process" (Robinson, 1969) whereby previous expectations for job satisfaction are lowered or given up. The job satisfactions found in several surveys seem to merely indicate fulfillment of drastically reduced expectations.

When survey research is supplemented by in-depth interviews, observation, and indirect queries, negative attitudes toward work become even more prominent. An illustrative case is the young man asked by Strauss (Work in America, 1973) whether he
had a good job. On responding in the affirmative, he was asked what made it a good job. He replied, "Don't get me wrong. I said I had a good job. I didn't say I had a good job." Rubin (1976) also found that respondents reporting themselves as satisfied at and with work confessed, on continuing the interview, that they were really not satisfied. But even taking survey research at face value, there are large and continuing decreases in work satisfaction among practically all occupation (Walfish, 1979), and even among that group who were once the most satisfied, the middle managers (World of Work Report, 1981).

The evidence for lack of work satisfaction is not confined to what people say -- their actions speak even louder. Perhaps most significant is the continual reduction in hours of work, which has diminished the average work week in the United States from fifty-three hours in 1900 to thirty-five hours in 1980 -- and this reduction takes into consideration part-time and second jobs. Such reductions in work time have not come about without the consent, or over the objections, of workers. On the contrary, most union negotiations are more concerned with hours, vacations, and holidays than they are with safety measures or even salary increases. Further, with the exception of some workaholics, no one works longer hours or more days than he or she is paid for, due to sheer enjoyment of the work. Finally, people are retiring early at an ever-increasing rate, and this not due to ill health, forced retirement, or financial inducements. Given the opportunity to retire at age sixty-two with 80% of the pensions they would acquire if they continued working until age sixty-five, over half the retirees on American Social
Security are opting for early retirement, foregoing both the three years of salary and 20% higher pensions. This number has risen from 21% of all retirees in 1965 to 52% in 1980. And, despite the mythology, retirees who are not in financial need are generally glad they retired, enjoying their retirement and wish they had retired earlier (Stagner; 1978; Schmidt, et al, 1979).

All of this evidence -- survey and experiential -- does not add up to a picture of people happy in their jobs, finding creativity, companionship, a sense of accomplishment, and self-actualization in their work. In fact, if one divides the components of work satisfaction into feelings about having to work at all, instead of engaging in some other activity, such as child-rearing, the arts, sports, etc.; feelings about the job, which includes pay, permanence, perquisites, status/stigma, and chances for advancement; feelings about the workplace, including physical conditions, hours, co-workers, supervision, and amenities; and feelings about the work itself, including interest, creativity, responsibility, societal necessity or desirability, and side effects such as pollution -- then it is indeed a rare working person who is satisfied in or with each of these areas, or even with a majority of them. When one reports satisfaction at work, it is usually "on balance," as it were, or with one area overshadowing the areas of lack of satisfaction.

In addition to the widespread lack of satisfaction with work which seems to exist, at least on the lower rungs of the occupational ladder, there are also the effects of the work itself, and the effects of feelings about work, on the physical and
mental well-being of the workers to consider. Many studies have been done as to how work can be used as a therapeutic measure for persons with physical and emotional problems. Little thought has been given to the problems caused by having to work, at the workplace, or by the work itself. Even the growing number of occupational social workers deal more with problems that concern employers, such as absenteeism, tardiness, and negligence caused by alcohol or drug abuse, than they do with problems that concern workers but do not affect their productivity. Indeed, if Herzberg's (1959; 1966) distinction between satisfiers and dissatisfiers is examined, most occupational social workers deal with removing dissatisfiers -- i.e., changing condition -- rather than increasing satisfaction, which requires restructuring jobs, and is not within their jurisdiction and power (Bar-Gal, 1982).

Recently, work stress has become a concern of occupational health personnel, spurred on by court rulings that work stress is a compensable work-disability (Shostak, 1980). In general, however, and certainly among social workers, it is lack of work which is thought to have many individual and societal implications for health and well-being. And, indeed, both socialization to work, and jobs as the only acceptable way of acquiring income, make lack of work a widespread cause of distress and social ills. As a consequence, social workers not only encourage, aid, and coerce people into going to work; they also partake of the ideology, and sometimes the activities which put full employment at the head of a hierarchy of social goals.

**Full employment -- the impossible dream**

The desire to provide people with jobs,
rather than simply giving them food or money, dates back to the earliest days, when people first left their family farms to become laborers. In fact, the building of the later pyramids has been described as a make-work project (Mendelssohn, 1977). Herod found it necessary to build a road around Old Jerusalem to employ the former Temple builders. Vespasian forbade the use of water power to move building supplies in order to preserve jobs for workers. In the days of the Industrial Revolution Luddites attempted to destroy machines which they saw as replacing human labor (read: jobs). In fact, Lord Byrons first speech in Parliament was against the death penalty for such people.

Since that time governments have expanded enormous effort to achieve full employment, including measures like work relief, public service jobs, public works, subsidies to employers, job creation, job training and re-training, public employment offices and even -- in some cases -- the government as employer of last resort. Despite these monumental efforts, continued for centuries now, no Western industrialized country has ever been able to achieve full employment -- i.e., more jobs than workers -- except during periods of war.

Further, due to statistical and definitional artifacts, the official figure concerning unemployment is usually 50% to 300% understated. In many countries the figure is based upon those people drawing unemployment compensation, thus ignoring those who have not applied, have exhausted their benefits, or who were not eligible for various reasons, such as not having acquired vestedness. In countries where the figure is derived from surveys, like the United States, the figure ignores those
who have become discouraged and stopped actively seeking work, as well as those who have part-time jobs despite their desire to work full time. In addition, in some places the jobless are paid to participate in various training and educational schemes, thus enabling the authorities to list them as students, rather than as unemployed; Sweden, for example, has more people in subsidized training courses than unemployed, which partially accounts for a low unemployment figure.

It has proved impossible to arrive at full employment even when this is defined as "more vacant jobs than people seeking work." When the definition becomes more exacting, e.g., "interesting work at decent pay under good conditions producing socially-desirable objects or services without deleterious side-effects," full employment becomes manifestly impossible. The truth of the matter seems to be that modern society does not need all of the human labor available; nor, even more important, the labor of everyone seeking or needing a job; nor all the labor of everyone holding a job.

The unemployment rate in Western industrialized countries, which has been rising sporadically but inexorably over the last fifty years (with the exception of war periods), is masked in large part by the continual reduction in work hours, which spreads existing work; plus maintenance of unnecessary jobs; and the growing amount of unproductive work time, more generally referred to as loafing on the job (Schrank, 1979; Cherrington, 1980; Walbank, 1980). Indeed, it has been estimated that present productivity could be maintained with one-half the existing work force (Kreps, 1971).

Even the desire for full employment, or
that people work harder than they do at their present jobs, is based upon a serious misconception concerning productivity. Changes in productivity are mainly the result of changes in machines, methods, materials, and energy -- not manpower. Human labor accounts for no more than 25% of changes in productivity, and perhaps for only 10% (Rosow, 1977).

Full employment -- the dangerous delusion

Not only has full employment proved impossible of attainment, as outlined above, but the search for full employment contains dangers for society, and for individuals. One of the societal dangers is implied in the figures quoted above concerning the human factor in productivity. Emphasizing that factor is an ineffective way to attain high productivity. The key to productivity is technology, and attempting to use humans instead of machines produces a drag on productivity efforts. Thus, the effort to provide everyone with a job deters the very result of high productivity from being attained.

Further, the need to provide jobs leads to a search for labor-intensive industries, instead of capital-intensive or technology-intensive. This puts the economy into direct competition with developing countries which have excess manpower and low standards of living. The only way that labor-intensive industries can survive in the developed countries is to match the labor costs of their competitors, which means fewer fringe benefits, longer hours, and lower salaries -- a process illustrated by the recent contract between the United Auto Workers of America and General Motors, in which the workers gave up salary and holidays to meet competition from Japanese
Finally, the need to provide jobs, regardless of the superfluousness of the work, leads to make-work and boondogling. Despite the impressive accomplishments of the WPA during the Great Depression -- evidence of which is still with us in terms of bridges, murals, plays, and successful artists -- two and a half million people eligible for WPA were never assigned, due to lack of useful work for them (Charnow, 1943), while everyone who lived through that experience remembers mostly the great bulk of WPA workers who were going through a slow charade in order not to use up the work available. Make-work projects today are no longer as harmless as WPA leaf-raking, but tend toward the manufacture of armaments (viz., the B-1 bomber in America) and other large-scale items of dubious value, like nuclear plants, which are defended as much in terms of their job-creating potential as concerning their intrinsic usefulness.

Insofar as individuals are concerned, the methods utilized to attain and maintain high employment lead to corruption, cynicism, negative self-images, and mental problems of various degrees of seriousness. Many of the jobs currently being performed by humans could be done as well, if not better, by machines. These machines work three shifts a day, never take vacations, demand no raises, and perform more and better work than many humans -- and, in some cases, perform jobs that people cannot do. The extension of technology into ever-widening areas of work is deterred only by the need to provide people with jobs. We are just at the beginning of the microprocessor and robot revolution, and a determined effort to use machines wherever and whenever possible -- one of the bases
for Japan's outstanding success -- would replace millions of people in the jobs that keep them unsatisfied, as noted above.

It is just this knowledge -- that they could easily be replaced by a machine, and are kept on only by the employer's or society's charity -- that affects many workers. As Liebow put it in a *New York Times* (1970) article: "no man (sic) can live with the terrible knowledge that he is not needed." A case in point: In 1974 the *New York Times* changed its printing method. To meet union objections, lifetime contracts containing excellent terms were given 830 workers, although only 350 were needed to produce the newspaper. Two hundred were induced to retire by excellent terms, while 280 people drew pay for useless work (Zimbalist, 1979). Such situations are hardly calculated to increase the self-esteem or the mental health of the worker. Millions of other workers know that they can be replaced by machines, or live in fear that they will be. The anxiety thus caused has never been specifically isolated or dealt with, let alone measured, but it undoubtedly affects great masses of workers.

And then there is the fact that most jobs do not require all of the work that one is capable of performing, but that the worker must nevertheless pretend to be busy. This often results in a conspiracy between workers, and sometimes between workers and their superordinates, to maintain the fiction of being busy all the time. Workers who sign in and then go out to take care of personal matters; those who have others insert their cards in the time-clock in their own absence; those who deliberately or consciously stretch their work to fill the assigned time (a la Parkinson); those who dawdle, gossip, and
simply idle; those who hold other jobs during their own ostensible working hours; those who do not come in, or come in late on Mondays -- all of these are reactions to non-serious work, not its causes.

It has been estimated that the average worker uses 44% of his or her potential (Walbank, 1980). In one survey, 54% of the workers said they could work harder than they do (Berg, Freedman and Freeman, 1978). In another study, workers who indicated that they could work harder were asked why they did not do so. In almost every case, the answer was that the job doesn't require it (Macarov, 1982). In order to pass the time away, workers use a variety of devices, such as setting small challenges for themselves. For example, the girl engaged in gutting tuna-fish who tried to see how high she could pile the catfood component before it tumbled over (Garson, 1975). Others engaged in horseplay, or in elaborate rituals, or fantasize, or even blank out work time entirely. It should be obvious that there is nothing in such a situation that speaks of or reinforces mental health. On the contrary, such self- and other - deception must exact a toll, and the attitudes and practices engaged in at work may be carried over into non-work situations, adding corruption, deception, and unhealthy personal relationships to society at large.

On the other hand, there remains the deep popular conception that there is much work that needs doing, and that somehow such work can be made interesting, self-actualizing, and worthwhile. The human services, in particular, are thought to be short-handed, and the answer to growing unemployment. However, closer examination reveals that the problem is not lack of personnel, but lack of conditions which
induce people to take or hold such jobs. In both the United States and Isreal, for example, there is said to be a shortage of nurses, but in both countries about a third of the registered nurses are not working, and another third work only part-time (Flick, 1983); Handless, et al, 1982). Were conditions offered that would induce all the nurses to work full-time, there is question whether the shortage would remain.

If there is a shortage of manpower in the human services, it is not in the professional or highly-skilled jobs, but among those who are expected to empty the bedpans, change the linens, push the wheelchairs, do the laundry, and wash the dishes -- in short, that which Gans (1974) called the dirty, dead-end jobs of society. Mildred Rein points out that about a third of the AFDC caseload have employment potential -- but only if the jobs offered pay more than the minimum wage, have stability, and offer good fringe benefits -- conditions which such jobs never meet. If there is work that needs doing, it does not offer variety, control, growth, and good remuneration. Indeed, technology usually moves into the hard-to-fill jobs through sheer lack of alternative in terms of humans willing to do the work. Hence, the work which "really needs doing," and which doesn't attract people, will be done by machines, or by system changes, ending the mythical open-ended job shortage in the services.

Implications for social work, social welfare, and society

Why do social workers, who are on the leading edge of concern for the physical and mental health of individuals and societies, allow themselves to be used to strengthen the redundancy of human labor,
the pretense that people enjoy their work and that it is good for them, and the stress, anxiety, and mental illness that is inherent in the present socioeconomic structure? The answer is clear: Even were social workers do agree concerning some, many, or all of the negative effects of work as outlined above, they would see no way in which their clients could support themselves other than through job-holding, regardless of clients' deeper wishes, and regardless of what working might do to the individual and the family.

What is needed is a different method of distributing the fruits of technologically-derived production so that human labor is minimized and the highest level of technology eagerly sought and embraced as freeing people to engage in more pleasurable activities. This requires both structural and value changes. Suggestions concerning the spread of cooperatives of worker-owned businesses; and a genuine collective using the example of the Israeli kibbutz (Macarov, 1980). Simultaneously, this would require changes in the value base of society, which currently enshrines work as the central value in the pantheon.

Arriving at such different values would not be easy, and it might be simpler to enlarge the definition of work to include them. That is, if work is seen as that which people do to acquire the material necessities and luxuries of life, including services, then they could be paid for doing those things which are now considered non-work, or leisure. Thus, if society were willing to reward people with livable incomes for studying anything that strikes their fancy; for exploring new physical and non-physical phenomena or territories; for participating in community projects; for learning and playing musical instruments;
for engaging in sports activities; and other things currently dismissed as leisure-time activities, then full employment and enjoying one's "work" might become a reality.

These possibilities are not as wild as they sound. Not only did the ancient Greeks live without work, the great thinkers -- Aristotle, Socrates, and Plato -- decried work as making people bad citizens, bad neighbors, and bad parents. The results of a society in which citizens did not have to work were bequeathed to us as the foundations of art, philosophy, theatre, and mathematics, among others. In European Jewry, the student of Talmud was held in the highest esteem and supported by the community. In our own day and place, we reward (and perhaps overreward) a few people for engaging in just the activities mentioned above -- musicians, sports stars, actors -- and spread support more widely for those who study, in terms of scholarships, stipends, and government loans. Extending this practice to include more and more people might be the simplest way of distributing technologically-acquired resources while avoiding severe societal unrest and upheaval.

In any case, it seems quite clear that the newly emerging technological society will create social disturbances and individual difficulties unless it is met planfully, creatively, and energetically by all those concerned with human happiness, among whom social workers and social welfare planners should stand in the vanguard.
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SOCIAL WORK INTERVENTION WITH THE AGED
Toward a Change in the Institutionalized Thought Structure

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ABSTRACT

The social problems associated with aging are viewed as derived from a series of socially defined meanings in the areas of: (1) power/authority, (2) responsibility, (3) productivity/work, (4) dependence/independence, and (5) knowledge/rationality. A parallel series of alternative meanings is proposed which make possible the creation of alternative institutional forms which hold promise for making contemporary problems substantially obsolete. An era of post-professionalism is envisioned in which helping agents become political activists committed to social change on the cognitive, as well as the material level.

Introduction

We view social problems as the product of collective, socially and historically based human imagination. Similarly, institutional responses to these social constructs are the product of their time
and their place in history. The identification and the specification of a social problem largely determines the nature of its solution. (1)

It is our purpose to apply these propositions to the problems and issues associated with aging and old age in our society. We begin by suggesting that, for the aged, the main problem may well be that aging itself is viewed as a problem.

Our approach is importantly influenced by both the sociology of knowledge and by modern critical theory. (2) We proceed from the assumption that, what in any society is defined as knowledge and as real, is an essential determinant of, and in turn determined by the social institutions that characterize that society. Thus, to change reality involves, among other things, the reconstruction of social meanings.

This paper will examine elements of the existing institutionalized thought structure (ITS) which have a specific affect upon aging. (3) Thereafter, it will suggest a series of alternative conceptualizations which, to our mind, hold the promise of changing the meaning of growing older in a way that will importantly reduce the oppressions that are increasingly experienced by all of us as we advance through the life course. It will conclude with some ideas on how social workers might have an impact upon changing societal perceptions of aging and upon the social services which have been established to respond to the perceived problems of older people.

A Conceptual Overview

Every society, as much as every
individual, strives to achieve and maintain conceptual coherence, i.e. a means of organizing and giving meaningful relevance to the complexity of human experience. (4) The very possibility of meaningful communication among humans and the existence of society as such hinges upon this phenomenon, which leads to what Roland Warren called, The Institutionalized Thought Structure.

Institutionalized thought structures are composed of loosely related, though not necessarily logically consistent, value-laden cognitive elements which dominate, explain, and give shape and legitimacy to the social order. (5) Though the institutionalized thought structure is a human product, it is commonly experienced as objective reality, as if it were eternal truth and logic. The ITS will vary from epoch to epoch and from society to society. It is never static, rather it constantly changes. The major ideas, institutions, and problems of any society may be viewed as an expression of a unique ITS emerging within a particular cultural/historical context. (See Figure I). These three elements, i.e. meanings, institutions, and problems, act upon each other in a mutually casual manner. It is not that one is regularly antecedent to the other, but they must somehow "make sense" within the context of the ITS.

As we have suggested, the ITS serves as a conservative force within any given society in the best sense of the word, providing for continuity and therefore for a desired and necessary element of predictability in human affairs. But how might change, especially planned change, in the ITS occur?

The change we are discussing is not
limited to changes in a particular institution, e.g. a specific policy or program, or in a particular idea or item of knowledge, but rather to changes in the fundamental thought structure of the society, e.g. the meaning of success, the concept of self, or the essential relationship of human beings to nature. We postulate that significant changes in social institutions will take place only when there are fundamental changes in the ITS.

Within relatively stable historical contexts, as for example in isolated peasant societies, the institutionalized thought structure is unlikely to be questioned or challenged. Under circumstances of modest instability what Radcliffe-Brown calls "readjustment changes" may take place. Examples of this kind of change are discussed by Piven and Cloware, and by Warren, Rose, and Bergunder. (6) But in an increasingly turbulent society, with the emergent awareness of severe contradictions, and as the consequence of the application of individual and collective genius, major challenges to the ITS may result. (7) An example of one of the most dramatic of such thought revolutions in the Western world occurred during the first and second century CE, sparked by the genius of Paul of Tarsus. Fifteen centuries later, Gallileo played a different, but similar role. (8)

One way to think about changes in the ITS is to appropriate the scheme of Thomas S. Kuhn, who, in his analysis of the history of science, distinguishes between normal science and extraordinary science. (9) Normal science produces incremental changes within the context of the existing thought structure. It is largely concerned
with verification, replication, and expanded application of received knowledge within the sciences. By contrast, extraordinary science permits new paradigms to emerge. Kuhn views the development of scientific knowledge not as a continuous process of growth but as an uneven process punctuated by extraordinary events. These extraordinary and fundamental reconceptualizations are brought into the forefront as a consequence of the accretion of anomalies which cannot be resolved within the context of normal science. One of the best known examples of such an occurrence is the Copernican "revolution" which undermined the "normal" concept, that the earth is the center of the universe.

Kuhn's concept of paradigms has been criticized for meaning nearly all things to all people. (10) It will not satisfy those who require all scientific truth and knowledge to be measureable and quantifiable. (But this, too, is a paradigmatic constellation.) For our purposes the term is useful in that we can compare it to the idea of ITS. In applying it to the meanings, institutions, and problems which impinge upon the field of aging we seek to identify those areas in which the established paradigm (i.e. the relevant elements of the ITS) produce anomalies which negatively affect not only those who are aged, but the coherence of the society as a whole. The highlighting of these anomalies and the development of experimental alternative conceptualizations may lead to the reconstruction of the ITS in a way that it will make it more genuinely possible to meet the needs of people.

Elements of the American Thought Structure

It is not our purpose to suggest a set
of systematically interrelated elements which constitute the ITS of modern American society. Others, notably Peter Berger, in *The Homeless Mind*, Milton Rokeach, and on a more popular level, Alvin Toffler and Christopher Lasch have made attempts to bring a synthesis to the consciousness of modernity. (11) Our ambitions are more modest in the sense that we seek to identify simply an array of values and associated cognitive structures, elements of the its which appear to impinge negatively upon the process of growing old, and which perpetuate the oppression of the aged.

We suggest that these elements of meaning which originate in the culture and history of the West, have evolved to a point where the institutional forms which emerged from them have become detrimental to the well being of all persons in our society since we all age and eventually we all grow old. They lead to anomalies which diminish human potentiality. In short they produce problems for which we must identify other than incremental, culture-bound, "normal" solutions.

It is largely accepted without question that:
1. The existing arrangements and distribution of power and political authority in America are good and desirable.

2. Social problems stem primarily from individual, rather than social structural deficiencies.

3. Human beings have differential worth, related to their productivity, which legitimizes the unequal distribution of rights.
4. Each person is ultimately responsible for her/him self; The social provision for meeting human needs is viewed residually.

5. Instrumental reason, which informs scientific and technological progress, will ultimately resolve all problems of society.

We will discuss each of these five societal assumptions separately.

The Social Construction of Old Age -- A Critical Appraisal

1. The legitimacy of the Political Status Quo

The political system of the United States is commonly understood to resemble a giant market. Separately and together, the variety of actors function so as to maximize their individual good, which in turn is thought to produce the best of all possible societies. (12) The status quo is legitimate (i.e. labeled just), and normatively dignified because it exists, and is the product of a just process. (13) It permits and encourages conflict among individuals and groups, but only within legitimate constraints, such as those of the market. Only those actions which are pursued in conformity with its rules are "realistic", i.e. realism becomes synonymous with system maintenance.

The aged population has in recent years been viewed increasingly as an interest group which competes within this postulated market for resources and power. Thus it is assumed that:

1. The major concerns of the aged will constitute a portion of the
2. Appropriate policies and programs will emerge to meet the interest and needs of the aged.

3. The aged are receiving their fair share within the system of partisan mutual adjustment.

In order to enhance this capacity to influence the political process, the aged are advised to organize, to form coalitions, and to lobby the centers of decision-making power. (14) Their failure to achieve their ends is to be accounted for by their lack of effective organization, their political apathy, their minority status, or their lack of effective (popular or professional) leadership. But, on the whole it is assumed that since the political system produces and defines justice, the welfare of the aged population is assured, to the extent that they can reasonably be considered entitled. In sum, politically there is not much more that can be done.

2. Individual Deficiencies

The emphasis on individual deficiencies as contrasted with social-structural problems has been dramatically labeled, "blaming the victim." It assumes that, if a condition is problematic, then the (deviant) individual is guilty and must change. This assumption is directly linked to the claim that this is the best of all possible societies.

Deviant behavior is thought to fall into two broad categories -- that for which the individual is at fault and that for which the individual is blameless. Fortunately for the aged, they are

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generally held blameless for the deficiencies associated with their advanced years. This can be explained, in large part, by the fact that aging is popularly construed not only as being associated with illness, but also as being illness. Illnesses are considered, in this society, to be beyond the fault of the victim.

Aging, viewed as a process of physical and mental deterioration, serves as the dominant explanation for the "problem" of old age. It is assumed that this process is inevitable, chronic, and natural. In essence it is viewed as an entropic process, culminating in death, whose effects might be retarded or mitigated primarily by the provision of medical services, but never reversed. Death is an important medical event; it is the ultimate illness.

All individuals of a given age are normatively expected to behave in certain ways and to exhibit particular problematic symptoms. Specific social institutions are structured so as to respond to these expected behaviors and deficiencies. The circle is completed when individuals learn to live up to the expectations which are imposed upon them. "Don't listen to me, I'm just a crazy old codger," they disarmingly have been taught to say, and to half believe. Thus we trace the "moral career" of the stigmatized elderly. (15) This is the most pernicious consequence of agism: the victims begin to believe the doctrine in the name of which they are oppressed. (16).

The political consequence of blaming the victim in the field of aging is to make it possible for society to avoid confronting the most universal social structural problem faced by millions of
elderly, economic deprivation.

3. Inequality

In Western society high social status is correlated with what is socially evaluated as economic productivity. Productivity is thought to derive from the investment of wealth and/or from what is defined as work. Those who are younger, vigorous, daring, white, male, and in possession of utilitarian skills are most likely to be working. Thus the aged, except for those few who are wealthy, are viewed as being nonproductive and of low social status. They are "surplus people." (17)

Inequality in the distribution of rights, in the sense that David Gil uses the word, is normatively justified as a stimulus to productivity. (18) Whereas equality is popularly promoted as an ideal in Western society, it is applied primarily to the "spiritual," less to the political, and not as all to the economic sphere. Poverty among the aged in America is entirely consistent with the powerful Puritan motto ascribed to Captain Myles Standish that, he who does not work should not eat. Wisdom, honor, life experience, long suffering, etc. simply will not serve as values worthy of economic reward.

There are multiple additional consequences of the low social status of the aged related to, but not systematically determined by their poverty. Their civil rights are easily violated, as in the imposition of involuntary institutionalization. It is popularly acceptable to think and speak of older people as if they were children whose lives have to be managed, and who have little capacity to make sensible decisions for themselves.
"They are expected to enjoy playing games, modeling with clay, and taking afternoon naps, much like children. When they are forced out of the labor force because they are assumed to be incompetent, inefficient, and unreliable, the elderly are subtly taught to accept these allegedly inevitable consequences of biological aging. Old age is believed to be neither functional nor very profitable. Thus it is thought to be purposeless.

4. Individual Responsibility – Societal Neglect

One of the most salient myths of American society is that of the "self-made man". Aside from its obvious sexist implications (can there be a self-made woman?), this myth gives expression to the social ideal of the autonomous and ambitious individualist who, by means of sheer determination and hard work, achieves success. Ideally, government minimally regulates individual ambition. Wilensky and Lebeaux' familiar distinction between residual and institutional social services is misleading. (19) It obscures the fact that all social welfare services in America are fundamentally residual, in the sense that they provide help and regulate the behavior of citizens who, ideally, should be independent and helping themselves.

Within this "culture of narcissism," where self-fulfillment and self-aggrandizement have become the socially sanctioned ideal, even duty and service to others are subsumed under the category of self-interest. (20) Thus, if benefits are provided for the elderly, the best justification for this limited largess is that, eventually, all of us will arrive at the same place. It is self-interest that justifies and explains the public interest. (21)
There is no need to review the retinue of underfunded services and programs which characterize the field of aging. Their emphasis is on crisis intervention and custodial care rather than on planning and prevention. The approach is segmented and problem-oriented rather than holistic. Often demeaning approaches to service are the consequence of treating individuals as if they were objects, or commodities. People are helped, but usually given little opportunity to reciprocate... This is one of the more refined forms of humiliation.

The most dangerous consequence of the residual social service approach to meeting the needs of the elderly is that it serves as an explanation and a justification, proposing that something is being done. But in fact nothing much is changed. The social service providers help to perpetuate the problems and the oppression because their actions do not significantly impact upon the political and cognitive context within which the problems associated with old age are defined. (22)

3. Progress and Rationality

Instrumental reason, often defined to be synonymous with rationality, involves the calculation of constantly more precise and more efficient means for the accomplishment of utilitarian ends. (23) Modern empirical science, the institutional incarnation of instrumental reason, has as its goal the ever greater mastery over nature. Progress in the modern world is thought to coincide largely with the progress of empirical science and of derived technologies. It is assumed that this value-neutral science, which has

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become synonymous with reason and the source of all true knowledge, will ultimately solve the problems of all mankind. (24)

In the field of aging, one of the consequences of this belief in empirical science, or "scientism" as it is called by the critical theorists, is the inordinate emphasis placed upon biological aging. (25) It is as if the physical deterioration of the body were the main problem and deathlessness the idealized goal. Here also the emphasis is upon the individual and his/her deficiencies. The solution is assumed to be technical/mechanical, and the social institutional issues are avoided. As before, aging is viewed as a type of pathology and death becomes the ultimate illness. Ironically, progress in life culminates in the denial of life's progress, in death.

A second, less obvious consequence of the belief in the invincibility of science and in progress is that it acquires a quasi-normative status, i.e. we moderns claim to be better than our predecessors because of our greater knowledge. The effect of this pretentious cognition upon the process of aging is expressed in the relationship between generations. Whereas in Africa and parts of Asia the aged are highly regarded because they are thought to be closer to the Source, among us the aged are denigrated because it is assumed that they know less and therefore are less competent. (26) The younger generations reign over their elders not only because they are physically stronger and economically advantaged, but also because they are assumed to be closer to the Truth.

In the realm of public policy the most mathematical of the social sciences,
economics, has become the paradigm for rationality. Every decision is assumed to have a quantifiable cost and an equally quantifiable benefit. The ideologically based judgments which are implicit in cost/benefit analysis are easily overlooked. (27) Thus in the field of aging, whereas service provision might, and often has been made profitable and efficient, it is impossible to make the claim that promoting the well-being of older persons is a cost-effective way to utilize societal resources.

Summary

In reviewing these key elements of the contemporary ITS, basic conceptualizations relating to power, guilt and responsibility, work, self-sufficiency, progress and rationality, we do not make the assumption that this is an ideology which is cynically imposed upon society by oppressors from above. Rather, these ideas have their roots in the political, cultural, economic, religious and philosophic history of the West. This thought structure has been internalized by all of us who have been socialized into this late twentieth century world. To bring about a change which is genuinely liberating requires critical thinking and critical learning about those who control the major institutions of society, among the professionals who manage them, and most especially among those who populate them.

We proceed in the next section with the task of critical thinking and move toward critical learning, leading to a sort of "desocialization," in order to make possible resocialization to new, alternative paradigms of thought and action. (28)
Elements of an Alternative Thought Structure

The aim of the remainder of this paper is to propose a series of alternative elements for a thought structure which, it is hoped will avoid some of the present anomalies associated with growing older and becoming aged. We have attempted to link these ideas to action proposals which have as their goal the rapid institutionalization of these new meanings.

The five alternative elements which we propose are approximately, but not fully parallel to the five key elements in the ITS which have been discussed above.

1. The legitimacy of the institutionalized thought structure is constantly open to question and challenge in the light of changing social and historical circumstances.

The legitimacy of inherited ideas is maintained primarily by those who have power. But both the source and the meaning of this power require critical examination. We would observe that, whereas the unquestioning acceptance of established authority invites tyranny, its opposite, total distrust of all social bonds of unequal power, is equally destructive of the possibility of social order. (29) It is not so much that a middle road must be found, as that a new social understanding of the meaning of power and authority must be formed.

We offer no simple formula for such a new understanding. We believe that it must not continue to be based upon the (masculine) capacity for violence and the political legitimation of coercive force.
What we have in mind is closer to the Ghandian concept of satyagraha, truth force, given a Western coloration. (30) The new power struggle which we envision is not to be limited to the confines of the established debate among vested political interests. Rather, the struggle must be at the level of a people's movement. It involves the recognition that the needed changes in people's lives will not be imposed from above, and that the power which counts is not the power of domination, to control nature and lives of others. Rather it is the power to control one's own life collectively and individually. (31)

For the aged this means the recognition of the severe limits of age-centered advocacy politics within the pluralistic context. Aging must become everyone's concern because aging is synonymous with living. It means "youth and aged together," as the Grey Panthers have said, promoting a people-centered rather than a power-centered society. But slogans such as these are not enough. In the life-world of people and institutions it means the building of economic and psychological independence from centralized control by strengthening self-help and mutual-help networks among all people. It means reducing dependence upon the mysteries of expertise, calling upon the under-utilized resources of youth and old age whose talents have been systematically defined as surplus. As we shall suggest below, this leads not simply to the expansion of voluntarism but an expansion of the meaning of work.

2. **Social problems derive primarily from problematic social conditions.**

The problems associated with old age,
the most pervasive of which are poverty, loneliness, and a sense of uselessness, can in large part be resolved by social-institutional changes rather than by changes demanded of the individual. We would suggest that physical well-being, which is intricately intertwined with the maintenance of a physically, socially, and mentally healthy life style, is not primarily dependent upon medical care. Poverty is not usually overcome by welfare payments and loneliness is not significantly reduced by counseling.

One of the types of social institutional change that is likely to be most productive for the reduction of problems associated with aging involves a major restructuring of the normative life cycle. (32) This means the redistribution of leisure, learning, work, and rest in a different sequence along the life course. Thus, opportunities for temporary retirement might be provided to parents when their children are infants. Work opportunities might be created for adolescents who do not care to study. Study leaves are offered to workers who are suffering from burn-out, and employment is made available for those who are older and do not care to remain at leisure.

The sequences of the normative life cycle derive from an era when life expectancy was much lower, when most women remained in the home, and old age was a rarity, when men were expected to hold one job for a lifetime, and only a minority of the population were educated beyond grade school. A major restructuring of activities and sequences along the life course is likely to make many of the current problems associated with not only old age, but also youth and middle age, obsolete.
3. **All human beings are equal in worth regardless of their capacity to produce or their socially ascribed status.**

A full agreement with the principle of human equality as carefully defined by the English social philosopher, R. W. Tawney, requires not only that all persons are regarded equal, regardless of sex, race, creed, or national origin, but also that they have equal civil, human and material rights, regardless of their relationship to the means of production. (33) Equality constitutes a cognition of others which neither unjustly glorifies them, nor is demeaning. While not a simple concept, its aim is to require the equal distribution of rights and the equal allocation of responsibilities among all citizens.

For the aged (and for all others who are not currently attached to the labor force) the application of the ideals of equality cold lead not only to the elimination of the guilt which is usually associated with this allegedly inferior status, but also to the provision of an adequate wage. The meaning of work could be changed so as to include multiple new activities such as cooking, housekeeping, caring for family and neighbors, and giving joy to others. (34) There is no reason wages cannot be paid for these activities. Such a redefinition of work would necessitate a societal commitment to full employment as a first priority. Our economy which is increasingly oriented toward the exchange of information and the provision of services may have a better potential of meeting this goal than the rapidly declining industrial economy. (35)

4. **To be human is to be a social being, dependent upon and responsible for the**
lives of others. To live is to share life.

Human beings are biologically, economically and socially dependent on one another. Not only economic goods but also knowledge, language, and consciousness itself are dependent upon communication with others. The social Darwinist world view of the survival of the fittest which has been used to justify self-aggrandizement might be replaced by Kropotkin's theory of the survival of those who cooperate. (36) Rather than assuming that all of the world's goods are limited, and therefore subject to the zero-sum rules of economics, many of the most valued goods are unlimited, subject to multiple-sum rules, e.g. love, knowledge, health, oy friendship, etc. The more you give, the more your and we and all of us have.

From this perspective the contemporary system of social welfare wherein everyone, including those who are aged, is expected to aim for maximum self-sufficiency and independence from others can be viewed as a unique, historical aberration. An alternative system would be based upon the assumption that all persons, regardless of age, are entitled to material and political rights, not because they are worthy and have worked hard, not because they are diseased or disabled, but because they are human, and all human beings need each other to maintain their humanity. This includes not only the right to medical care, of food, or housing, but also the right to give and to share of themselves with others. Within the newer cohorts of predominantly middle-class aged, maintaining opportunities to give and share knowledge, wisdom, talent, love, and friendship is likely to be even more significant than the opportunity to
receive. (37)

5. **It is primarily cultural/historical knowledge rather than the capacity for technical mastery over nature which grants coherence and meaningfulness to human existence.**

Rational human action requires more than technical competence and includes a vision of, and a compulsion to create the good. (38) Such a vision is invariably a product of the history and culture of a people. Those who can only with difficulty identify with it because they believe that they are "self-made" and that the past and future are irrelevant to their being in the present, may be risking their own sanity. (39)

For all persons, i.e. all of us who are aging, such an understanding permits of a cyclical, rather than an undirectional view of life. Birth, growth and death all serve to mark the rhythms of circular time. People, generations, and civilizations come and go. The solutions to today's problems become the problems for tomorrow's solutions. The frontiers of knowledge are not all before us. We are not unquestionably wiser than our forbears, and in the past life was not uniformly squalid. Our own life makes sense only as an extension of the lives of others, those with whom we share our lives now, those who came before us, and those who will follow. In short we would emphasize that life and living is sacred, and only unimportantly functional.

The practical implications of the adoption of such an alternative conception would lead to the development of social institutions which are maximally age integrated. There would remain little
justification for maintaining educational institutions and welfare programs which utilize chronological age as the primary criterion in the allocation of benefits to individuals. The classification of adults by age would in many settings become totally irrelevant.

Aside from the major implications of such a changed view of the self in the world and in history, this alternative conception might rid us of such notions as the obsolescence of the aged, the fearfulness of death, and the idea that time is our master. This would enable us to cease committing major societal resources toward the control of death, and instead focus on the never-ending spiritual need to celebrate life, through music, art, science, and poetry.

Implication for change in the profession of Social Work

We have suggested a series of alternative conceptualizations, ideas affecting the way we think about time, work, power, and reality. We have asserted that change on the institutional level, change that can genuinely lead to the alleviation and prevention of social problems, must include changes in societally defined meanings. In this final section, our purpose is to touch briefly upon how these ideas might impact upon the profession of social work.

Social workers who are in substantial agreement with the critical approach which has been developed in this paper are likely to want to engage in any or all of the following actions:

1. Join in exposing the destructive consequences of present belief
systems as they impact upon individual lives, upon social institutions, and most specifically, upon the system of social services intended to meet the needs of the elderly.

2. Expand upon the types of alternative conceptualization which we have begun to suggest and join with others who are like-minded in creating a new language of human welfare.

3. Work toward the experimental institutionalization of these meanings in new, innovative settings.

Effective engagement in actions of this type involves a significant level of personal risk. Most of us inconsistently try to maintain ourselves in this world, while simultaneously investing important energies in giving shape to the other world, the world that should be. The trick is to try to be what we want to become, individually and together. But in this effort we are easily sidetracked, mainly because there is an inconsistence between what we intellectually know, and what we feel. The rationalizations are many. We get coopted into serving what are defined as the pressing needs now. We have to be "realistic" despite our knowledge that in helping sustain the limits of realism we become both perpetrators and victims of injustice. We yearn for an elusive personal security, and for what is absurdly called success. In short, full engagement in challenging the ITS includes a threat to our status and our claimed rights as professionals.

Social workers, like other professionals, are in an important way an
elite group in contemporary society. They participate in "mythmaking" as it affects their area of expertise, from a position of authority. (40) As elites, they help to structure meanings, language, and expectations within the society as a whole, and most especially among their clients. (41) Thus, the authority to designate a particular interventive act as helping, rather than as oppression, and the right to define categories of deviance are largely granted to social workers as an implicit professional right and responsibility. As Edelman cogently suggests, the language of helping that social workers use is a political language and its utilization in practice is a political act. (42)

We would therefore suggest that the political resources that accompany the professional status of social workers be harnessed to bring about change in both the social welfare system and the profession itself. We look forward to the historical evolution of the post-professional helper.

Post-professional social work practice is overtly political. It does not attempt to hide behind the skirts of what is neither an objective scientific knowledge base nor a value neutral technology. Its primary loyalty is toward those who are systematically disadvantaged, not to particular institutions, methodologies, agencies, or professional associations. Post-professional will be wary of classification and categorization of individuals by age, sex, race, or disability. They recognize that within this society, shaped by this ITS, distinctions such as these are easily used to pit one disadvantaged constituency against another. They know that the truly needy includes nearly everybody. Post-professional practice never ceases to be
self-critical, recognizing that both traditional professionalism as well as the types of practice that are likely to succeed it are to be understood only within their historical and cultural context: they are meaningful only within their particular space and time. (43)

Thus will the continued exploitation of talent, the genius, the experience, and the commitment of social workers in the service of an unjust social order be gradually converted to a new, authentic form of practice. Those who would challenge these views because they appear to be hopelessly utopian and unrealistic should know that every argument for realism, in the final analysis, is but an argument for the prevention of change.

As for the field of aging, this is an area in which great opportunities lie before us. Politically, this opportunity derives from the fact that all human beings are included; the potential constituency is everyone. Social workers tragically share with other helping professionals, and with the society as a whole, negative attitudes toward aging and old age. (44) They must start there, changing not merely their own attitudes, but also, and more fundamentally, the basic meanings for the entire society. As a new ITS becomes more fully developed and understood, we can expect social workers to evolve different approaches to, for example, health as distinguished from medicine, regeneration as distinguished from retirement, lifetime wages as distinguished from OASDI. If these efforts and others like them are successful, they may lead to the creation of new people's movements including all of us, young and old, who share in this vision of power for liberation not domination, work for fulfillment not exploitation, life
and service to meet the needs of people not for profit, and knowledge to re-endow the world with sacredness, not for utility. (45).

NOTES

1. We distinguish, of course, between social problems and private troubles.


4. The maintenance of conceptual coherence is achieved by means of what Peter Marris calls the, "conservative impulse." This is not political conservatism but rather a cognitive process within which new experience is adapted to the existing thought structure. See Loss and Change, N.Y., Anchos, 1975, p.4.

5. Berger and Luckmann, op.cit., p.64.

6. Frances Piven and Richard Cloward,

7. The concept of turbulent environments was developed by F. E. Emery. Futures We're In, Canberra, Australian National University, 1974, pp. 19-30.

8. Fundamental changes in ITS may also result from political revolutions, though we are inclined to believe that, if such is to be the intended effect, the cognitive changes must substantially precede the political changes. This is one way to distinguish between revolutions, (which are accompanied by cognitive changes) and rebellions (in which there is merely a playing of "musical chairs").


12. Charles E. Lindblom, The Intelligence of Democracy, N.Y. Free Press, 1965; Edward C. Banfield, Political Influence N.Y. Free Press, 1961; also see Norman Birnbaum, on the Possibility of a New Politics in the West, Beyond the Crisis


16. Paolo Freire discusses a similar phenomenon among the peasants of Brazil. "So often do they hear that they are good for nothing, know nothing, and are incapable of learning anything—that they are sick, lazy and unproductive—that in the end they have become convinced of their own unfitness. . . " *Pedagogy of the Oppressed*. N.Y., Seabury, 1970, p. 49.


22. See. Carol Estes, *The Aging Enterprise* San Francisco, Josey Bass, 1979, p. 11f. We define oppression as the
treatment of human beings as if they are objects.


29. Walter Lippman highlighted this issue as the central dilemma of liberalism more than fifty years ago. *A Preface to*


31. The authors, three American males, have been influenced by the literature of the contemporary women's liberation movement. Note that liberation is viewed collectively. See especially, Susan Griffin, Woman and Nature, N.Y. Harper, 1980.


34. Work in America, an NIMH product whose publication was aborted by the Nixon administration, first raised these issues. Cambridge, MIT Press, 1963; also see, Shimon Gottschalk, Fifty Years of Moosehaven: The Lessons of Experience, The Gerontologist 1973.

35. See, Barry Bluestone, The Deinstitutionalization of America, N.Y. Basic Books; also, Allan Wolfe, America Impasse, Boston South End, 1981.

36. Pitor Kropotkin, Mutual Aid,
This is a classic example of ideology in science. Both T. H. Huxley, the follower of Darwin, and Kropotkin, the two major antagonists in this turn-of-the-century debate, based their arguments on the same data.


38. This idea is almost as old as the Western intellectual tradition itself. For Plato, in The Republic, rationality is identified with "the good".


42. op.cit., pp. 57-76.

43. The concept of post-professionalism which is introduced here requires further expansion. A separate paper on this topic is in process.

44. R.M. Coe, Professional Perspectives on
This paper reports the results of a national comparative study of nursing home ombudsman programs for the institutionalized elderly. Of recent origin, patient representative programs have received little critical assessment as to their success in improving the quality of life of America's most vulnerable aged. At the same time, anticipated increases in the number of institutionalized aged coupled with current austerity measures in the health and human services underscores the present and future need to design effective and efficient monitoring/advocacy mechanisms to prevent abuses in long stay institutions. The paper focuses on a de-
scription of the current configuration of state and local sector roles and responsibilities in carrying out long term care monitoring services. Based on study findings, proposals are presented for suggested program changes and innovative strategies for coordinating state and area level advocacy initiatives.

Introduction

The nursing home industry is faced with an impending crisis. Federal budget cuts coupled with the current administration's philosophy of reducing the scope of regulatory policies in the long term care sector portends potentially negative consequences for the institutionalized elderly. The federal government contends that relaxing or eliminating many of its own regulations on the nursing home industry will reduce costs and paperwork and give long term care facilities greater operating flexibility. It is claimed that this can be achieved without jeopardizing the rights and safety of patients (New York Times, March 4, 1982). Others, however, are less convinced. Opposition to current deregulation initiatives transcends professional disciplines and traditional biases of particular aging interest groups. Such diverse associations and organizations as the American Medical Association, the American Nurses Association, the National Association of Social Workers, the National Citizens' Coalition for Nursing Home Reform, the American Association of Retired Persons, Americans for Better Care and the American Association of Homes for the Aging have all voiced serious concern with the current anti-monitoring climate in Washington. More recently, even Richard S. Schweiker, Secretary of Health and Human Services, has also expressed disapproval of
current initiatives by the Reagan Administration (New York Times, March 20, 1982). These groups and others have suggested that nursing home self-regulation may eventually lead to decrements in the level of care provided the long-stay facility resident.

In light of what seems to be inevitable reductions in Federal long term care oversight responsibilities, alternative mechanisms for patient redress in institutions gain significance. Of particular relevance may be the set roles and responsibilities that state and local advocacy bodies will have to assume in the field of institutional brokerage.

Study Methodology

A two phased study of local and state level long term care ombudsman programs throughout the United States provides data as to the feasibility of non-regulatory community empowerment strategies in nursing homes (Monk and Kaye, 1981: Monk, Kaye and Litwin, 1982). Of particular research interest was the issue of the form institutional mediation has taken in the recent past, and the form it should take in the future. Potential variation in state wide versus local programming efforts was anticipated. The relative dearth of data available on the preferred course of development and the actual effectiveness of the ombudsman function in long term care at various levels within the individual states spurred this aspect of the study.

The research was conducted during the period January 1980 to December 1981. It followed an ex post facto survey design. No appropriate base line data or prior measures existed at the inception of the research to allow for panel or other long-
itudinal study designs. Data collection during the second phase (on which this paper is based) stemmed principally from structured questionnaires mailed to targeted respondents. Semi-structured interviews conducted during observational on-site visits to nine selected state programs supplemented the questionnaire data. Additional non-obtrusive data in the form of reports and other printed material solicited from the state ombudsmen further illuminated the primary data derived from the questionnaire.

Two foci of inquiry were encompassed in the study design: measurement of perspectives on the current state of the nursing home ombudsman program in each state, and consideration of varying views concerning the future design of such programs. Two major groups of respondents were addressed: the state nursing home ombudsmen and representatives of the long term care delivery network.

The long term care network was composed of state level representatives from the following:
1. Older Americans Advocacy Assistance Programs (Legal Service);
2. State Units on Aging;
3. State Departments of Health;
4. State Departments of Welfare;
5. State Associations of Not-For-Profit Long Term Care Facilities;
6. State Associations of Proprietary Long Term Care Facilities; &
7. State Community Action Interest Groups for the Elderly.

The total study N was 265 or 74.0 percent of all respondent group categories. Findings presented in this paper are based on responses received from state ombudsmen only.
Ombudsmen and Ombudsman Programs

The ombudsman, which originated in Scandinavia, was first conceived as an independent, impartial officer of the legislature who responded to complaints by citizens about public maladministration. The function of the ombudsman was to investigate such complaints and to recommend appropriate avenues for redress. The power of the position, however, was informal, rooted in the prestige of the officeholder, and effected by means of persuasion. The ombudsman was not empowered to reverse or revise administrative action (Rowat, 1965; Gellhorn, 1967).

The nursing home ombudsman program has evolved over the last decade from at least three separate mandates. President Nixon's 1971 eight point plan for improving nursing home care resulted in the first model ombudsman projects. They remained operational until 1975. Subsequent program development funds were provided through Administration on Aging discretionary grants issued between 1975 and 1978 to any state desiring to implement a nursing home ombudsman program. Finally, the 1978 amendments to the Older Americans Act required all states to establish a long term care ombudsman program.

Findings

Findings presented below will serve to summarize differences in experience between state level and local level long term care mediation programs in the areas of: 1) nursing home problems and complaints; 2) issue effectiveness; and 3) program impact.

1) Nursing Home Problems and Complaints
Two scales measuring long term care issues and long term care facility complaints were constructed and found internally reliable. Their application serves to measure state ombudsmen's perception of the nursing home mediation program's current problem focus, and to identify issues and complaints which are of foremost concern.

Table 1 summarizes the means, standard deviations and relative internal rankings for each of twelve long term care issues. The table summarizes the state ombudsmen's perceptions of the frequency of addressing each issue and of the relative difficulty in addressing them. As can be seen, a general trend emerges from the data.

The five most frequently addressed issues at the state level—1) residents' rights; 2) consumer education for long term care; 3) nursing home regulation/enforcement; 4) resident abuse; and 5) alternatives to institutionalization—were all among the issues perceived as less difficult to address, with the exception of nursing home regulation/enforcement. On the other hand, the six least frequently addressed issues—12) relocation trauma; 11) resident participation in facility governance; 10) Medicaid discrimination; 9) boarding home standards; 8) mental health needs of long term care residents; and 7) the upgrading of nursing home staff—were all among the issues perceived as more difficult to address, with the exception of mental health needs of long term care residents.

The data thus suggest two possible explanations concerning the ombudsmen's perceived problem focus. It may be interpreted that ombudsmen came to perceive those areas of most frequent contact as
less difficult to handle, or, conversely, they indeed tend to concentrate more activity in areas that are objectively less difficult to address. It should be noted in addition that the issues identified as those most frequently addressed are the very areas with which state ombudsman activity is associated: rights, regulation and public education. Those issues perceived as less frequently addressed (and more difficult to address) involve areas peculiar to long term care. Hence perhaps the greater difficulty of an ombudsman mechanism in its initial development to address and resolve specific long term care problems.

An analysis of the frequency and perceived difficulty of addressing complaints at the facility or local level reveals the opposite trend: with the exception of one item, there seems to be a general positive correlation between the frequency and difficulty of addressing long term care facility complaints. Table 2 summarizes these data.

The problem or complaint found to be most often addressed by the ombudsman program is the quality of food and nutrition in the long term care facility. This complaint is seen by ombudsmen to be one of the least difficult to address and resolve. The remaining complaint items reveal the opposite trend. The more often a complaint is addressed, the more difficult it is generally seen to be. The following complaints, addressed in descending order of frequency, were found to constitute the four most difficult complaints to resolve—health care, protection of personal property, administration and personal care. Personal allowances and facility sanitation complaints are addressed less often and
perceived to be less than moderately difficult. Environmental safety as a problem is perceived to be the least difficult and the least frequently addressed of all the complaint areas listed.

The findings, therefore, suggest opposing trends at the state and local levels in the relationship between perceived frequency and difficulty of addressing issues and complaints. Consideration of state level issues reveal a negative correlation between perceived frequency and difficulty while attending to local level complaints reveals on the whole a positive correlation between perceived frequency and difficulty. While the data did not allow for examination of causality, support is nevertheless presented for differing trends in perceptions of local and state level ombudsman activity. The next two sections of findings examine the state and local differences hinted at in the findings to this point. Comparative perceptions are presented by state ombudsmen of ombudsman program effectiveness and impact at the state and local program levels.

2) Issue Effectiveness

Table 3 summarizes the comparative analysis of a selected number of advocacy issues measured across state and local levels. The analysis clarifies in which issue areas the respective program levels have achieved significantly greater effectiveness.

In terms of the relative ranking of responses, the state level ombudsman program was perceived to achieve the greatest effectiveness in the area of provision of information for legislators and long term care program planners, closely followed by
their capacity to assist in the protection of resident rights. Moderate success rates were reported for the establishment of a complaint resolution mechanism, the alerting of nursing home staff to patient needs and the establishment of better relationships between the nursing home and the community. Less than moderate effectiveness was indicated for the state level ombudsman program in proposing changes in nursing home policies and regulations.

The same issues considered for effectiveness at the local ombudsman program level reveal both differences and similarities. Greatest effectiveness was realized in the alerting of nursing home staff to patient needs. Assisting in the protection of resident rights, on the other hand, retained its second place position as noted for state level ombudsman programs. Efforts at establishing better community/nursing home relations and complaint resolution mechanisms were seen to have been moderately successful. The provision of information and making policy proposals, on the other hand, were viewed as activities less effectively carried out at the local level.

Comparative T-tests showed significant differences in the perceived effectiveness rates when viewing selected issue areas at both state and local levels. The nursing home ombudsman program was found to be significantly more effective at the state level in proposing changes in nursing home policies and regulations, and in providing information for legislators and long term care program planners, than at the local level. Conversely, the local level ombudsman program was viewed as significantly more effective than its state level counterpart in alerting nursing home staff and administration to patient needs. The
remaining issue areas were perceived by the respondents to be equally well addressed at both state and local levels of the nursing home ombudsman program.

3) Program Impact

A similar analysis conducted for areas appearing in a larger scale of program impact further clarifies which dimensions of monitoring are better addressed at the local level. Table 4 summarizes the means, relative ranks, standard deviation and comparative T-tests for four areas of possible impact. As the table indicates, state ombudsman respondents assigned identical patterns for the ordering of impact items at both the state and local levels of the ombudsman program. Increasing the accountability of staff in nursing homes was seen to be the area most positively impacted upon at both program levels, followed by upgrading the quality of nursing home/community relations, staff/resident relations and relation among staff in nursing homes.

Comparative T-tests point, however, to significant differences in the relative magnitude of impact at the respective program levels. Specifically, the local nursing home ombudsman program was seen to achieve significantly greater impact in improving the quality of nursing home/community relations and staff/resident relations than the state level program. The accountability of staff actions in nursing homes on the other hand, was seen to be positively impacted on at equivalent levels at both state and local levels of the nursing home ombudsman program.

The findings from the two tables suggest, therefore, that areas related to the establishment and enforcement of
patient rights, including legislative influence, are most effectively addressed and impacted on at the state level. The more immediate, interpersonal issues emerging out of the day-to-day operations of the long term care facility, on the other hand, are seen to be most successfully addressed by the mediational interventions of a local ombudsman program.

Conclusions

In looking toward a future scenario for nursing home monitoring programs, and based on study data, two divergent models can be sketched here. They have direct implications for program planning at the state and local levels, extending well beyond long term care ombudsman projects specifically.

Figure 1 presents in summary fashion the range of relevant patient representation program dimensions and their respective characteristic features in each of the two potential program models (state-based and locality-based). It should be noted that the dimensions and characteristics are dichotomized as exclusive "ideal types" for the sake of analytic comparison. In all likelihood, however, each dimension constitutes a continuum of choice for which the respective program pathway components serve as end points. Thus a given state-level or community-level institutional mediation program may be situated at variant points on the continuum for each program dimension. The reasons as to why a given program is placed at one rather than another point along the continuum are considered subsequent to presentation of the pathway models. Implications for the collective selection of characteristic program dimension choices will also be addressed.
As can be seen from Figure 1, state level nursing home advocacy programs may best develop along the path of a "patients' rights" program model, whereas local level initiatives would do well to reflect a "quality of life" oriented mode. Each has its concomitant cluster of programmatic characteristics. Sets of such components may be grouped within three dimensions: 1) program philosophy; 2) external organizational factors; and 3) internal management factors.

A summary statement of the state level "patients' rights" model reflects an advocacy program which is statutorily empowered government based, statewide in scope, formalistic in its organizational relations and established and funded through state legislation. The basic approach of the "patients' rights" model entails a watchdogging focus, partisan on behalf of long term care consumers and geared toward systemic changes. Such programs are more likely to be staffed by professionals -- specialists in legalistic and long term care regulatory matters -- who engage in joint efforts with public interest law representatives and citizens' organizations. The "patients' rights" advocate utilizes complaint statistics compiled through formal record keeping to advocate impact upon those areas of recurring complaints.

The "quality of life" program model, on the other hand, is more often than not operationalized by a smaller scale, community embedded, voluntary organization which works through its own fundraising efforts and gains informal bases of cooperation at the long term care facility level. The basic approach of this model may be said to be a collaborative one in which volunteers work with facility personnel to support individual nursing home patients
who have expressed some difficulty. Such volunteers are recruited through their own strong desire to aid others, and are sustained by peer support and intensive supervision from local ombudsman program staff. The focus of the "quality of life" ombudsman is the improvement of the day-to-day life of nursing home patients by ameliorating interpersonal conflict and individual, concrete conflicts with facility staff, or with other resident/patients.

What determines whether a given nursing home advocacy program will: a) develop in the predominant direction of one pathway or the other; b) select a varied mix of components from each path model; or c) attempt the simultaneous operationalization of both models for patient representation services? Clearly there is no single formula to predict a specific outcome for a developing long term care advocacy program. Variations can be seen to occur due to the degree of financial and legislative resources made available to the evolving service, the scope of necessary coverage and other factors that may or may not be influential in a particular state. A selected list of such factors that shape decision rules and which in turn determine program choices immediately follow. Additional factors invariably can and should be identified for each state and locality engaged in ombudsman and other patient representation-type services. The factors identified here include:

1) the funding level and/or presence of alternative sources of financial support;

2) the size of the institutionalized aged population:

3) the scope and configuration of the long term care system;

4) the influence of special interest
groups;
5) the status of enabling legislation;
6) the status of alternative state regulatory and monitoring systems;
7) community norms/public attitudes;
8) predilections of the state's chief executive;
9) the history and severity of past abuse in long term care; and
10) the state population -- size -- ethnicity and rural/urban composition.

In sum, two major programmatic types have been identified and described. They respond to the presumed capacities of state level and community level advocacy initiatives. Factors which may guide the selection of program development emphasis have been suggested. The two program pathways outlined above are equally legitimate courses for long term care advocacy programs to follow. Even so, conditions may dictate the appropriateness of one strategy of the other regardless of geographic scope.

It is also conceivable that state and community programs may follow both orientations to programming at certain points, depending on the types of long term care grievances elicited. Indeed, long term care advocacy remains a highly variable art. It will be useful for patient representatives to maintain ongoing lines of communication with their counterparts operating along both pathways to facilitate the sharing of effective interventive strategies.

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IMPROVING THE MENTAL HEALTH CARE
DELIVERY SYSTEM FOR ELDERLY
NURSING HOME PATIENTS

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ABSTRACT

It is well known that the mental health care delivery system for aged nursing home patients is inadequate. Based on information gained from face to face interviews and from a mail survey of nursing home personnel, the range and usefulness of the resources and services available for mental health care in nursing homes are identified. This information is then used to derive recommendations for the development of a more effective mental health care delivery package for nursing homes.

MENTAL DISORDERS IN NURSING HOMES

Dimensions of the problem.

The diagnosis of mental disorders remains an inexact art with very low reliability (e.g., Rosenhan, 1973, 1975; Hoffman, 1982). Consequently, figures on the incidence and prevalence of different types of mental disorders can be treated only as 'best guesses.' Estimates of the
percentage of nursing home residents with mental disorders, therefore, range very widely from study to study, depending primarily on how many of the psychiatric classifications officially recognized by the American Psychiatric Association are counted and on the skills and training of the diagnosticians who make the diagnoses. One national estimate sets the figures at about 58% and 19% respectively for the prevalence of organic brain syndromes and other mental disorders among nursing home patients (1973-74 National Nursing Home Survey, cited in Glasscote, 1976:25). Based at least on these estimates, it would appear that about four out of every five patients in the nation's nursing homes are in need of mental health care services. The dimensions of the need for mental health care delivery in nursing homes are therefore very large. It is well known, however, that the mental health care delivery system in nursing homes is woefully inadequate (eg., Stotsky, 1970; Group for the Advancement of Psychiatry, 1971; U.S. Subcommittee on Aging, 1971; Kahn, 1975; Glasscote et al., 1976,1977; U.S. House Subcommittee on Health and Long Term Care 1976; Berkman, 1977; Gordon and Gordon, 1981; and Butler and Lewis, 1982).

Our concern in this paper is in identifying the range and effectiveness of resources and services that are being used for mental health care delivery in nursing homes. Though some of the resources and services to be described in this report could be used to care for all officially recognized mental disorders, we shall limit our discussions here to their use for only the severe disorders of organic brain syndromes (hereafter abbreviated as OBS) and functional psychoses (hereafter abbreviated as FP). Both of these disorders, particularly OBSs, are
widespread among nursing home patients.

**OBS and FP**

OBSs are mental disorders attributable to physical impairment of the nervous system as a result of injury, disease, or a number of other factors. The most common diseases associated with OBS among the elderly are Alzheimer's and arteriosclerosis. OBSs resulting from these two diseases are called chronic organic brain syndromes and are not at present curable. Other conditions, however, such as infection, drug abuse, malnutrition, heart disease, stroke, and so on can produce temporary states of OBS known as acute organic brain syndromes. Since these conditions are sometimes reversible or can often be controlled, a careful physical examination is needed to determine the cause of all observed symptoms of OBS. Only in this way can the reversible conditions of OBS be identified and corrected. Reversible conditions producing temporary symptoms of OBS, however, may also appear after a condition of chronic OBS has been diagnosed, resulting in a compounding of mental disorder symptoms. Continuing follow-up physical examinations are therefore needed even after a chronic OBS diagnosis has been made so as to identify and correct reversible conditions when they occur.

Symptoms of OBS include impairment of memory, intellect, judgment, orientation and emotional control. Psychotic symptoms, such as hallucinations and delusions, may be a part of the OBS or may represent a separate, 'functional' mental problem requiring separate diagnosis and treatment. Because of the inexact nature of the diagnostic process, however, some functionally psychotic residents may be

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diagnosed as having an OBS, thus leading to inappropriate treatment (cf., Hoffman, 1982). Worse yet, since no effective treatment for OBS exists, these misdiagnosed patients may receive no treatment at all. This situation is especially likely if the patient is elderly, since deviant behaviors among the elderly, in contrast to other age groups, are commonly attributed to senility.

Symptoms of functional psychoses (FP) are of two major sorts, cognitive and affective, and include hallucinations, delusions, disordered thought, inappropriate affective display, depression, and mania.

Unfortunately, there is no known cure for chronic OBS or for FP. The state of the art of present treatment remains largely maintenance in nature, with emphasis placed on keeping the patient at the highest level of functioning possible and enjoying the highest quality of life as possible. The prognosis is for indefinite long term care.

**Housing the mentally ill**

As a primary health care provider for the OBS and FP patient, nursing homes, as noted above, have been criticized frequently for the amount and quality of mental health care they are able to provide. Insufficient and poorly trained staff, high turnover, low pay, and low morale have all been cited as deficiencies affecting the quality of mental health care nursing homes can deliver. A good deal of the problem, however, stems from the fact that nursing homes were never originally intended to be homes for the mentally ill, but have been pressed into this service by the deinstitutionalization movement.
The passage of Medicare and Medicaid reimbursement funds in the 1960s made it financially possible for an explosive growth to occur in the number of nursing homes nationwide. This growth complimented and was made necessary by the wholesale deinstitutionalization of a very large numbers of mental patients from state facilities. Put simply, the patients had to go somewhere, and if relatives were unwilling to take them into their homes, the patients ended up in nursing homes, boarding homes and homeless on the streets. The result has been that the large state institutions for the mentally ill have been replaced as mental health care providers for many patients by the nursing homes, which are "little community institutions." Glasscote (1976:3), for example, notes that 40% of the elderly released from the state mental health hospitals between 1961 and 1973 were transferred directly to nursing homes. Since the deinstitutionalization movement began, many mentally ill patients who would have gone to the state mental health hospital now are diverted to nursing homes. Again, this is especially true of the elderly mental patient.

Since the housing of mental patients in nursing homes is possible largely as a result of the Medicare and Medicaid programs, it is important to note how the regulations of these programs affect mental health care delivery to those patients. Of the regulations accompanying these new federal funding programs, those of Medicaid are the most important at present in their impact on the quality of mental health care in nursing homes. The minimum health care requirements specified and reimbursed through Medicaid for staffing and services in nursing homes have become, with few exceptions, the maximum staffing patterns
and services nursing homes have been able to provide (Glasscote, 1976:82). These regulations do not provide reimbursement for a mental health professional to be on the staff at nursing homes, nor are requirements made that nurses have psychiatric training. Furthermore, most states do not allow community mental health centers to bill Medicaid directly for services rendered to nursing homes.

Faced with a very large number of mentally disordered patients and lacking the staff, skills, knowledge and Medicaid reimbursement to provide high quality care to these patients, nursing home personnel have as matters of occupational commitment and of concern for their patients, sought out and made use of a variety of ad hoc mental health resources and services. As noted above, our study was designed to identity and evaluate the effectiveness of these resources and services and to recommend how they could best be put together into a more effective package for improving mental health care delivery to aged nursing home patients.

THE STUDY

Following an extensive literature review, preliminary interviews were conducted with staff members at several nursing homes in an urban area. These interviews were unstructured and centered on the issues involved in the provision of mental health care to nursing home patients. A wealth of qualitative information was obtained at this point in the study about the variety and effectiveness of resources and services being used for mental health care of aged nursing home patients. In order to get more standardized estimates of the usefulness of these diverse resources and
services, a structured questionnaire was developed from this initial information and was filled out by the staff in eight of twenty-five nursing homes in the same urban county. The nursing homes represented by this sample ranged in size from 60 to 272 beds and included both intermediate and skilled care services. All but one of these homes was proprietary.

The quantitative estimates that were obtained from the questionnaire conformed fully to the qualitative observations that were made in the earlier interviews, lending convergent validity to our findings. These findings were further validated by being presented at a local workshop for nursing home and community mental health center personnel. Discussions with the workshop participants provided additional evidence of the accuracy of our basic findings concerning the range and usefulness of the various resources and services for mental health care in nursing homes. Dialogue with these workshop participants also confirmed the viability and importance of our recommendations for improving the organization of mental health care delivery to nursing home residents.

Estimates obtained from our questionnaire indicate that of all the residents in the nursing homes in our sample, 55% and 6% respectively had a diagnosis of OBS or FP. That is, two-thirds of the patients have a severe mental disorder. These estimates no doubt underrepresent the true prevalence of severe mental disorders among the patient population. It is clear, nonetheless, that there is an extensive need for the delivery of mental health services to patients in the nursing homes in our sample.
The major mental health resources and services that were being used for these patients are listed in Table 1 by order of the frequency of their reported use. The resources included attending physicians; family and friends of patients; community mental health center; city, county or state agencies; volunteers (other than family); local hospitals; ministers; and nursing school traineeship programs. The services included reality orientation, psychotropic drug therapy, remotivation therapy, group psychotherapy, individual psychotherapy, behavior modification, electroshock therapy, and milieu therapy. The frequency with which each resource was used ranged from all eight nursing homes (100%) using attending physicians to no homes (0%) using local nursing school traineeship programs. The estimated percentage of all residents receiving each service ranged from 52% for reality orientation to none for electroshock. These estimates were provided by the directors of nursing at the various facilities. Also obtained from directors of nursing were ratings of the usefulness of each resource and service for mental health care. We shall provide a summary discussion of the effectiveness of each resource and service in turn and then draw out implications for how mental health care delivery in nursing homes can be improved.

MENTAL HEALTH RESOURCES

Attending Physicians

The most used resource for mental health care in nursing homes are attending physicians. It is ironic that family physicians or physicians who are assigned to patients are the principal mental health resource for nursing homes, since these
physicians generally have very little training in mental health care (see Goldberg, Latif and Abrams, 1970:221; and Hoffman, 1982). It is no doubt for this reason that they are rated by directors of nursing as being only slightly useful in providing mental health care and are used almost exclusively to obtain prescriptions for psychotropic drugs.

Widespread discontent was voiced over the difficulty in getting physicians to come out to see patients. As one director of nursing put it: "Unless I can line up six or seven patients to be seen by a doctor, they generally don't want to come out; they don't feel there is enough money in it to make it worth their while." Of course this criticism is more true for Medicaid reimbursed doctors than for family physicians, but it must be kept in mind that the majority of nursing home residents are on Medicaid.

Physicians were also faulted for failure to seek professional, psychiatric consultation and for failure to provide follow-up evaluation of patients when psychotropic drugs were prescribed (cf., Glasscote, et al., 1976:70-71). Frequently drugs were prescribed over the phone to be used by nurses prn. Several nurses expressed frustration with this since they lacked the training to make judgements about when it is most appropriate to administer the drugs, how long to continue them, what their side effects are, how they interact with other drugs, and what a maintenance dosage given current blood level amounts should be. Blood level tests were rarely done in any case, resulting in what nurses believed were probable over- and under - use of drugs. Follow-up evaluation by physicians of the results from using these drugs were infrequent.
Family and Friends

The second most frequently used mental health resource is family and friends of the patient. As a resource, however, they were not found to be particularly useful. While family and friends could provide a good deal of emotional support to patients by serving as central reminders of the identities they had established in their lives, this support often is not forthcoming.

Nursing home personnel can give examples readily of how family and friends of patients have a big help not only in providing hands-on physical care for a patient, but in helping them to deal with stress, grief, and depression. As one nurse pointed out: "Each patient needs lots of love, and no one can provide the same sort of love to an elderly patient than a son or daughter or grandson or niece can give." By the same token, however, no one can inflict the same sort of emotional pain that a son or daughter or grandson or niece can by failing to visit, or by unkind words or actions. Family fights are a common part of social life, and they carry over into the nursing home setting. Feelings of guilt, rejection, frustration, resentment, and power struggles for family dominance can result in open disputes, cruel remarks, and even physical aggression.

Unfortunately, the staff of the nursing home all too often are left to deal with the unpleasant outcomes of these struggles between patients and relatives. They are faced, for example, with frequent, unfair criticisms from guilt-ridden family members concerning the care provided to their loved ones and with denial of the very real mental and physical problems the loved ones
possess. And they are left in every case to soothe patients distressed over the infrequency of visits by relatives or to pick up the pieces after family fights occur. A domineering daughter of a patient, for example, visited her mother every day, keeping her in a constant state of agitation and upsetting well-meaning staff members as well. Far more common as a problem, however, are the infrequent visitors, who show no appreciation of the hard work put in by the staff to keep mother or dad clean, alert, and as healthy as possible, but who complain loudly about real or imagined deficiencies in service.

**Community Mental Health Centers**

Community mental health centers (hereafter abbreviated as CMHCs) and other city, county, and state agencies are the next most commonly used mental health resources, being used by 5 of 8 (62%) of the nursing homes in our sample. Of all resources, CMHCs received the highest rating for their usefulness for this purpose, while other city, county and state agencies were not rated as particularly useful. We shall discuss the CMHC first and then consider the other agencies used by nursing homes.

One would expect the local CMHC to be the most important mental health resource for nursing homes, and consequently it is surprising at first to find that three of the nursing homes had no relationship with their local CMHC. But even of the five who maintain some level of relationship, in almost all cases the relationship is minimal. The reasons that such relations tend to be minimal or non-existent are too complex to detail here, but at least some cursory observations are needed.
The community mental health movement resulted in the creation of community mental health centers that were intended to provide services to all persons within prescribed catchment areas. In fact, inadequate funding has meant that catchment areas and CMHCs have been created at present for only about a fourth of the U.S. population (Butler and LEwis, 1982:275). Therefore, not all nursing homes have local CMHCs as a possible resource, though those in our sample did. Furthermore, nursing homes generally have found CMHCs to be uninterested in the aged, in OBS, and to be ideologically opposed to nursing home care. Indeed, it was recognition of the continuing failure of the CMHCs to meet the needs of the elderly that resulted in the legal requirement by the Public Health Service Act of 1975 (Public Law 94-63) that federally funded CMHCs make a special effort to reach the aged. As a result of this law, CMHCs began to set aside staff time for geriatric services. But even as of the recent federal deregulation of the CMHCs under President Reagan, many CMHCs still had not met these stipulations by developing aging teams or engaging in much in the way of outreach to the aged. And even those with active aging teams paid little attention to the nursing home resident, in contrast to other aged persons in the community, despite the fact that the aged in nursing homes were easy to find and were very much in need of services.

CMHCs were established under the new mental health ideology of keeping people out of large institutions for long term care and in productive lives in their communities. Nursing homes, as themselves institutions for long term care, violate this cherished tenent. It is not surprising, therefore, that CMHC workers in the four catchment areas of the county of
our study verified in interviews we conducted with them that they considered nursing homes to provide inappropriate environments for the treatment of mental patients. We found among CMHC workers widespread lack of interest in working with nursing homes. But even more important that this ideological opposition to nursing homes is, we believe, the lack of interest by CMHC workers in the elderly as patients and in OBS as a mental disorder. Both the elderly and the OBS patient, and certainly the elderly OBS patient, are largely written off as being bad investments of time, energy and scarce resources and as being unpleasant clients with which to work. Furthermore, we were told again and again that current funding emphases are on the 'young chronic.' The term 'chronic' we found cryptically to exclude OBS; 'youth' ended somewhere in the fifties and definitely by the sixties.

In short, CMHCs have not actively solicited nursing home referrals and have been generally lackadaisical and even uncooperative in providing services to them when asked. The services they offer are generally restricted to patient evaluation and to consultation on psychotropic drug prescriptions when asked. Extensive inservice training for nursing homes had been offered by a CMHC in one of the four catchment areas of our study up until the time that the state cut all funding for consultation and education. Emergency calls were discouraged, and in only one nursing home in the entire county was CMHC staff time provided for regular, ongoing therapy in the form of individual and group counseling (this service was a special project funded by the city and state). Follow-up care and evaluation was otherwise limited or non-existent.
Several directors of nursing told us of the enormous frustration they feel when a patient experiences a severe psychotic episode, or deteriorates to an unmanageable condition, and yet they are unable to get either the local CMHC or the attending physician to come out to do something about it. If CMHC workers do come out, it is usually one, two, or more days later, and they then request large amounts of documentation of the history of the episode. Of course they need as much information as possible to make their best judgement about what to do, but their demands are frequently unrealistic in view of the pressures on time faced by nurses. As one nurse put it, their demands for information: "would require us to be authors, keeping elaborate notes of everything patients do and say, everything their families do and say, and everything we do and say." Furthermore, CMHC workers frequently accuse the staff of exaggerating the problem or, even worse, creating it. Several directors of nursing told us that CMHC workers made them feel that it is they who are "crazy," not the patients. Naturally this does little to facilitate good will by nurses toward the CMHC, nor is it anything but a blow to nursing home staff morale.

As a consequence, CMHCs are rarely called by the nursing home personnel, despite the overwhelming number of mental disorders they must deal with among their patients. They have also learned to call CMHCs for only certain requests, such as drug consultation. Even this is done rarely, however, since it is a billed procedure that requires the initiation and authorization of the attending physician, who, as noted above, is usually not present or adequately oriented to psychiatric care.
Within the context of these very restricted relations with the local CMHC, directors of nursing find what services they receive from the CMHC to be very useful. But in almost all cases we were told that more services were much needed and would be much appreciated. The exceptions were the directors of nursing who had simply run out of patience with the CMHC; as one put it: "We have no relationship with the CMHC and wish to continue the present relationship."

City, County and State Agencies

Under the general heading of city, county, and state agencies, only the State Department of Social Services was mentioned as being in moderately frequent use as a mental health resource, though it was not considered to be particularly helpful for this purpose. The assistance it provides is, for the most part, informational. Direct assistance was occasionally given in dealing with patients who were a danger to themselves or others, in making alternative placement evaluation, in obtaining volunteers and financial assistance, and in providing social worker visits to aid in patient adjustment to the nursing home or in family counseling. Shifting public financial priorities, however, kept these services limited and their continuation uncertain.

Clergy

Ministers, other volunteers, and the local hospitals were used as resources for mental health care by half (50%) of the nursing homes in the sample. Ministers and other volunteers were both found to be somewhat useful for this purpose, tying for second place behind only the CMHC as the most useful of resources. Hospitals, on
the other hand, were found to be only slightly useful.

Clergy can shake some patients out of lethargy and withdrawal, giving them a renewed sense of purpose and hope. They can also alleviate pent-up feelings of guilt, grief, emptiness, and betrayal, feelings that are common among nursing home residents. They furthermore can assist in putting patients back into contact with the dominant beliefs of our culture. They frequently fail to achieve these ends for a variety of reasons, however. And this is why only half of the nursing homes made any use of clergy for this purpose.

Modernday clergy, particularly in Protestant and Jewish sects, are trained more in the intellectual aspects of their faiths, than in aspects which are emotional or people-oriented. Consequently their messages of solace, love, and hope far too often are conveyed via high-sounding pronouncements of distant principles and abstract concepts, rather than through warm physical contact or through honest, immediate expressions of pleasure in being in the presence of a fellow believer. One nurse told us that she found Catholic priests to be better than clergy of other faiths at reaching patients and raising their spirits because they seem more adapted to close, earthy interactions with their parishioners. Protestant clergy, by contrast, often seem aloof and distant, failing to remember names of patients or to give patients a warm embrace. Some nurses found they couldn't even get a local minister to come to the nursing home; as one director of nursing put it: "They are impossible, and I don't know what to do about it." Another said: "They give us the impression of "Who cares'."
Volunteers

Surprisingly, half (50%) of our sample did not use volunteers (other than family or friends) for mental health purposes, though the half who did found them more useful than any resource other than CMHCs. Volunteers can help with activities and with group and individual counselling. They also have the time to provide the extra love and attention to patients that families may not provide and that nursing home staff can give only so much of in view of the limits of their time and emotional energy. Recruiting, organizing and supervising volunteers, however, requires a good deal of time, and nursing homes are often too understaffed to carry on an active volunteer program. The activities and social services directors have their hands full and have neither the time nor usually the training to put together and run such a program. Volunteers are usually adequately available from church, fraternal and educational organizations, but without the capacity to plan and supervise their services, they can provide services that are inappropriate or ineffective for residents, and may end up standing around not knowing what to do, or simply getting in the way of ongoing required nursing activities.

Local Hospitals

The local hospitals were a source of great frustration for many directors of nursing. Only half had any relations at all with local hospitals, and further questioning revealed that these relations consisted almost entirely of emergency hospitalization for acute psychotic breakdowns of residents; other sorts of mental health services from hospitals were very rarely forthcoming. Though four (50%)
of the nursing homes in our sample had found it necessary to seek emergency hospitalization for patient mental disturbances during the past year, only three had formal arrangements with a local hospital to handle such psychotic emergencies. As one director of nursing put it: "I have tried to get a patient admitted to the local hospital, but without success, even for crisis intervention." As another put it: "They refuse to admit or help." And yet another: "It is literally impossible to get any kind of admission for acute psychotic or alcoholic behavior without court orders, actual assault, 72 hour hold, or other procedures requiring too much time to be useful in a crisis situation." Such comments were commonplace in our interviews and questionnaires results.

Nursing School Traineeship Programs

A final resource we asked about, but which had received little usage, was the local nursing school traineeship programs. Though none of the nursing homes in our sample had made use of this resource, we did find a nursing home during our preliminary interviews that had. This nursing home had a traineeship program for local psychiatric nursing students who came into the home twice weekly to provide therapeutic counseling and group sessions for residents with OBS and FP. The nursing personnel at this home found this to be a very useful adjunct to their own services and were quite enthused about it. The did note, however, that it requires a good deal of planning, supervision, time, and effort from their staff to be useful. Also, the usefulness of the students depended a lot on the personal characteristics of each individual student and on the level of supportive instruction given by the local
school faculty.

MENTAL HEALTH SERVICES

The services we identified in our study are listed in Table 1. Here we will discuss the extent of usage and the effectiveness of each.

Reality Orientation

The most frequently used mental health service in nursing homes is reality orientation, with approximately 52% of residents in the nursing homes in our sample receiving it. As the name suggests, the service is intended to bring patients into contact with those basic elements of reality that make social life possible, such as their identity, their geographic location, the date and time of day, the objects in their environment, current public events and past personal histories (see Drummond, et al., 1978). Along with remotivation therapy, group psychotherapy, and behavior modification, this service ranks among the most satisfying of those offered in nursing homes. An additional question asking directors of nursing to rank all services in order of their usefulness resulted in reality orientation being selected first by 50% of our sample.

Two particular advantages of reality orientation are that it requires little training to administer and it can be given continuously as nurses go about performing their usual physical care activities. In fact, all nursing homes reported using it, and some indicated that they used it for all patients. Typical comments are as follows: "Aids and staff are trained to talk to residents and not around or through them"; "It is important to involve the
resident in everything you do and to let him feel that this is his home; "All staff members participate by action and words"; "we have a tape for one patient who keeps asking about important events in her life; the highlights and important events are on the tape for her to play." In all of our face-to-face interviews, we found enthusiasm for reality orientation.

There are some problems with reality orientation, however, as there are with all mental health services for severely and chronically mentally ill patients (see Schwenk, 1979). As noted earlier, the state of the art in mental health services for such patients is largely maintenance in nature and sets as its primary goal that of improving the quality of the patients' immediate life; no dramatic recoveries are to be expected. It is consequently very easy to experience occupational 'burn-out' as one applies the services over and over and over again with little or no sign of patient improvement. Indeed, this is the most common complaint to be heard about reality orientation. As one nurse put it: "How many times can you tell someone what their name is or that you are not 'out to get them' without getting very tired of doing so, getting bored, feeling very, very hopeless or going 'crazy' yourself." Many nurses noted the excitement they felt when a patient suddenly would speak for the first time in months during reality orientation, would suddenly recognize an apple, or suddenly remember his former occupation. This excitement would eventually turn to frustration however, since the patients inevitably and quickly return to their stupor or delusions. Were such short returns to reality really worth the endless hours of effort? This is a question everyone asks of themselves. Our observations suggest that those nurses who
stay in their jobs longest tend to be those who report that the effort is worthwhile and satisfying.

**Psychotropic Drug Therapy**

After reality orientation, the next most commonly used mental health service is psychotropic drug therapy. A little more than one fourth of all patients in the nursing homes of our sample were reported to be receiving psychotropic drugs. Of all mental health services, however, psychotropic drug therapy was rated least satisfying by directors of nursing. Many of the problems here can be traced to the earlier discussion of the lack of adequate psychiatric training by attending physicians, the failure to seek out professional psychiatric evaluations and recommendations on drug prescriptions, and the general inadequacy of follow-up evaluation of drug performance. One director of nursing expressed her belief that the prescription of long term, maintenance, psychotropic drug therapy for many of her patients was frequently done as a matter of convenience by attending physicians who simply did not want to take the time with patients to try any other kind of therapy. It was very common, for example, for prescriptions to be given over the phone with no personal examination being made. It is not surprising under these conditions that psychotropic drugs have produced so little satisfaction as a therapeutic technique.

Though highly touted in the popular press, scientific conclusions concerning the usefulness of psychotropic drugs must remain cautious. Contrary to widespread belief, the extensive release of patients from the state mental health hospitals did not occur because of the introduction of
psychotropic drugs. The extensive release of these patients, which began during the early to mid-sixties, was more the result of the community mental health movement, the introduction of the Great Society poverty programs (particularly Medicare and Medicaid), and the rise of the nursing home industry, than it was of the introduction of psychotropic drug therapy a full decade earlier.

Drug therapy for chronic OBSs remains largely underdeveloped and ineffective, while drug therapies for FPs continue to be at best experimental. Though there are popular hypotheses, no conclusive evidence exists for how psychotropic drugs, such as the phenothiazines, work on the central nervous system; and of course there are no sure ways to predict what the results of the use of these drugs will be for any given patient. To be effective, careful follow-up evaluations are therefore required when these drugs are administered.

But in addition to these problems, all researchers freely admit that these drugs do not cure persons of mental disorders, but merely assist in controlling the presentation of some of the more undesirable symptoms. Drug therapy, therefore, remains a maintenance therapy, with continuing remission of all symptoms after the cessation of drugs being credited, it it occurs, either to some other sort of therapy or to an unknown spontaneous dynamic. Unless used with careful evaluation before, during and after application, drug therapy can prove to be ineffective, to produce highly undesirable short term or long term (and even permanent) side effects, and even to produce conditions that mimic symptoms of mental disorders. In the latter case, the patient may be misdiagnosed as being
afflicted by yet another mental disorder and be given more psychotropic drugs to counterbalance these effects (see Hoffman, 1982).

In short, psychotropic drugs are in wide usage in nursing homes as a therapeutic service for the mentally disordered. They are not, however, producing satisfactory results according to nursing home personnel. The problem lies in the lack of skilled use of these drugs and in the lack of adequate follow-up evaluation. The dimensions of the problem nationwide are probably much greater than would be implied by the estimate in our sample of 26% psychotropic drug usage by nursing home patients. Glasscote (1976:74) found in his national sample that 56% of skilled nursing home patients received antipsychotic drugs and 12% received antidepressants. A 1974 Senate report (U.S. Senate Subcommittee on Aging, 1974) indicated that on average patients in the nations' nursing homes receive 4.2 different medications of all sorts per day. The widespread use of psychotropic drugs coupled with their potential for interactions with the many other drugs being used, poses a quite serious issue in long term care of the elderly patient.

Remotivation Therapy

The only other mental health service in wide use was remotivation therapy, which was applied to 23% of the nursing home patients in our sample. No other service received ratings as high as this one among nursing homes that used it.

The motivation of patients is a common part of nursing home care, especially for patients who have become bedridden, incontinent, who have lost other self-care
skills, who no longer care about their personal appearance, or who refuse to eat or to leave their beds. Getting patients to engage in activities that stimulate their muscles and their minds or that could provide enjoyable, rewarding experiences if physical or emotional doubts could be removed are also common problems. In many cases nurses practice what is often called 'cookie therapy', that is, food is offered as an incentive to get a patient to bathe, to brush their hair, or so on. Sometimes stern directives help, and in other cases warm encouragement seems best. In general, the skills are the same as any parent uses to get their adolescent children to make their beds, quit lying around on the couch, eat healthful foods, help around the house, get better grades at school, etc. This is true because in many respects the lives of nursing home patients are as transitional and disconnected from viable social roles as are the lives of most adolescents.

Like reality orientation, remotivation therapy is a set of common-sense practices that are part and parcel of everyday social life. Anyone can apply remotivation techniques with little or no training. As is true of reality orientation, however, 'burn-out' of staff using these techniques on recalcitrant patients is high. Because desired results tend to occur more frequently and to last for longer periods of time, however, satisfaction with remotivation therapy tends to be greater than for reality orientation. It must be kept in mind, however, that these two kinds of therapies apply to different sorts of patients: A certain level of reality orientation is required in order for remotivation to be successful. Following remotivation, or concurrent with it, more advanced services, such as occupational and recreational therapy, are needed.
Psychotherapy

Only three to four percent of nursing home residents in our sample are receiving any form of psychotherapy, either in groups or as individuals. Psychotherapy was reported to produce somewhat satisfying results, however, by staff who use it. Most psychotherapy that is occurring is done in groups and is led by minimally trained or untrained volunteers.

Psychotherapy is a 'talk-therapy' that encourages people to discuss openly their problems, their hopes and their fears and to reach some sort of healthy resolution about their future goals and past actions. Talk therapy seems to work best for the well-oriented, motivated individual who suffers from repressed feelings of guilt, grief, abandonment, rejection, inferiority, and so on. Such feelings are of course common among nursing home residents. Talk therapies, however, have not found to be particularly effective in alleviating major symptoms of organic brain syndromes or functional psychoses. Furthermore, evidence, although sketchy, suggests that talk therapies are effective when applied by minimally trained therapists as by therapists with advanced training (see the review on this issue in Orford, 1976:169-170). Given the likely magnitude of repressed feelings among the residents in nursing homes, it is therefore not surprising that we should find even such limited use of psychotherapy by minimally trained individuals to result in relatively high levels of satisfaction by directors of nursing.
Behavior Modification

Less than one percent of nursing home residents are receiving behavior modification treatment, though this service is rated by directors of nursing as second only to remotivation therapy in terms of its satisfactory effects. 'Cookie therapy,' as described above is a form of behavior modification, though it can not be expected to have an enduring effect unless it is carefully scheduled and secondary reinforcers are eventually introduced.

Behavior modification in nursing homes generally has not advanced beyond 'cookie' or 'cigarette therapy' because skilled therapists are needed to make continual evaluation of the behavior or patients and of the stimuli of the nursing home environment. Furthermore, all staff would have to work together to create and maintain the sort of environment that would be needed to shape patient behavior successfully. Unfortunately, nursing homes have neither the staff nor time to make such an effort possible. Another problem, of course, are the possible infringements on patients' rights that behavior modification may impose.

But yet another, more fundamental problem is the fact that the natural stimuli of the environment of the nursing home can themselves have perverse effects on patient behaviors (e.g., Lieberman, 1968). Designed to deliver maintenance and rehabilitative services to patients, the peculiar characteristics of the nursing home can nonetheless, and quite unwittingly, produce the opposite effects of deterioration and even death among patients. As is true in any institution for residential living, living conditions are highly regimented and public, with
people expected to eat, sleep, and to control and restrict their behaviors in accordance with bureaucratic rules designed to facilitate the ease with which the institution itself can be operated. Behaviors are monitored twenty-four hours a day, day after day, and corrective action is taken for rule infraction. The contrast between the lifestyle and freedom of action experienced by the patient before entering the nursing home and the regimentation of the nursing home itself poses an exceedingly difficult adjustment problem for new patients and can lead to the rapid deterioration of their physical and mental conditions and to earlier than expected deaths.

Once in the nursing home, previously favored activities may be restricted or forbidden, and contacts with friends, former neighbors or relatives become more distant, irregular and uncontrollable. In response to the loss of these natural avenues of self-expression and activity, patients become agitated or excessively subdued. Symptoms of withdrawal and depression, as well as inactivity, become common. The institutional response to these problems is to introduce artificial activities to try to fill up the patients' time and to keep them as physically and mentally active as possible.

Unlike persons in other institutions for residential living, such as the army, monasteries, or communes, patients in nursing homes not only face a lifestyle not of their own making ad disjointed from the one of their past, but they face this environment with very real and generally severe physical and mental illnesses. What's more, most face it with the awareness that their previous personal identities are dead or dying and that they
now await only physical death itself. To be most effective, the application of behavior modification must take into account and control for all of these detrimental impacts of institutional stimuli on patient motivation and behavior.

A major advantage of behavior modification is that, like drug therapy, it does not require the understanding or cooperation of the patient in order for it to work, which makes it ideal for the deeply confused organic brain syndrome patients or the delusional, functionally psychotic patients. Unlike drug therapy, however, it requires an enormous amount of staff time to administer. Furthermore, there is insufficient evidence to believe that behavior modification can produce enduring changes in nursing home patient behaviors after therapy is ended. As long as a patient is in a well-controlled environment, or a 'token economy,' behaviors can be shaped to a remarkable degree. When the therapy is ended by the removal of these rigid environmental controls, however, patients can revert to their former undesirable behaviors unless careful introduction of secondary reinforcers has been made and these secondary reinforcers are present in the patient's uncontrolled environment. Given the environmental stimuli of the total institution, as described above, reversion to undesirable behaviors seems all the more likely if behavior modification therapy is ended.

On the positive side, given the relatively high satisfaction shown with behavior modification by those few nursing home personnel who have tried it in a least a simplified way, more extensive application of it in the remotivation of patients would certainly seem advisable. Trained personnel on staff in the nursing
homes would be required to make this possible.

**Electroshock Therapy**

The remaining services included in this study were provided either to no residents or to very, very few. Electroshock, for example, was given to no patients, despite the fact that it is known to be effective in alleviating symptoms of psychotic depression.

Nurses were quite open in telling of their dislike of the very idea of electroshock. Yet it is ironic that prejudice against the use of electroshock as a treatment far exceeds that toward the use of psychotropic drugs, since there are few grounds for such a bias in choices. Little more is known, for example, about how psychotropic drugs work to produce desirable effects than is known about how electroshock works to produce desirable effects. Furthermore, in contrast to drug treatment, electroshock treatment for chronic depression is of very limited duration, produces rapid results, and more often leads to complete remission of symptoms. Finally, the undesirable side effects of electroshock, viz., confusion and loss of memory, are certainly no worse than those found from some psychotropic drug therapies, such as hypotension, jaundice, leukopenia, heart problems, respiratory failure, Parkinsonism, tardive dyskinesia, agranulocytosis and retinitis. Yet a fourth of all nursing home patients in our sample are placed on long term, maintenance regimens of psychotropic drug therapy, with little or no follow-up evaluation, while none receive electroshock treatment.

**Milieu Therapy**

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We included milieu therapy in our questionnaire even though earlier interviews led us to believe that we would not find anyone using it. Our interest in this service stemmed from the literature which suggested that milieu therapy could be among the most useful forms of treatment (e.g., Colthart, 1974). Since nursing home personnel were unacquainted with the term, we added a definition of it to the questionnaires.

In milieu therapy, as in behavior modification, all staff, including aids, come together to discuss problem patients and to decide how best to coordinate their actions to deal with each patient most effectively. By involving everyone in these meetings, higher rapport and morale is created, as well as more consistent and coordinated treatment of the patient by all staff. It is especially important to have aids involved because they provide virtually all hands-on care to the patients.

Nursing homes are all presently using a very limited variation of this model when the director of nursing seeks information from select staff members to decide how to deal with a problem patient. Routine patient care conferences were also common, where relevant staff would meet to consider the medical circumstances, problems, and rehabilitative potentials of each patient.

Other Services

The only other services mentioned were sensory stimulation, recreational therapy, and family conferences. These services were reported as being in use for mental health purposes for less than one percent of the residents however. Sensory
stimulation is an adjunct to reality orientation in which patients are presented objects to touch, smell, hear, and so on and are oriented simultaneously to the meaning of the object. Music therapy, for example, is a form of sensory stimulation. Dance therapy, which involves sensory stimulation, is a form of recreational therapy that often is used after patients have become remotivated to engage in activities (music therapy, of course, could also be use as a recreation therapy).

Family conferences are held on an ad hoc basis, provided families were willing to get involved. Generally these conferences are problem-solving meetings designed to discuss how to deal with problems posed by the patients' behavior or with problems the patients or relatives are having with the health care practices of the nursing home. Quite often the meetings deal with such issues as how to get a patient to stop aggressive behavior or to take prescribed drugs. Directors of nursing related, however, that: "We find that we spend a good deal of time and effort in these conferences 'treating' the family." Since so few nursing homes report using patient care conferences for mental health purposes, it would seem that it has been found to be more trouble than assistance (which is not to neglect the real importance of providing 'treatment' for the family).

Recommendations

The problem of how to make public provision for society's chronically mentally ill persons will likely remain a serious issue for the foreseeable future.
Unless some rather remarkable breakthroughs occur in the technology of mental health therapy, continuous care and treatment of these persons in residential-based facilities will likely remain the way in which this public obligation will have to be met. With the deinstitutionalization of mental patients from costly state mental health hospitals, we saw the rapid growth of the nursing home industry to provide residential services. While deinstitutionalization alleviated the states from the full financial burden of health care costs for the mentally ill, it merely shifted a major share of these costs onto the federal programs of social security, Medicare, and Medicaid. As a result, for example, nursing homes now collect a little more than half of all the money spent by the federal government on Medicaid each year.

While deinstitutionalization resulted in a governmental shift of the financial burden for the provision of public mental health care services to the aged mentally ill, it would appear that it has otherwise merely taken the mental patient out of the frying pan of the big mental health institutions and put them into the fire of the little mental health institutions of nursing homes, where mental health care delivery is woefully inadequate. Such a conclusion is overly hasty, however. Nursing homes have been found by some researchers to be less dehumanizing than the state hospitals and generally more healthy places for the elderly mentally ill to be (e.g., Glasscote, 1976, Stotsky, 1973); furthermore, nursing homes do not necessarily differ much from the state institutions in the actual amount of mental health services offered, since the state institutions were themselves woefully inadequate in this regard. Still, the range and quality of mental health services
that are being offered in the nation's nursing homes are unarguably far less than a humanistically-oriented society would desire. Based on our study, therefore, we would like to draw up recommendations for how mental health resource utilization and service implementation can be improved in nursing homes.

First, since Medicaid is the principal public funding source for services to the aged in nursing homes, its policies must be changed to recognize and deal with the pervasive existence of severe mental disorders among nursing home patients. A careful, professional evaluation of the mental as well as the physical health of all nursing home residents is needed at patient intake and periodically thereafter, and should be reimbursable by Medicaid. These evaluations should be conducted by skilled, psychiatrically trained professionals. Treatment plans should then be drawn up to include an outline of therapies and goals not only for physical rehabilitation and maintenance, but for mental rehabilitation and maintenance as well.

Second, Medicaid reimbursement should be extended to provide funding for a full-time mental health worker in the nursing home, such as a clinical psychologist, psychiatric nurse, or psychiatric social worker. Despite the preponderant numbers of mentally ill in nursing homes, present Medicaid regulations make no such provisions. The resident mental health worker would provide services to be described shortly.

In addition to Medicaid changes in the funding of nursing home operations, community mental health centers (CMHCs) need to be better funded so as to be able
to provide outreach therapy, consultation, and education to nursing homes. Furthermore, CMHC staff should be better trained to provide these services to the elderly and to nursing homes. Contracts reimbursable through Medicaid and state departments of mental health should be made between CMHCs and the nursing homes in their catchment areas so as to make closer, continuous service delivery possible. When nursing homes are not in the catchment area of a CMHC, similar services should be contracted through local hospitals or mental health clinics. Given the concentration of severely mentally disabled residents in nursing homes, CMHCs (or other contracted mental health providers) should devote at least a full-time staff position simply to provide services to nursing homes in their catchment areas.

Attending physicians are rarely competent to deal with a specialty problem, such as mental illness, and, for a variety of reasons, are generally unwilling to devote face-to-face time with nursing home patients. They are therefore unlikely to become a useful resource for mental health care of the elderly and probably contribute a great deal to the misuse of psychotropic drug therapy. With regular psychiatric evaluation of patients being conducted as described above and with a consulting CMHC worker and a full-time mental health worker on the nursing home staff, the attending physician will be relieved of the responsibility of recognizing mental health needs when they occur. Furthermore, all prescriptions for psychotropic drugs should be cleared through the consulting psychiatrist, and professional follow-up evaluations of the effectiveness of the drugs should be written into the treatment plan. The effective use of psychotropic drug therapy, and electroshock as well, can
no doubt be much improved if applied under professional, psychiatric direction.

Reality orientation, remotivation techniques and individual and group psychotherapy are services generally found to be useful in nursing homes, though they have not all received widespread use. Reality orientation and remotivation techniques can be readily learned by nursing home staff and applied as a part of their ongoing patient care services. Because of high staff turnover, however, continuous in-service training would need to be provided by either the resident mental health worker or by the local CMHC worker. Individual and group psychotherapy should be used more extensively and could be conducted by the following persons: The resident mental health worker, the CMHC worker assigned to the nursing home, and by volunteers working under the guidance of the mental health worker.

The importance of the effective use of volunteers cannot be overemphasized. Found to be among the most useful of resources for mental health services by directors of nursing, volunteers remain nonetheless a much underutilized resource in many nursing homes. Reality orientation, remotivation therapy, and individual and group psychotherapy can be extremely time-consuming, trying services that easily lead to staff 'burn-out'. This is especially true when these services are used for the continuing maintenance of the quality of life of severely mentally ill patients, that is, those with organic brain syndromes and functional psychoses. Volunteers, however, provide an ever fresh supply of
energy for the delivery of these services and may be able to do so with minimal training and supervision.

We would propose that the recruitment of such volunteers from civic organizations, church groups, and schools (especially local social worker, clinical psychology and psychiatric nursing programs) be made a primary responsibility of the social services director. Training and supervision of these volunteers should be the shared responsibility of the resident mental health worker and activity director. Finding, training and supervising these volunteers will require staff time and commitment, but could easily lead to a payoff of ten or more free hours of service for every staff hour devoted.

Our data suggest that this balance of resources and services would provide the most practical and effective package for improving the mental health care delivery system for aged nursing home residents. While some of our recommendations require new funding of staff positions and service contracts, others require simply a reallocation of existing resources. The proposed new funding is reasonable in view of the very large, unmet, mental health care needs in nursing homes. Furthermore, it is a public obligation for us to provide maintenance and rehabilitative care for these severely mentally ill nursing home patients. These individuals have otherwise become excluded from residential services in state mental health hospitals by the deinstitutionalization movement and consequently have been forced into nursing homes as the only available alternative for residential mental health care. Coupled with the proposal for reallocation and re-emphasis of staff duties and service mix, the specific refunding proposals we have
made would lead to a substantial increase in the quality of mental health care in the nation's nursing homes.

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TABLE ONE: Director of nursing evaluations of each mental health resource and service being used in nursing homes, ranked by frequency of their use.

<table>
<thead>
<tr>
<th>RESOURCES</th>
<th>% of nursing homes using this resource (n=8)</th>
<th>average usefulness score on a five point scale</th>
<th>SERVICES</th>
<th>average % of patients receiving this service</th>
<th>average satisfaction on a five point scale**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. attending physicians</td>
<td>100</td>
<td>3.7</td>
<td>1. reality orientation</td>
<td>52</td>
<td>4.1</td>
</tr>
<tr>
<td>2. family and friends of patient</td>
<td>88</td>
<td>3.2</td>
<td>2. psychotropic drug therapy</td>
<td>26</td>
<td>2.8</td>
</tr>
<tr>
<td>3. community mental health center</td>
<td>62</td>
<td>4.5</td>
<td>3. rewiritation therapy</td>
<td>23</td>
<td>4.7</td>
</tr>
<tr>
<td>4. city, county or state agency</td>
<td>62</td>
<td>3.2</td>
<td>4. group psychotherapy</td>
<td>3</td>
<td>4.0</td>
</tr>
<tr>
<td>5. volunteers (non-family)</td>
<td>50</td>
<td>4.0</td>
<td>5. individual psychotherapy</td>
<td>1</td>
<td>3.5</td>
</tr>
<tr>
<td>6. local hospitals</td>
<td>50</td>
<td>3.4</td>
<td>6. behavior modification</td>
<td>1</td>
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<td>7. ministers</td>
<td>50</td>
<td>3.9</td>
<td>7. milieu therapy</td>
<td>0</td>
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<tr>
<td>8. nursing school traineeship program</td>
<td>0</td>
<td>0</td>
<td>8. electroshock therapy</td>
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</tbody>
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* 1 = not at all useful; 2 = not very useful; 3 = neutral or uncertain; 4 = somewhat useful; 5 = very useful

** 1 = very dissatisfied; 2 = somewhat dissatisfied; 3 = neutral or uncertain; 4 = somewhat satisfied; 5 = very satisfied

# not calculable
EMPOWERMENT THROUGH THE NEEDS ASSESSMENT PROCESS (1)

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ABSTRACT

One of the most persistent issues in social welfare planning has been the relative roles of service provision and social change. They have often been conceived as dichotomous: the assumption is that one precludes the other, on both ideological and methodological grounds. However, this division may be more the product of turf wars and fuzzy thinking than any necessary dichotomy. In this article a rationale for viewing service delivery and social change as dimensions of a single process -- empowerment -- is developed. Next the needs assessment is examined as a vehicle for implementing the process of empowerment. Finally, a case study of this use of needs assessment is presented and analyzed.

John S. Wodarski stated the matter directly: "the salient issue is whether (social welfare) should be based upon data or upon a philosophy of life" (1981: viii). On one side of this issue are those who see the field as a social movement, dedicated to strengthening the position of
the least well-off members of society. In its extreme form, those who take this position see themselves as contributing to "an organized movement for social change which is particularly concerned with building organizations and stimulating political debate so as to encourage collective action" (Pringle, 1981: 177). Seen as a social movement, social welfare is based in a philosophical and ideological conception of what "the good society" is, and how to achieve it (Friedmann, 1979).

On the other side are those who see social welfare as a nascent science in which interventions can be designed and carried out in ways that produce predictable outcomes. One of the most visible exponents of the scientific position, Joel Fischer (1981), feels a palpable "movement toward ... scientifically based practice" (200; emphasis in original). Another advocate of scientific social welfare quotes Jacob Bronowski's observation that "science ... asserts nothing which is outside observation" (Maas, 1977: 1184). This means, in effect, that scientific social welfare is incommensurate with social welfare as a social movement, since the latter is based in unobservable philosophical and ideological conceptions.

These seemingly dichotomous positions have led to divergent forms of practice. Understood as a social movement, social welfare is politics -- concerned with who gets what, where, when, and how. Its practice tends to take the form of community work and to emphasize issues of redistribution and social justice. Understood as science, social welfare is concerned with delivering services. Its practice tends to be clinical in nature and to focus on changing individual
behavior; it emphasizes issues of deviance and adjustment to societal norms. Social movement supporters see themselves as advocates for righteousness and a better society and see the scientific position as an implicit rationale for the -- in their view -- fundamentally unjust status quo. Supporters of the scientific position see themselves as the vanguard of a new, intellectually legitimate, demonstrably effective social welfare system and see the social movement position as an embarrassing anachronism.

All this places social welfare planners -- those responsible for designing policies and programs -- in a difficult position. If social change and service delivery are incommensurable, and social welfare organizations have to choose one or the other, where are the planners to put the emphasis? On what basis can they decide? A way out of this dilemma can be found by looking a bit further at the social movement and scientific positions. They are not so dichotomous as Wodarski and others believe. First, each has empowerment as the major goal for its clientele, providing clients with some added measure of control over their lives. Second, and most important from a planning perspective, both the social movement and scientific perspectives are based on the imputed expertise of professionals -- in the first instance, on philosophical and ideological expertise; in the second, on empirical expertise. Neither seeks the clients' perceptions of what is needed or how to proceed with regard to policy or program development.

Given the shared goal of empowerment, introducing clients' views into the social welfare planning process and blending them with the imputed expertise of professionals
can allow planners to avoid the either-or choice forced on them by proponents of the social movement and scientific perspectives. In this article I discuss the needs assessments process as a vehicle for doing so, and then describe and analyze an example of its use for this purpose.

QUALITATIVE NEEDS ASSESSMENT

Needs assessments are commonly understood to be on the cusp of politics and science. They bring public light onto what could otherwise easily be a completely political or completely technical planning process. "Assessment information helps to assure that there will be additional inputs to prevent sole reliance on professional formulations of service needs and/or to prevent overriding influence by the most vocal or powerful community groups . . ." (Siegel et al., 1978: 222). However, the "additional inputs" referred to are most often the products of applied social research; social indicators, surveys, and other hard data. Needs assessments are conceptualized as attempts to elicit the views of the public on whatever issues are of concern to the planning process. Bruce Gates, for example, sees needs assessments as "formal attempts to identify and quantify the levels of various needs . . . (and) as methods of generating information useful in program decision making" (1980: 101; cf. Rossi, Freeman, and Wright, 1979 and Mayer nd Greenwood, 1980).

This is admittedly a step forward in bringing the public's views into the social welfare planning process, but it does little to help planners avoid the either/or choice discussed above. To accomplish the latter it is necessary to understand the needs assessment process as "an opportunity for citizens to participate in the
decisions that will affect the conditions of their lives, . . . (as) a tool with which citizens together with public officials may make (informed) decisions about their social environment" (League of California Cities, 1975: 13-14).

To see the needs assessment as interactive citizen participation it is helpful to think of it as an exchange, in the economic sense, between the citizens and the social welfare organization (MacNair, 1981). In needs assessment an effective exchange requires representation of all sectors of the community with a potential interest in influencing program decisions and maintenance of a balance in which each participant receives value.

The value exchanged in a truly interactive needs assessment is information and understanding. The best theoretical formulation of this is probably John Friedmann's concept of mutual learning (1973; cf. 7). The two sets of actors involved, professionals and community members, have different but equally important kinds of knowledge. Professionals have scientific-technical knowledge about the problems and issues facing the community. Community members have direct experience with these problems and issues. When a mutual exchange between these two sets of actors occurs, empowerment is advanced in that:

1. the direct experience of community members with community problems and issues becomes an explicit part of the decision-making process for allocation of resources to social change and/or service delivery efforts; and

2. community members gain scientific-technical knowledge about their
This knowledge exchange or mutual learning requires needs assessment technologies that are unstructured so that exchanges can be wide-ranging, but systematic to assure coverage of specified areas of concern. Such technologies fall into the social science tradition called phenomenology: they seek to understand social reality not in the objective sense of the scientific view of social welfare, nor in the philosophical/ideological sense of the social movement view; rather, they seek to understand social reality from the frame of reference of the subject being studied, in this case the community members (Bogdan and Taylor, 1975).

Key informant research an be readily adapted to this purpose. Key informant research is commonly used in conducting needs assessments. "Key informants are people who are particularly knowledgeable and articulate, people whose insights can prove particularly useful in helping an observer understand what is happening" (Patton, 1980). However, informants are most often drawn from the ranks of service providers and community influentials (Siegel et al., 1978). Such people may not be in a position to accurately reflect the community members' frame of reference and in any case do not have the community members' direct experience with community problems and issues. Moreover, the process of empowerment of community members will certainly not occur if informants are limited to service providers and influentials. Informants must therefore be drawn from the "grass roots". In addition, the interaction must be a genuine two-way exchange rather than the more typical one-way passage of information from informant to professional in the traditional use of
key informants.

To summarize, the object of this type of needs assessment is to structure meaningful passage of information from the community to the social welfare institution, information useful for the planning of services which have meaning from the community members' perspective; and meaningful passage of information from the social welfare organization to the community, information useful for social change/community development from the community members' perspective. In this way, planning for both service delivery and social change can occur within the context of client empowerment. This process is most easily seen in the context of a case example.

NEEDS ASSESSMENT IN ONE CAA

Setting (2)

From their inception in the middle 1960's, Community Action Agencies were mandated to provide opportunities for participation by their constituents in CAA decision-making. The nature and extent of this participation changed over time as the mission of the CAA's changed in response to the ebb and flow of national politics. Originally conceived (at least by some) as social change agencies, under the Nixon administration the CAA's became primarily service delivery agencies operating in a manner not unlike any other social service provider. Many of the CAA's made good faith efforts to involve their clientele in service planning, using various face-to-face needs assessment techniques. Under the Carter administration the CAA's were pushed in the direction of community
development. This meant an expansion in emphasis from provision of services into the promotion of self-help and economic development.

The double emphasis on service delivery and community development presented the CAA's with both a problem and an opportunity. They were forced to face in an operational sense the classic dilemma of social welfare, social change vs. scientific service delivery. In doing so they had to re-examine the meaning of public participation in CAA decision-making. Does being a respondent in a traditional needs assessment for program planning, or sitting on an advisory board, constitute meaningful participation; or are there other, more useful forms of input for clients? Some CAA's responded by redefining their roles, organizing and working with client groups on community change projects as well as meeting social service needs.

One CAA, which for purposes of this paper will be called Social and Economic Opportunities (SEO) responded to this challenge by re-thinking its approach to planning. SEO served a rural, conservative area of California and probably retreated further from its original social action orientation than some of its urban counterpart agencies during the Nixon years. Moreover, the agency had suffered through a series of damaging internal political struggles during the early seventies. It emerged from this turmoil as the quintessential social service agency, providing a broad range of valuable, albeit traditional, programming in its service area, and doing little which could be characterized as innovative or developmental.
The stability and unity of purpose brought about by putting SEO into the service delivery mold were important to an administration and staff that had experienced several years of turbulence. The one area of concern felt by SEO was the lack of public participation in their planning efforts. The usual face-to-face techniques such as surveys and public meetings produced too little participation and/or were too costly. A planning consultant (3) was brought in to try to improve participation. Coincidentally, the community development mandate was being considered by the SEO staff at the same time, and the consultant was asked or input in this area as well.

In discussions among the administration, planning staff, and consultant, it became apparent that the problem of participation could be defined as a community development issue and conversely that the community development question could be defined as a participation issue. The common link, as discussed above, is empowerment. Meaningful participation in the planning of services is a form of empowerment: through participation, community members can shape the services available in their community. Community development can also be a form of empowerment if it involves community members in community change projects. The problem for the consultant and SEO planning staff became development of a planning strategy that would promote empowerment-- through both the planning of services and community development.

Use of the Key Informant Technique

After reviewing past agency experiences with face-to-face techniques and informally assessing the political position of SEO in
the community, the consultant and planning staff developed a plan for implementing an interactive needs assessment, based on mutual learning and the key informant technique. The conservative nature of the SEO service area, the internal turmoil that had plagued SEO, and the lack of participation in recent needs assessment efforts combined to produce the sense of a politically weak agency. There was concern that well-informed community members might be reluctant to be closely identified with SEO. The first step therefore consisted of developing a group of informants. These people would meet with agency planning staff, administrators, and board members on an informal basis -- for example over coffee, lunch, or a couple of beers -- to share perceptions of SEO programs, of community issues and concerns, of possible new directions for SEO to take. Once a group of informants was in place they were to be organized into information exchange networks, based on geography and interest. These networks would be a vehicle for community people to inform SEO of their needs and wants and obtain necessary technical assistance for grassroots community change efforts.

Initially, the service area was divided into four natural geographic areas: the somewhat isolated north coastal area; the cattle and grain producing inland valley in the northern part of the county; the vegetable growing southern county; and the county seat and its immediate environs. The six major constituent groups in the service area were also identified; seniors, the disabled, farm workers, single-parent families, the un/underemployed, and racial/ethnic minorities. It was hoped that two informants from each group could be found in each of the geographic areas, making a total for forty-eight. It was
believed that these numbers would connect SEO with a solid cross-section of its clientele.

The SEO administration approved the use of key informants for the federally mandated public participation in program planning, giving the project some legitimacy and validity within the organization and among its constituency. The planning staff was assigned the task of finding informants as a part of the preparation of the SEO annual plan, a federally mandated activity.

Potential informants were identified in a variety of ways. Inquiries were made of service providers and organized client groups. Planning staff spent time at community meetings, in social agency waiting rooms, and in coffee shops, laundromats, and taverns, speaking informally with people. Staff identified themselves at the outset as being from SEO. They sought individuals in each of the categories mentioned above who seemed to have potential as informants: Those who were well-informed about community concerns, were articulate, and seemed to be well-known in the community though not occupying formal leadership positions. The project was described to them and their participation solicited. No formal designation of key informants were made at this time. Rather, those who showed promise and expressed interest were contacted regularly but informally by the planning staff and their views sought.

The major problem encountered in finding informants was suspicion on the part of community people who were approached. Those who were well-informed about community concerns knew the reputation of SEO and doubted that their
participation in an SEO project would produce anything meaningful. Three months of part-time effort by the planning staff were required before a breakthrough occurred. The effort to identify potential informants had made the planning staff aware of a group of tenants -- including two potential informants -- who were involved in a dispute with a local housing authority. SEO was able to arrange legal counsel for the tenants and as a result the two potential informants agreed to participate in the project.

By demonstrating tangibly SEO's concern with empowerment, the planning staff was able to get the project off the ground. People began to respond more positively to requests for participation. However, at the end of nine months the full complement of forty-eight informants was far from realized. Only one of the geographic areas had twelve informants, and one had only two informant. In total, only twenty-six informants, slightly more than half the planned number, had been recruited. This was partly the result of over-optimism by the consultant and planning staff. The amount of time and effort required to recruit informants was underestimated and the amount of time planning staff would be able to devote to the project was overestimated, resulting in unrealistic target figures.

Discussion between planning staff and several of the informants indicated a more basic problem, however. As the agency was organized, planning was an administrative function. The Planning Director was supervised by the Executive Director and the planning office was seen as having staff rather than line functions. Organizationally as well as practically the planning office was limited to providing

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data and analysis for the agency's service programs. The incident of arranging legal counsel clearly fell outside the purview of the planning office as it ordinarily functioned. The informants of course did not understand this from an administrative science perspective. They simply saw that the planning office's job was defined as internal administration and could not understand how community empowerment could be a part of that function.

At that point the SEO made clear its commitment to the key informant needs assessment process. Despite the limited success (in terms of numbers) in recruiting informants, they agreed to incorporate the informants' insights into the one-year plan. The Executive Director was most impressed with the critique of the agency's organization that had emerged from staff-informant interaction, and a reorganization was written into the plan. The planning office was given line responsibility for the programming of services and a community development component was established within the planning office. It was hoped that these changes would make community empowerment a central function of planning and increase the likelihood of success of the project.

At this point some minor but significant modifications were made in the project. Instead of dividing the service area into natural geographic units it was divided into five political units corresponding with the county's supervisorial (commissioners) districts. This was done to make it possible to organize the information networks along political lines. That is, in addition to providing planning information to SEO, the networks could work with other agencies to improve services and serve as focal points
for community-based activities. Organizing along political unit boundaries made it clear that these were constituent groups not only of SEO but of public agencies and elected officials.

At this writing SEO is in the early stages of developing these networks of key informants, but it is possible to draw a number of inferences for social welfare planning from this case.

DISCUSSION AND ANALYSIS

The first observation to be made about this case is the clear tradeoff - exchange - that occurred when SEO responded to the informants' critique of the agency's organizational structure. By following the critique, SEO relinquished some of its power, some of its control over its own affairs. However, in doing so it gained credibility among its constituency. The agency was behaving as a part of the community by responding to the perceptive analysis of community members. It is important to keep in mind that this is not community control; the reorganization occurred as a result of mutual learning, not non-negotiable demands.

The ideal of a social welfare organization as a part of the community it serves is more often honored in the breach than in the doing. This is so in good measure because of the issue of power. Despite the feeling that it is a self-evident good to be a part of the community, agencies are reluctant to relinquish meaningful control to the community. His discussion of the SEO case is organized
around the theme of control. I will first consider questions of organizational and administrative behavior, then some programmatic issues, and finally offer a few remarks about the ideology of social welfare vis-a-vis this case.

Organizational/Administrative Behavior

The key informant needs assessment would never have been initiated without a high level of commitment on the part of SEO administration and planning staff. All those involved believed in the value of a balanced partnership between the agency and its constituents, on both a theoretical and a practical level. They were willing to risk some loss of control because they saw the idea of a balanced partnership as good in principle. More pragmatically, they knew the history of the agency and saw the project as an opportunity to rebuild the constituency support that had been lost over the years. The project offered at least two ways or this to occur. First, the key informants -- if handled sensitively -- could become credible spokespersons for SEO. They must not be co-opted, lest they lose community support; nor must they be allowed to take control of the agency, lest the kind of political infighting recur that had caused so many problems in the past. The necessity to maintain a balance between co-optation and community control made the mutual learning idea extremely attractive. Second, SEO had been doing planning for the past several years with little community input. As a result, the agency was unsure of the degree to which it was responding to its constituents' needs. The key informant project could build constituency support simply by giving SEO information that would allow it to respond purposively.
SEO administration and planning staff were willing to offer an exchange, then. At the cost of some loss of control over the agency they would gain community support and a better fix on whether or not their activities were responding to community needs.

**Programmatic Issues**

It is at the program level that an agency has its major impacts on a community. It is also at this level that professional prerogatives are most jealously guarded. Thus, the major payoffs and the major problems in the question of control occur here.

The presumed advantages gained by the key informant process include: increased responsiveness of services, because mutual learning allows them to be focused more precisely on community needs than do other techniques; greater efficiency, because mutual learning allows more accurate identification of those services most appropriate to community needs; and -- most important -- mutual learning provides the opportunity for meaningful technical assistance because it is a balanced (two-way) exchange between the agency and community.

The problem with mutual learning is that it is subject to being construed by service providers as undermining their professional expertise. The notion that it is helpful to blend the processed knowledge of professionals with the personal knowledge of their clientele in the development of agency programs seems to be persuasive in principle to most human service professionals, but in the SEO experience it has been difficult to implement.
The community development component, being within the planning office, presented few problems. Nor was the assignment of line responsibility for the programming of services met with resistance. Moreover, service providers were eager to discuss programs and community concerns with informants and planning staff. However, they were simply unable to engage in the kind of dialogue necessary for mutual learning. There seemed to be a second-order failure to communicate: the service providers didn't understand that they didn't understand. What informants saw as insensitivity or worse -- racism, for example -- on the part of program staff, service providers saw as proper professional demeanor; what informants saw as bureaucratic obfuscation, service providers saw as priority setting.

It may be unfair to place the onus completely on the service providers, but the tentative analysis of the planning staff and consultant is that the former have been unable to even partially relinquish control of their programs to the community. Again, this can be explained in terms of exchange. There is little direct gain to be had by service providers if they give up some control. The advantage to SEQ as a whole is clear enough, but it is not clear how having a more responsive or appropriate program would help service providers. On the contrary, there is potential for harm, from their point of view. If the mutual learning process produces an understanding that a given service is inappropriate or unresponsive it might be phased out, or service providers placed at risk in some other way. In this situation, then, the best strategy for service providers might very well be second-order failure to communicate.
The Ideology of Social Welfare

The SEO project enables us to draw some interesting inferences about the present state of social welfare. This article began by arguing that the goal of empowerment links the views of social welfare as a social movement and as a science. The key informant needs assessment was presented as an example of that linkage. Beginning with twin commitments to social change at the community level and to use of the social science concept of phenomenology -- trying to understand social reality from the frame of reference of community members, SEO devised a way for a modern formal social welfare agency to respond directly to constituent concerns. Evidence that the agency did respond is found in the reorganization and the creation of a community development component.

On the other hand, if the views of social welfare as a social movement and as a science have been successfully combined here, under the rubric of empowerment, how is the response of the service delivery staff to be explained? There would seem to be a basic conflict between the commitment to empowerment and the prevailing concept of professionalism, a conflict that runs through social welfare generally -- whether viewed as a social movement or as a science. The key informant needs assessment has highlighted this conflict but provides little help in resolving it.

Client empowerment is a "basic truth" of social welfare. The purpose of social welfare is to help "individuals, groups or communities to enhance their capacity for social functioning and to create societal
conditions favorable to their goals" (National Association of Social Workers, 1973: 4-5). To accomplish this, practitioners must be willing to share control of their scientific-technical knowledge. As a profession, social welfare is generally practiced under the auspices of formal organizations; service providers have shown no qualms about sharing control of professional practice with these formal organizations. To the extent that there is concern, it appears to be because agencies are seen to oppress clients (e.g., Cloward and Piven, 1975). However, service providers have shown little inclination toward an analogous sharing of control of professional practice with clients. In the case of SEO service providers, any suggestion that the informants might have something important to say about what kinds of services should be offered, how they should be structured, or under what conditions they should be available, was taken as a threat to professional autonomy. This occurred despite the willingness of the organization as a whole to share control, and despite the agreement in principle of the service delivery staff with the notion of empowerment.

There is an apparent conflict, then, between the ideal of empowerment and the ideal of professional autonomy as it relates to practitioner-client relations that even an agency as open as SEO, using a process of balanced exchange such as mutual learning, cannot overcome. Social welfare will do well to give attention to this ideological dilemma if it intends to take empowerment seriously.

NOTES

(1) This is a revised version of a paper presented at the 108th Annual Forum,
In keeping with the tradition of case-study social science, I have chosen to mask the identity of the agency under discussion. At the risk of sacrificing some credibility and verisimilitude, I prefer to spare the subjects discussed in this article any possibility of discomfort or embarrassment. I have intruded on their "common sense world" with an alternative vision which I hope is useful to the field of social welfare.

The author of this article is the planning consultant involved. For stylistic reasons it seemed better to place the consultant in the third person. All observations and conclusions reported are those of the author, acting as consultant to SEO on this project.

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Feminist therapy is directed not only at individual, but also at social change. Because of this dual aim of feminist therapy, the symbolic interactionist perspective, which describes individual initiative as a source of social change, is suggested as a theoretical orientation which can provide a useful model for feminist therapy. More specifically, the empathy/role-taking model for the client-therapist relationship is outlined here.

Feminist therapy emerged during the social revolution of the 1960's to offer women a new therapeutic approach sensitized to their special needs (Gilbert, 1980: 246). The popularization of consciousness raising groups was an indicator of the necessity to make women aware that they were not alone as a precondition to
describing the common problem of women or changing the conditions that fostered it. It is important to recall that in the absence of a clear delineation of the general malaise felt by women Betty Friedan referred to it as "the problem that has no name" (Friedan, 1963).

What has been termed feminist therapy is not a single approach, but a number of different techniques or approaches depending on the theoretical training and orientation of the therapist. However, "the basic assumption underlying feminist therapy is that ideology, social structure, and behavior are inextricably interwoven" (Gilbert, 1980: 247). That is, although the problem usually comes to awareness as a disturbance in one's thinking or feelings (internal), the conditions that foster the disturbance are the limiting and conflicting social expectations for women (external). We suggest that social psychology, more specifically, empathy or role-taking can provide a useful model for enabling women to identify and differentiate between the identity and role difficulties that are inside themselves and outside themselves.

**Feminist Therapy and Sex Roles**

The crucial biological facts are that some women become pregnant and have children and that some men are physically stronger. These facts have served as legitimations for males having dominant positions over women in religion, work, and other aspects of life in most societies through time (McCall, 1979: 210-211). Under conditions of continuous physical struggle against death or human extinction requiring strength and endurance, male dominance/superiority over women is not an unreasonable arrangement. Whether sex
roles were designed by societies to accommodate survival needs or were predetermined by biological inevitability. Made no difference when the arrangement was pragmatic. However, the question is an urgent one in Modern Western Societies with such advanced technology that intellect, not physical strength, is at a premium; childbearing is, for most women an option; and survival of the species is more assuredly under human control.

Although female subordination has existed throughout history, some women have defied social prohibitions against leading, Excelling, or achieving in "men's" endeavors. Often they disguised their identities, such as the writer, George Sand, whose gender identity was concealed behind that masculine nom de plume, or they were regarded as exceptional; their accomplishments did nothing to alter the general notion of normal female capabilities. Armed only with an opposing logic, belief, and insufficient scientific evidence, the few women who challenged male superiority were regarded as abnormal, less than female. Women who worked for expanded rights and equal treatment were ridiculed and vilified.

By the time of the social revolution of the 1960's when any belief or custom was attacked if not based on science, logic, or revolutionary ideals, the women's movement found itself and was vindicated by the new spate of medical and social scientific studies. Research studies from various fields provided a stream of consistent findings which helped to clarify which sex differences are attributed to socialization rather than biology (e.g. Linton, 1970; Maccoby, 1966; Marmon, 1968; Mischel, 1966; Money, 1965; Money, Hampson and Hampson, 1957). In general, it is clear that many
traits have been assigned arbitrarily as masculine or feminine simply in order to differentiate between the sexes.

"Society has constructed the feminine female and the masculine male; our task is to see that, in the future, society constructs the full human being" (Deckard, 1979: 59). The feminist goal is to expose the fact that so much of that which has been labeled masculine or feminine has no support in "nature" science, physiology, or social necessity. Men benefit from a system that subsidizes their achievement aims by offering them more pay, promotions, training, and almost exclusive control of visible power positions from nursery through graduate school and throughout the life cycle.

It must be remembered that each succeeding generation of males does not reinvent a plot to dominate females. Instead, both sexes come into an already existing world order which provides for each individual, from the moment of being wrapped in a pink or blue blanket, a consistent stream of messages that selectively approve one's expected sex role behaviors and disapprove divergence. The expected behaviors become habits, beliefs, acts carried out without conscious consideration. An individual may try new behaviors or may develop a non-traditional idea of her/himself, but these are usually given up in the face of competing definitions from others. We learn to test the "validity" of our self concept by checking it against the opinions of others, it is only the very sick person, or the healthy person with a strong ego (self-definition), who can sustain a self concept not accepted by others, or can gain acceptance from others of a competing self concept that one holds. For example, it is

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difficult for a woman to maintain a concept of herself as a normal female who is a good athlete, or to convince others that she is both a normal female and a good athlete when almost all whom she encounters regard her a mediocre at her sport, or as abnormal or masculine. Often an individual who seeks help from a therapist begins with a sense of confusion and anxiety as s/he asks, "Is it normal for me to think/feel/act this way?"

Feminist Therapy and Social Change

It is commonly held view that there is a woman's "place" and that it is "in the home". Although it is not the goal of feminist therapy to support that view, neither is the goal to develop a new definition of a woman's "place." Instead, the goal is to allow both men and women to recognize and explore their own feelings and interests, to learn to feel comfortable with themselves, and to accept themselves as a precondition to gaining acceptance from others. Often individuals seek help before a specific problem is articulated and there is only a generalized sense of dissatisfaction with self, relationships, or daily living. Not all women or men have the same needs or goals in therapy, and it is critical that the therapist help the client to formulate and move toward her/his goals, no those of the therapist. For example, some homemakers may need to ventilate anger about how they are being treated by their husbands, by men in general, and/or by themselves. They may wish to become more assertive in their sexual behavior, but to remain dependent and unknowledgeable regarding money. That is, they may choose to change only part of their behaviors that facilitate the general impression others have of them as dependent
and uninitiating. It is necessary that the therapist identify accurately the client's thinking and feeling in order to understand how the client makes sense of her/his own behavior.

Because feminist therapy aims to help individuals to learn to feel comfortable with and to develop themselves in ways that may not be suited to traditional notions, there must also be some assistance in understanding the feelings and behaviors of others who define one as "different". Feminist therapy aims to help individuals to adjust to their own needs and potential and to gain from others acceptance as healthy women or men. It deals with problems that arise from the discomfort of individuals who do not find themselves satisfied with the limited repertoire of interests, talents, and responses that traditional sex roles demand of them. The genesis of the problem, according to feminist therapists, is in the discrepancy between social demands and individual needs.

The symbolic interactionist perspective seems especially appropriate to feminist therapy because of the simultaneous focus on individual thought and action/response, and on the social structure as it context. From this point of view, social structure is not regarded as fixed, but as a continually evolving set of expectations. There are mutually shared expectations for one's own and for the behavior of others, dependent on the social location of each. The structure, or set of expectations, is maintained when actors meet expectations. The structure is changed when an individual's initiatives or unique responses become accepted by others. Innovations or social change can occur because of the failure of an individual to
understand the symbolically communicated expectations, or by a deliberate decision to establish new patterns/expectations. This theoretical framework is crucial to feminist therapy, the goal of which in symbolic interactionist terms, is to enable women and men to: perceive accurately what others expect of them; recognize and associate their own and others' feeling responses with the perceived expectations; know what their options and the consequences are for meeting expectations or innovating behaviors; and develop effectiveness and self esteem in being an active creator of social structure by working toward social change. The goal of feminist therapy is, ultimately, to bring about social change by helping individuals to develop personal effectiveness as change agents. How broad or limited the social change goals might be is one of the sets of options and choices individuals learn to identify and to make.

Research on therapy indicates that what effective therapies have in common is empathy or what sociologists call role taking. Traux and Carkhuff (1967) concluded that the best counselors are high in empathy, warmth, and genuineness -- all of which must be communicated to the client. Fix and Haffkes review (1976: 101) specifies that facilitative communication is the effective component. The good listener, generally, is viewed by the client as open and accepting (Goodman, 1972). On the basis of the limited data available, it appears that accurate role taking is a prerequisite for effective counseling. Given the importance of this ability in the therapist, it is curious that the literature has not drawn together the data which indicate factors affecting empathic ability. The rest of this paper is such an attempt.
Empathy/Role taking -- The Process

Role taking, or empathy, is a prerequisite for social interaction of any kind, and most certainly a requirement for effective therapy because the outcome depends upon the interaction of client and therapist, not upon the actions of one alone. Although one can analyze the behavior of participants separately, the perspective demands an attempt to explain the conduct of the individual in terms of the organized conduct of the social group. The social act is not explained by building it up out of a stimulus plus a response; it must be taken as a dynamic whole--as something going on--no part of which can be understood by itself (Mead, 1934:7).

There is an action, object, or expressed belief, not to which one automatically reacts, rather to which we must assign meaning or interpret before we can undertake a response (Blumer, 1969). This view of humans as active rather than passive participants in social life is a constant theme in the symbolic interactionist perspective of social psychology which developed from Mead.

Role-taking consists of the ability to put oneself in the place of others and to see things as others do. By constructing the attitude of other, one is able to (1) anticipate the behavior or responses of others and (2) to think about one's own behavior from the view of the other. Turner, among others, assumes that a major determinant of our behavior is the fact that there are expectations which we are required to fulfill. It is also assumed
that we view others largely in terms of their roles, that we assume behavior is an expression of expectations or requirements of social location.

The role becomes the part of references for placing interpretations on specific actions, for anticipating that one line of action will follow upon another, and for making evaluations of individual actions (Turner, 1969:218).

The second attribute is explained by Mead:

The reflexive character of self-consciousness enables the individual to contemplate himself as a whole; his ability to take the social attitudes of other individuals ... toward himself ... makes possible his bringing himself ... within his own experiential purview ... (1934:309ff).

According to Strauss, the meaning we assign to ourselves is dependent, not only on those toward whom we are acting, but also on those who are absent (1964:xxii).

The process of role taking is essentially that of hypothesizing. The first hypothesis one makes is an inference about what kind of person the other is, to identify the other. This provides a basis for predicting because we assume that people will act or feel in ways consistent with their social location (Berger, 1963) and, especially, role prescriptions. Naming, identifying, or otherwise classifying individuals as representative of a class enables interaction. The placement of individuals into categories is accompanied by influences of attitude and imputations of motive (Strauss, 1959;
The questions we ask ourselves are basically: If I were in that person's social position, what would I do, how would I feel? If I were in her/his position, what would I expect of me? This process is an internal conversation in which, theoretically, all interactants will negotiate until the identities are mutually agreed upon.

Role theory has generated a great deal of research and the richness of the empirical findings as well as the elegance of the theory lends itself to the development of an outline for effective role taking. Not all persons are equally good role takers. Heiss (1981) notes two areas which affect accuracy of role taking: the amount and kind of information available and one's ability to process this information.

**Amount of Information**

The general rule of thumb is that the more information about other, the more accurate one's role taking. We have the greatest difficulty in inferring attitudes, motives, intentions, and future behavior of others when we know the least. The best role taking occurs when the information we have is both in depth and salient. Four factors affect the amount and kind of information: characteristics of the therapist; characteristics of the client; characteristics of the situation; and the nature of the relationship between the client and the therapist.

Therapist characteristics are an important starting point for the purpose of perspective in the analysis because role taking occurs in the mind of the therapist. Life experience as a human has exposed the counselor to certain types of people either
directly, through interaction and observation or indirectly, from oral accounts, literature, or dramatizations. The degree to which one has had the opportunity to become familiar with certain types of others provides an informational base. Exposure is not enough, the therapist must also have remembered what similar others in the past have done and felt; recall must occur. Even with a background of preparedness, the role taker must be motivated to go to the trouble required by the mental exercise. People can be variously motivated. Being motivated by the need for approval, intellectual curiosity, or purient interest will also affect how much and what information is sought.

Heiss (1981) notes a difference between those who are field-independent people, who do not look to others, and field-dependent persons. The latter look for more information by being more attentive, making more requests, and interacting with others more. Difference in perceptual style, thus, seems to be related to certain aspects of personality.

Differences in power between interactants affects the information available for role taking (Henley, 1977). The more powerful person tends to assume less need for sensitive hypothesizing about the other. The powerful demand one's attention because they have the ability to reward or punish us and we have been taught to have respect for persons of high position. At times of disagreement about definition or interpretation, the powerful person can dismiss even an insistent other. In the therapist-client situation, the therapist is the "expert" who is credentialed and from whom the client is seeking help. Variations in role taking accuracy based on variations in power are found by race, sex,
and social position.

One of the most basic factors affecting role taking accuracy is what might be termed structured cognitive equipment (Strauss, 1959; Goldstein, 1973). Any role taking is based on categorization and obviously, the number and kind of categories and meanings one has as a way of organizing perception will make a difference. For instance, the more fine the distinctions seen among people, the more likely there will be accuracy in role taking.

Characteristics of the client also influence the information available and, therefore, role taking accuracy. The degree to which a client is open and willing to provide information is somewhat dependent upon her/his position vis a vis the therapist. Less powerful persons, for instance blacks, women and those of lower social status, are usually more self-disclosing in encounters with those they define as powerful or as their "betters" (Eakins and Eakins, 1978). The openness may be more apparent than real. It is generally assumed that people who emphasize their conforming behavior conceal information while those who reveal deviance are presumed to be more honestly self-disclosing. In our actual interactions with others, we rely upon information conveyed verbally as well as nonverbally. Some of the information can take the form of explanation of "accounts" (Scott and Lyman, 1973), thus we are able to learn from some clients not only what the situation is but also their understanding of it. Clients who are evasive, avoiding explanation of certain situations, also reveal something important.

The social attributes of the client are
the most obvious and important pieces of information we have about her/him (Stone, 1981a). Of course, it is not the attributes per se which the therapist uses in interaction, rather it is the meaning of the attributes to the counselor which determines role taking of all kinds. When we first meet people, we identify them, we categorize them according to characteristics such as race, sex, age and social status. Of all the attributes each of us has, some are more visible and central to our definitions of each other. These master statuses (Hughes, 1945) are probably such important definers that we forget the degree to which they orient our interaction with others. We behave differently toward others -- tone of voice, eye contact, demeanor, and so on -- on the basis of understandings of their social locations which we judge first, by their overt identities. We approach an interaction holding typifications of expectations, motives, personality, attitudes and character of certain categories of persons (Jones and Davis, 1965).

Not only do master statuses influence our judgements, but appearance, body type, posture, gesture, and facial expression are used as bases in inferring personality and moral worth. Clothing adds another dimension; one about which we are more conscious and ready to manipulate in order to create certain impressions and evaluations on the part of others (Stone, 1981b). We tend to judge others' social class, ethnicity, personality and political ideology depending upon how they dress.

**Characteristics of the situation** comprise a third area affecting role taking accuracy (McHugh, 1968). As with any characteristic influencing interaction, it
is the meaning applied to the situation, rather than an objective assessment of it which matters. To paraphrase Thomas (1973), if people define situations as real, they are real in their consequences. Physical and social distance tend to inhibit effective role taking: having to shout to someone with a hearing difficulty, or speaking with someone who does not speak our language well are both inimical. Being in a situation with many distracting -- phones ringing, people interrupting and outside noise -- reduces our ability to concentrate and our feelings of comfort with the situation. Private, as opposed to public, encounters allow others to feel more free to give pertinent information as well as facilitating attention.

The above circumstances dealing with goal are complicated by the specific topic used as the medium for attaining the goal. People vary in their openness according to subject matter. Some subjects make us uncomfortable, some are defined as essentially private, of some we are ignorant, and some might involve embaressment or we might fear that others would judge us negatively. To the extent we do not reveal feelings about behaviors regarding certain areas of life, accurate role taking is inhibited. This is particularly so in terms of our deviant behaviors. We all have a stake in projecting an image of respectability and because our character tends to be judged on the basis of our violations rather than our conformities, we prefer to mask that part of ourselves (Strauss, 1959).

The nature of the relationship between the therapist and the client is the last general area affecting role taking accuracy because of its connection to how much information is available. If the client
feels secure that s/he will not be judged, then self-disclosure is more likely. However, if the client feels that revealed information would be damaging to the relationship, or that confidentiality would not be maintained, then certain facts and feelings remain hidden. Information availability is increased when interactants have feedback that demonstrates that they are "understood".

Certain characteristics of the relationship which are more structural have a definite influence on role taking. For instance, the duration of the relationship in an historical sense as well as duration of encounter affect amount of information. In like manner, the frequency of interactions increases information and role taking accuracy. A final point -- one which probably increases role taking accuracy in counselor-client interaction -- is the degree to which all parties in an encounter expect that role taking will play an important part in the relationship.

Information processing

Role taking is ultimately a process of imputation and attribution. People do not tell us, directly, about their motives, character, and attitudes, rather on the basis of the information we have ferreted out, we make guesses. Processing involves making inferences based on the information available and not all are equally skilled at so doing. In fact, an individual probably evidences variability in processing skills according to factors such as fatigue, the situation, and client characteristics. Heiss (1981) concludes that it is not a uni-dimensional trait although information processing is probably a generalized, stable ability. He reports there is an apparent positive correlation
between intelligence and role taking ability. Some of the ability may be due to cognitive habit. Some people may close off prematurely the process of drawing inferences. For instance, a social characteristic such as sex evokes certain ideas of attributes, personality types, competencies and so on. If one prematurely closes the process of making connections between characteristic and attribute, then the correct interpretation may not come to mind.

Because we are dealing with clients as total persons, each with a number of identities, it is not feasible nor is it laudable to consider each identity singly or in turn (Karp and Yoels, 1979). We see people as configurations of identities. This is complicated by the fact that many of the relevant identities are not merely dichotomous, they are continuous. Gender is dichotomous while age is continuous with social definitions varying considerably even where there is only a small objective difference. Our tendency is to make judgements quickly. This appears to be "natural" and a good beginning, yet we have to remain attentive and be prepared to revise our inferences as more information is received.

When a therapist shares with the client a common social location, then she or he has a better basis for making correct inferences. Being of the same race, sex, social class, and ethnicity gives one the experience of having been there already and the likelihood of some part of a socially constructed reality in common is increased. Similar interests, background, and status are very effective predictors of accurate role taking. However, being of the same background and status as the client is not necessary: one
can have obtained extensive information and/or had extensive interaction with certain categories of persons and thereby gained the necessary knowledge for accurate role taking.

Summary

Feminist therapy deals with the self doubt about whether it is "natural" to want more than tradition allows, with the need to explore options and likely consequences, and with learning how to live with choices that are made. It does not begin with socially determined notions of healthy female or healthy male behavior, but with the client's self concept and needs.

In order to begin where the client is, and to help her/him to choose her/his own course, the therapist must view the situation from the client's point of view. Research in social psychology on the empathy/role taking process indicates (1) that not all candidates are equally suited for role taking; (2) that the process involves imagining (hypothesizing) the attitudes of the client toward the situation and the therapist, and offering a concrete verbal expression to check the accuracy of the hypothesis and to recognize the client's feelings.

Various factors affect the differences in role taking abilities among therapists, and for any one therapist depending on circumstances. These include: amount of information available; therapist and client characteristics and attributes; differences in power between client and therapist; characteristics of the relationship; and factors related to the information processing skills of the therapist.
Indeed, the body of theory developed thus far about the empathy/role taking process can provide not only an appropriate guide to skill development areas for feminist therapists, but suggests also a need for the generation of more new knowledge through clinical research.

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ABSTRACT

This study examines the future work plans of nonremarried widows under age 55 who have dependent children at home (N=2,599). All families in this study were receiving survivor benefits from social security in 1978. Human capital resources of the widow, economic need, her age, and family situational variables were included in multiple regression analyses as possible predictors of future work plans. The results support the importance of human capital resources and age of the widow, support the importance of economic need only for widows already working, and suggest that family situational variables are less significant in predicting widows' future work plans. The source of data for this study is the 1978 Survey of Survivor Families with Children conducted by the Social Security Administration.

This research was conducted January-August, 1982, using the 1978 Survey of Survivor Families with Children.

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This study investigates factors associated with future work plans of nonremarried widows who have dependent children receiving survivor benefits under social security. More specifically, it examines whether human capital variables and income variables make a difference in widows' plans to improve their job opportunities. A study on widows' future work plans is important because when their youngest child reaches age 18, they will be off the social security benefit rolls. (Age 18 is applicable for the sample in this study. This age was lowered to 16 under the 1981 Omnibus Budget Reconciliation Act.) They will then be on their own until the time that they become eligible for aged survivor benefits. The minimum age for such benefits is 60. Thus, it seems crucial for young widows to plan ahead in order to improve their employment situation. In 1978, there were 600,500 families headed by such widows (Hastings and Springer, 1980).

Nonremarried widows on social security are in a unique position among nonremarried mothers with dependent children. Although the death of their husbands results in a loss of income, the financial condition of widows is better relative to that of single or divorced mothers. Social security benefits place families headed by widows in a somewhat better financial position than other single mothers. In regard to work behavior, these benefits may give widows a certain amount of freedom to plan their future. On the other hand, benefits may act as a work disincentive. Widows on social security have received less attention in the literature than other groups of nonmarried mothers. So, little is known about the work plans of this particular group of women. This study partially fills this gap in knowledge by addressing the following questions. What types of widows have a positive plan to improve their job opportunities? Does the level of family income make a difference? Do human capital resources possessed by the widow make a difference? Which factor is more important?

Thus, the purpose of this paper is to examine the future work plans of nonremarried widows whose families are currently receiving survivor benefits under social security, in order to make an inference on how well widows can be expected to weather the break in social security benefits. The study investigates types of widowed mothers who plan to improve their employment opportunities in the next three
years by (a) going back to school to prepare for a job, (b) getting a job, if not currently employed, or (c) getting a better job, if employed. The primary focus of this paper is to examine the strength of two groups of predictor variables known to be associated with labor force participation of widows. One group deals with family income; the other group deals with human capital variables, viz., health, education, vocational training, and work experience. Family situational variables are considered as controls.

Using the same data file as that used for the present study, a recent study by the Social Security Administration investigated the likelihood of returning to school among nonremarried widows whose youngest child was in the age range of 16 and 17 (Grad, 1981). Through a multiple classification analysis, it found that age, educational achievement, health status, and labor force participation of widows were statistically significant predictors of widows' planning to go back to school. The present study augments the study by the Social Security Administration. This study focuses on nonremarried widows with children under age 18, while the study by the Social Security Administration focused on that segment of nonremarried widows whose youngest child falls in the age range of 16 and 17. Furthermore, the present study differs from the Social Security Administration's study in another sense. It includes a more comprehensive set of predictor variables which are not only directly related to widows but are also related to family circumstances—that is, family situational variables (discussed below). Lastly, the present study deals with widows' plans for future employment as well.

CONCEPTUAL FRAMEWORK

The research literature on working mothers has provided a variety of conceptual schemes to classify variables associated with women's decisions to work. Sobol's (1963) typology of factors that influence future employment plans of wives has been widely used and adapted and is the basis for the grouping of variables developed for the current study. Sobol's classification includes economic need, facilitating conditions such as education and work experience (these will be included in a grouping termed human capital variables in the present study), and family situational variables.
Sobol's typology is particularly appropriate for the present study since both are concerned with understanding types of women who are planning a future commitment to employment rather than those who are currently employed. Factors predictive of current employment may reflect transitory changes in family income or composition and so may be somewhat different from those associated with long-term career plans (Waite, 1976).

**Economic Need.** As a group, widows' income from all sources is low; for example, it is about half that of remarried widows or of widowers (Hastings and Springer, 1980). Most widows experience a drop in standard of living after the death of their husbands. Even allowing for reduced expenses caused by the loss of a family member, most widows are not living at their former levels (Mallan, 1975).

A previous study supports the hypothesis that level of income is inversely related to widows' decisions to work (Mallan, 1975). Studies on other populations of women also have shown a correlation between the husband's income and his wife's employment (Cain, 1966; Gordon and Kammeyer, 1980). Women whose husbands have lower incomes are more likely than others to work.

However, the relationship of income to the long-term work careers of women is not well understood. In planning for future employment, current income may be less important than the woman's expectation of her future financial situation. Sobol (1963) found that women who believed that their family's income would be chronically low, or who expected their financial situation to deteriorate, were more likely to plan a long work career than others. In addition, Waite (1976), in a longitudinal study, found that the level of their husband's earnings was not strongly associated with whether or not women had long work careers. The present study will explore further the effect of current income on the long-range work plans of widows.

**Human capital variables.** Economists view human capital as comprising the individual's education, vocational training, and work experience. Together, these variables are considered the worker's stock of capital that affects her or his level of earnings (Becker, 1964; Mincer, 1970; Sørenson, 1976). Recently, the human capital concept has been
expanded to include physical qualities, social contact, and perceptions about self and work (Kalacheck and Raines, 1976; Ozawa, 1980). Borrowing from these theorists, the present study examines four human capital variables as predictors of future work plans: health of the widow, education, vocational training, and work experience. These variables are conceptualized as the personal resources the widow possesses to improve her economic condition through increased work commitment. One can expect that nonremarried widows who already have a high level of human capital will anticipate a greater return on additional investment in themselves through going back to school for greater job opportunities or obtaining a better job. Also, studies on working women have shown that these variables are related to a mother's decision to work (Sobol, 1963; Waite, 1976; Hiller and Philliber, 1980; Gordon and Kammeyer, 1980). Of the human capital variables considered in this study, we expect that health, education, and vocational training will positively predict which widows plan to increase their work commitment in the future. On the other hand, work experience—another human capital variable in this study—may be related to the dependent variables in the opposite direction. This is anticipated because after many years of work, returning to school or getting a new job may have a diminishing return. Thus, widows with many years of work experience may not have incentives to increase their levels of work commitment in the future.

Family situational variables and other control variables. The age and number of children and the length of time elapsed since the death of a husband fall into the category of variables involving family situation. The age and number of children have been shown to affect the widow's labor force activity (Mallan, 1975). The presence of young children is often a barrier to outside employment for their mothers, at least partly because child care costs may make employment unprofitable (Nye, 1974). The presence of many children at home may also create a barrier (Gordon and Kammeyer, 1980). The length of time elapsed since the death of a husband may have some bearing on the widow's plans on future employment. For one thing, some families receive a lump sum payment from private life insurance programs. Such payment makes the financial conditions of bereaved families somewhat better off immediately following the husband's death, which, in turn, may influence the widow's
future plans. Moreover, the emotional impact of the husband's death may affect the timing of the widow's planning for the future (Lopata, 1970; Maddison and Viola, 1968). Therefore, this variable needs to be included in a regression analysis at least as a control. Age and racial background of the widow are other control variables that we believe need to be included in the present study. The age of the widow has been found to affect her labor force activity in a previous study (Mallan, 1975). Since nonwhite women, especially black women, have traditionally shown a higher rate of labor force participation, race, too, should be included as a control (U.S. Bureau of the Census, 1981: 381). Because the main focus of this study is on income and human capital variables, these family situational variables and other control variables should be considered as controls—not major independent variables.

In summary, the literature suggests that the present analysis will support the following general hypotheses:

1. Other things being equal, widows with lower incomes are more likely than other widows to plan to obtain more work-related education, and/or get a job (if currently not employed) or get a better job (if currently employed) in the next three years.

2. Other things being equal, widows with greater human capital resources are more likely than other widows to plan to obtain more work-related education, and/or get a job (if currently not employed) or get a better job (if currently employed) in the next three years.

METHODOLOGY

Data Source

The present study uses the 1978 Survey of Survivor Families with Children. These data were collected by the Social Security Administration in the Spring of 1978. This Survey involves the national population of all families with at least one child under 18 years of age receiving Survivors Insurance benefits under social security in 1977. The Survey covers responses to questions pertaining to psychological conditions, quality of life, health conditions, and health insurance coverage, as well as recipiency and the level of
private and public transfer income and total family income. These data provide a particularly rich source of information on recipients of survivor benefits and their children, including widowers, remarried widowers, and widows (Hastings and Springer, 1980). The study reported here includes in its sample 2,599 nonremarried widows age 55 or younger with children, a group of widows most likely to face the termination of benefits when the youngest child reaches age 18.

Operational Definitions of Variables

Dependent Variables:

Two variables are identified to explicate the widow's commitment to future employment: work-related school plans and future job plans.

Work-related school plans are measured by a dichotomous variable. When respondents stated that they were either "very likely" or "somewhat likely" to return to school in the next three years to prepare for a job, a score of one was given. Respondents who indicated that they were "somewhat unlikely" or "very unlikely" to return to school in the next three years to prepare for a job received a score of zero.

Future job plans are measured by a dichotomous variable. When respondents stated that they were either "very likely" or "somewhat likely" to get a job (or get a better job than they now have if already employed) in the next three years, a score of one was given. Respondents who indicated that they were "somewhat unlikely" or "very unlikely" to get a job (or get a better job if already employed) in the next three years received a score of zero.

Taken together, these dependent variables are considered to measure the widow's interest in and plans for increasing her job opportunities—or work commitment—over the next three years.

Independent Variables:

Current total family income includes earnings by family members; unearned income from private sources such as dividends, rents, and interest; and private transfer payments.
Perceived health status (human capital) is defined as how a respondent perceives her health status relative to working. Respondents who answered "no" to the question "Do you have a physical or health condition that limits the kind or amount of work you do?" received a score of one; those answering "yes" received a score of zero.

Education (human capital) is measured by the number of years of completed schooling. Possible scores range from zero to 17 (17 indicates 17 or more years of schooling).

Vocational training (human capital) is measured by the question "Have you ever received any vocational or technical training?" A score of one indicates a positive response, zero a negative response.

Work experience (human capital) is defined as the number of years that the respondent has been employed either full or part time.

Control Variables:

Age of widow is measured by the respondent's age in years.

Race is defined as the respondent's statement as to whether she is white or of some other ethnic background.

Number of years of widowhood is the difference between 1977 and the year the spouse died.

Number of children living at home is defined as the total number of children sharing the respondent's household, whether or not they are currently receiving social security benefits and regardless of age.

Age of youngest child, measured in years, considers the age of the youngest child living with the mother.

Current work status is measured by respondent's statement as to whether or not she was working in 1977. Those who were working in 1977 received a score of one, all others a score of zero. Note that this variable was not entered into the regression equation, but was used to divide the respondents into two groups: working and non-working. Regression analyses were done separately on each group.
All data used for independent and control variables reflect the respondent's situation as of 1977. The data for the dependent variables reflect the respondent's plans as of 1978. All cases have been weighted by the Social Security Administration to adjust for non-responses and universe cell weight.

Data Analysis

The hypotheses set forth were tested by ordinary least squares regression analyses, using the Statistical Package for the Social Sciences (SPSS) program. SPSS was also used to perform descriptive and other statistical analyses.

FINDINGS

Table 1 presents the means and proportions of the independent and dependent variables for working and non-working mothers. Both groups have about the same average age and years of widowhood. Working widows have somewhat fewer children and their children tend to be older. Working widows have a much higher income. They also score higher on the human capital variables; a larger percentage of working than non-working widows have no health problems and have obtained vocational training, and working widows have more years of education and work experience than those who are not working. About the same percentage of working as non-working widows plan to return to school. The percentage of non-working widows planning to get a job is about the same as the percentage of working widows planning to get a better job.

Regression Results of Work-Related School Plans Among Nonremarried Widows

Table 2 presents the results of the regression analyses for working and non-working widows on the likelihood of their returning to school in the next three years to prepare for a job.

Working widows. Regression results indicate that income is inversely related to the widow's planning to return to school (p< 0.001).
<table>
<thead>
<tr>
<th>Widows' Characteristics</th>
<th>Working Widows (N=1,547)</th>
<th>Non-working Widows (N=1,052)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>43.69</td>
<td>43.07</td>
</tr>
<tr>
<td>Non-white</td>
<td>.23*</td>
<td>.31</td>
</tr>
<tr>
<td>Number of years of widowhood</td>
<td>5.50</td>
<td>5.41</td>
</tr>
<tr>
<td>Number of children at home</td>
<td>2.68*</td>
<td>2.95</td>
</tr>
<tr>
<td>Age of youngest child</td>
<td>12.50*</td>
<td>10.98</td>
</tr>
<tr>
<td>Current total family income</td>
<td>$14,865.28*</td>
<td>$9,695.31</td>
</tr>
<tr>
<td>No perceived health problems</td>
<td>.79*</td>
<td>.53</td>
</tr>
<tr>
<td>Number of years of education</td>
<td>11.74*</td>
<td>10.38</td>
</tr>
<tr>
<td>Vocational training</td>
<td>.37*</td>
<td>.25</td>
</tr>
<tr>
<td>Number of years of work experience</td>
<td>14.92*</td>
<td>6.60</td>
</tr>
</tbody>
</table>

| Commitment to Future Employment         |                         |                             |
| Work-related school plans               | .36                      | .37                         |
| Future job plans¹                       | .49                      | .50                         |

* Indicates that the difference between means or proportions of working and non-working widows is significant at the 0.01 level.

¹ Means "Will get a better job within three years" for working widows and "Will get a job within three years" for non-working widows.
## TABLE 2

**Regression Results:**
Determinants of Widows' Work-Related School Plans

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Standardized Beta Weights (F-ratios in parentheses)</th>
<th>Working Widows</th>
<th>Non-working Widows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>-0.228</td>
<td>(46.522)***</td>
<td>-0.227</td>
</tr>
<tr>
<td></td>
<td>(12.644)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-white</td>
<td>0.093</td>
<td>(12.644)***</td>
<td>0.122</td>
</tr>
<tr>
<td></td>
<td>(12.644)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of years of widowhood</td>
<td>0.038</td>
<td>(2.327)</td>
<td>0.049</td>
</tr>
<tr>
<td></td>
<td>(5.993)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of children at home</td>
<td>0.066</td>
<td>(5.993)*</td>
<td>-0.015</td>
</tr>
<tr>
<td></td>
<td>(6.313)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of youngest child</td>
<td>0.081</td>
<td>(6.313)*</td>
<td>0.082</td>
</tr>
<tr>
<td></td>
<td>(5.993)*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current total family income</td>
<td>-0.099</td>
<td>(12.531)***</td>
<td>0.003</td>
</tr>
<tr>
<td></td>
<td>(12.531)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No perceived health problems</td>
<td>-0.006</td>
<td>(0.079)</td>
<td>0.075</td>
</tr>
<tr>
<td></td>
<td>(0.079)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of years of education</td>
<td>0.162</td>
<td>(36.632)***</td>
<td>0.160</td>
</tr>
<tr>
<td></td>
<td>(36.632)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocational training</td>
<td>0.100</td>
<td>(16.801)***</td>
<td>0.108</td>
</tr>
<tr>
<td></td>
<td>(16.801)***</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of years of work experience</td>
<td>-0.075</td>
<td>(8.086)**</td>
<td>-0.040</td>
</tr>
<tr>
<td></td>
<td>(8.086)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>0.550</td>
<td>0.632</td>
<td></td>
</tr>
</tbody>
</table>

R²  | 0.107 | 0.155  |

F-ratio of the regression model | 18.547*** | 19.166*** |

Sample size | 1,547 | 1,052 |

* Statistically significant at the 0.05 level.
** Statistically significant at the 0.01 level.
*** Statistically significant at the 0.001 level.
Widows with less income say they are going back to improve their job skills more often than widows with more income. Among the human capital variables, education and past vocational training are positively and strongly related to the dependent variable \( (p < 0.001) \). Widows who already have more education or those who have vocational training are more likely to return to school. On the other hand, the number of years of work experience is negatively related to the dependent variable \( (p < 0.01) \). The directions of relationships between these independent variables regarding human capital and the dependent variable are as predicted. Of the control variables, age is negatively related and being non-white (race) is positively related to the widow's planning to go back to school \( (p < 0.001) \). Notice the strength of these variables as predictors of the dependent variable. It is interesting to note also that widows with a larger number of children at home say more frequently that they are going back to school than those with fewer children \( (p < 0.05) \). On the other hand, other things being equal, widows whose youngest child is of advancing age are more likely to go back to school \( (p < 0.05) \).

**Non-working widows.** For widows who are not currently working, income does not make any difference in their future plans regarding going back to school. In contrast, the human capital variables are strong predictors of their future plans. Widows in good health are more likely to plan to go back to school than widows in poor health \( (p < 0.05) \). The same thing can be said about widows who have more education \( (p < 0.001) \) and about widows who have prior vocational training \( (p < 0.001) \). Of the control variables, again, age is negatively related and being non-white (race) is positively related to the dependent variable \( (p < 0.001) \). Notice again the strength of these variables in predicting the dependent variable. As in the case of working widows, non-working widows with their youngest child of advancing age appear to find it relatively easy to plan for returning to school \( (p < 0.05) \).

**Regression Results of Future Job Plans Among Nonremarried Widows**

Table 3 presents the results of the regression analyses for working and non-working widows on their job plans for the next three years.
TABLE 3
Regression Results:
Determinants of Widows' Future Job Plans

<table>
<thead>
<tr>
<th>Independent Variables</th>
<th>Working Widows</th>
<th>Non-working Widows</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Standardized Beta Weights</td>
<td>Standardized Beta Weights</td>
</tr>
<tr>
<td></td>
<td>(F-ratios in parentheses)</td>
<td>(F-ratios in parentheses)</td>
</tr>
<tr>
<td>Age</td>
<td>-0.137</td>
<td>-0.248</td>
</tr>
<tr>
<td></td>
<td>(16.476)***</td>
<td>(40.272)***</td>
</tr>
<tr>
<td>Non-white</td>
<td>0.044</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>(2.862)</td>
<td>(0.007)</td>
</tr>
<tr>
<td>Number of years of widowhood</td>
<td>0.008</td>
<td>-0.041</td>
</tr>
<tr>
<td></td>
<td>(0.105)</td>
<td>(1.941)</td>
</tr>
<tr>
<td>Number of children at home</td>
<td>0.055</td>
<td>0.009</td>
</tr>
<tr>
<td></td>
<td>(4.094)*</td>
<td>(0.074)</td>
</tr>
<tr>
<td>Age of youngest child</td>
<td>0.034</td>
<td>0.150</td>
</tr>
<tr>
<td></td>
<td>(1.091)</td>
<td>(14.193)***</td>
</tr>
<tr>
<td>Current total family income</td>
<td>-0.158</td>
<td>-0.045</td>
</tr>
<tr>
<td></td>
<td>(31.075)***</td>
<td>(1.984)</td>
</tr>
<tr>
<td>No perceived health problems</td>
<td>-0.019</td>
<td>0.187</td>
</tr>
<tr>
<td></td>
<td>(0.591)</td>
<td>(37.706)***</td>
</tr>
<tr>
<td>Number of years of education</td>
<td>0.137</td>
<td>0.179</td>
</tr>
<tr>
<td></td>
<td>(25.631)***</td>
<td>(30.975)***</td>
</tr>
<tr>
<td>Vocational training</td>
<td>0.062</td>
<td>0.066</td>
</tr>
<tr>
<td></td>
<td>(6.358)*</td>
<td>(4.788)*</td>
</tr>
<tr>
<td>Number of years of work experience</td>
<td>-0.121</td>
<td>-0.007</td>
</tr>
<tr>
<td></td>
<td>(20.609)***</td>
<td>(0.065)</td>
</tr>
<tr>
<td>Constant</td>
<td>0.723</td>
<td>0.571</td>
</tr>
<tr>
<td>$R^2$</td>
<td>0.084</td>
<td>0.147</td>
</tr>
<tr>
<td>F-ratio of the regression model</td>
<td>14.266***</td>
<td>18.069***</td>
</tr>
<tr>
<td>Sample size</td>
<td>1,547</td>
<td>1,052</td>
</tr>
</tbody>
</table>

* Statistically significant at the 0.05 level.
** Statistically significant at the 0.01 level.
*** Statistically significant at the 0.001 level.

1 Means "Will get a better job within three years" for working widows and "Will get a job within three years" for non-working widows.
**Working widows.** For working widows, the predictors of the widow's plan to get a better job are almost the same as the predictors of planning to go back to school. Women with lower incomes are much more likely than others to expect to get a better job within three years following the time of the survey \((p < 0.001)\). Of the human capital variables, the educational level of widows is positively related to their intention to get a better job \((p < 0.001)\) and so is vocational training that the widows have taken in the past \((p < 0.05)\). On the other hand, the number of years of work experience is negatively related to the dependent variable \((p < 0.001)\). Such a negative relationship was also observed in the regression analysis of work-related school plans among working widows. Just as in the case of work-related school plans, widows tend to say they will get a better job if they are young \((p < 0.001)\) and if they have more children at home \((p < 0.05)\). However, race and age of youngest child are not statistically significant predictors; this contrasts with the finding regarding school plans.

**Non-working widows.** For non-working widows, current income level does not exert a statistically significant impact on widows' plans to get a job within three years following the time of the survey. Focusing on human capital variables, women without limiting physical conditions are much more likely than others to plan to get a job \((p < 0.001)\) and so are more educated women \((p < 0.001)\). Notice the strength of these human capital variables as predictors of the dependent variable. Vocational training—another human capital variable—is also positively related to the dependent variable \((p < 0.05)\). Age continues to be an important factor \((p < 0.001)\); younger widows are more likely to return to work. Also, widows with the youngest child of advancing age find it easier to plan to get a job \((p < 0.001)\).

**DISCUSSION**

**Interest in working.** The results of this study show that as a group, nonremarried widows receiving survivor benefits expect to work. Over half of the widows in this study were employed. Of those not working, 50 percent planned to get a job in the next three years. Over a third of all widows expected to return to school for education to improve their job skills. This work orientation is especially noteworthy considering that a constraint to paid employment exists for
these women. At certain levels of earnings, these widows face a high implicit tax rate on their earnings. In 1978, when the survey was taken, these widows could earn up to $3,420 without their social security benefits being reduced. However, earnings beyond this exempt amount were subjected to a 50 cent reduction in benefit for each excess dollar earned. (The widow's earnings would not affect benefits for her children, however.) A precise determination of the effect of high implicit tax rates on the work behavior of widows is beyond the scope of this study, but the results described here suggest that it does not act as a serious deterrent to employment. The widows appear to find that the advantages of working outweigh the disadvantages of reduced or forfeited social security benefits.

Although as a group widows are characterized by an orientation to paid employment, there are significant differences between those who plan an increased work commitment in the future and those who do not. Differences in human capital resources, income, family situation, and other circumstances were found between widows more likely to go back to school or get a job (or get a better job if already employed) and those unlikely to do so. Below is a discussion of these aspects of widows' future plans.

Human capital resources. As a group, health, education, and vocational training emerge as strong predictors of a widow's future plans. In general, widows with a higher level of human capital expected to increase their work commitment over the next three years while those with less human capital did not. Education was a very important determinant to both future school and job plans. As expected, those who had obtained more education and vocational training were more likely to plan to return to school than those who had not. Apparently, those with an already high level of education and/or vocational training believed that investing in still more schooling would pay off to a greater extent those whose educational background was lower. This generalization can be made also in regard to the widow's plans to get a better job (or get a job, if not employed).

On the other hand, work experience, another human capital variable, was found to be negatively related to the dependent variables among working widows. From these findings regarding human capital variables, one can
generalize that, while many human capital variables are positively related to a person's plans regarding future employment opportunities, not all human capital variables are so related. Apparently, number of years work experience is such an exception. Differential effects of human capital variables on future plans may be related to the perceived pay-off from increasing future commitment to employment.

The widow's perception of the state of her health was a significant indicator of both her present work status and her commitment to future employment. As Table 1 indicates, 79 percent of those working believed that they had no limiting conditions on the amount of work they did, while only 53 percent of the non-working women shared this positive view of their health. Thus, poor health may be a barrier that keeps widows from entering the labor force. For non-working widows, their perceived state of health also affected their expectations about what they could accomplish in the future, as those in good health were much more likely than others to plan an increased commitment to employment.

Taken together, the strong effect of the human capital variables on the widow's commitment to future employment suggests that, to a great extent, their future well-being depends on their own capabilities and personal resources. In general, those more able to compete successfully in the labor market are planning to increase their commitment to paid employment and are likely to adjust successfully to the period when benefits cease. On the other hand, widows with less human capital do not appear to be planning for the future by increasing their ability to be self-sufficient and can be expected to face serious financial difficulties when benefits cease.

Economic need. Among working widows, income level was negatively associated with commitment to future employment. This finding supports the view that economic need pushes the widow into planning for future employment. Women who are deprived of income anticipate a bleak economic future and thus are more likely than others to plan to increase their work commitment. On the other hand, income does not affect the future plans of non-working widows. This finding may stem from the fact that their income is comprised primarily of social security benefits, which have a relatively narrow range. The range is truncated
at both ends by minimum and maximum levels of benefits provided under social security. The resulting small variation in income causes its regression coefficient to be small. These two findings, put together, allow the authors to infer that it is the level of earnings—not the level of social security benefits—that influences the widow's plans on future employment. Widows who earn less are more compelled to do something about their future job opportunities than those who earn more. But this cannot be said about social security benefits. Non-working widows who receive less social security benefits may not necessarily feel more urgency to do something about their job prospects than those whose benefits are larger, granted that the range of social security benefits is relatively small.

**Family situational variables and other control variables.** For all widows in the study, age was a particularly important determinant of their level of commitment to future work efforts. Younger widows were much more likely than others to plan to go to school or get a job (get a better job, if already employed) in the next three years, even though older widows faced the more immediate prospect of losing social security benefits. This finding suggests that women who are going to increase their commitment to future work efforts make plans to do so when they are young. If they wait until they are older, it may be too late for them to embark on a career, even though their need may be greater since they soon will lose their survivor benefits.

All other things being equal, non-white widows (80 percent of whom were black in this study) were more likely than white widows to plan an increased work commitment in the future. This finding may be related to the traditional role expectation of black women, who have a higher probability of being the head of the household and thus may feel greater financial responsibility to support their families than do white women (Beckett and Smith, 1981).

That the time elapsed since the death of a husband does not influence the widow's future plans is interesting. It shows that the probability that a widow has future school plans or job plans is the same regardless of the time when her husband died. Apparently, mourning, feeling depressed, and financial upheavals that tend to occur following the death of a husband do not affect the widow in regard to planning for future employment.

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The major findings from this study can be summarized as follows: it is the human capital possessed by the widows which mainly determines widows' future plans to increase their work commitment. Widows who already have economic resources in themselves do more to improve their job conditions. A low level of income adds another push for widows to commit themselves to working. However, probably lack of income alone is not a sufficient reason for the widow's decision to plan positively for future employment. And if the widows do commit themselves to future advancement, it will happen when they are young. Family situational variables affect the widows' plans to some degree, but not as strongly as the traditional view of women might suggest. Nonremarried widows of today seem to plan their future employment based on their own qualifications and resources more than on family considerations.

FOOTNOTES

1. Preliminary findings from a study by Martha N. Ozawa and William T. Alpert on the effects of implicit tax rates on the earnings involving social security benefits indicate that widows' working behavior is not adversely affected by the reduction of benefits when they earn beyond the exempted amount.

REFERENCES


AFDC, FOOD STAMP, AND MEDICAID UTILIZATION: A RESEARCH NOTE

Mark R. Rank and Paul R. Voss
Department of Rural Sociology
University of Wisconsin-Madison

During the past 20 years, social welfare programs have been expanding both in terms of federal and state expenditures, and in terms of numbers of recipients. Among the programs involved in this expansion were Aid to Families with Dependent Children, Food Stamps, and Medicaid. However, knowledge of the sheer numbers of people and dollars involved provides at best an incomplete picture of these social welfare programs. The researcher, policy planner, and government administrator must also have an understanding of who is at risk of utilizing welfare in the general population. Such knowledge may provide insight into the present and future implications of policy changes. Therefore, the purpose of this research note is to provide a detailed analysis of the percentage of the population, broken down by demographic characteristics, involved in the Aid to Families with Dependent Children, Food Stamp, and/or Medicaid programs.

METHODOLOGY

Since late 1980, records of several welfare programs in Wisconsin have been completely computerized. Wisconsin's Bureau of Economic Assistance, Department of Health and Social Services, maintains a centralized, computerized data base of all applicants for three means-tested income transfer programs: Aid to Families with Dependent Children (AFDC); Food Stamps (FS); and Medicaid (MA). When individuals apply for an AFDC, Food Stamp, and/or Medicaid grant, the information on the combined application form is keyed from a county office into the centralized Computer Reporting
Network (CRN). Data files are retained over time, and information is continually updated according to program regulations. The CRN system thus presents an ideal opportunity for studying the characteristics and changing dynamics of Wisconsin welfare recipients. Specifically in this research note, individuals in the AFDC, Food Stamp, and/or Medicaid programs are examined.

A 2 percent random sample was drawn of cases receiving income or in-kind payments as of July 31, 1981, for one or more of the three programs. The total number of cases on the CRN system in July, 1981, was 176,072—resulting in a sample size of 3,587 case heads (or households). A total of 10,393 individuals were included in the sample—representing all persons who were listed on the welfare application form as present in the household, whether eligible for assistance or not. The data, therefore, permits an examination both at the household and at the individual level.

In the analysis, we make no attempt to differentiate between individuals who received AFDC, Food Stamps, Medicaid, or some combination of programs. Rather, our concern is limited to whether individuals receive an income and/or in-kind transfer payment aimed at low income families. Thus, we focus on the percentage of Wisconsin residents who either reside in a household receiving aid, are listed on the welfare grant, or are case heads (applicants) of such households.

Our 2 percent sample was first multiplied by 50 to estimate the state's total AFDC, FS, and MA population. These figures then were divided by appropriate 1980 Census figures in order to calculate the proportion of Wisconsin's population receiving aid. The Census data were used because they represent the best available numbers for computing the kinds of percentages needed for this analysis and they are reasonably close in time to the date of our sample. The numbers are shown separately for groups by sex, race, age, county of residence, household structure, and several combinations of these variables. We are able to estimate, for example, the percentage of white females ages 20 to 24 in the population who apply for and receive aid, are listed on the grant, or are residing in a household receiving aid.

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Several notes of caution are necessary regarding these calculations. First, the overall 1980 state population was somewhat smaller than the 1981 population, and therefore our percentages will be slightly inflated (although the reverse may be true for some age groups). Second, the Census tends to undercount particular racial and ethnic groups, causing our percentages for blacks to be somewhat inflated as well. Third, although data are gathered for individuals on the CRN system by age, sex, county of residence, and household structure, information on race is only available for the case head. Thus, we are making the assumption in the analysis that if the case head is, for example, white, then the individuals residing in the household are also white. Clearly a certain amount of error will be introduced by this assumption. And finally, our calculation of household structure makes the implicit assumption that the duration of specific household types does not differ between the welfare population and the overall population. For example, we assume that single parent families on welfare remain in that state (i.e., one spouse present) as long as single parent families in the overall population. Again, some amount of error will be introduced by this assumption. However, in spite of these cautions, the calculations based on this procedure are felt to be indicative of welfare utilization in Wisconsin, and certainly these problems do not substantially alter the trends reported.

RESULTS

Table 1 shows the estimated percentage of the population residing in households receiving either AFDC, Food Stamps, and/or Medicaid. The analysis is broken down by four demographic characteristics: sex, race, age, and county of residence. These percentages are based on the inflation of our sample counts to produce estimates of the total welfare population. The true percentages will vary somewhat from these figures due to the before mentioned problems, as well as sampling error.

Looking first at the total percentage of residents classified as case heads (column 1), an estimate of 3.8 percent of the total population apply for and receive either AFDC, FS, and/or MA. However, it is clear that not all residents are equally likely to be case heads receiving welfare. For example, females (5.8 percent) are much more likely than males (1.6 percent) to be receiving aid. Likewise, 16.1 percent
of blacks apply for and receive aid while the percentage for whites is 2.8 percent. Age also reveals differences in the patterns and likelihood of participating in one or more of the three transfer programs. Among Wisconsin residents aged 20 to 24, 7.9 percent are case heads of households receiving aid. The percentage slowly drops over the course of the life cycle until age 70. A very high proportion of those aged 75 and above who are receiving aid, reflect Medicaid participation. Geographic residence also is related to participation. For Milwaukee County (containing Milwaukee City, the largest urban concentration in the state), 5.7 percent of the residents are case heads, while the corresponding percentages for other Wisconsin metropolitan and nonmetropolitan residents are 3.2 percent and 3.4 percent.

Turning to columns 2 and 3, the estimated percentage of individuals with particular demographic characteristics who are listed on the welfare grant (column 2), and who are residing in a household receiving aid (column 3), reveals patterns similar to that of column 1. However, one important and not altogether surprising finding (given the nature and intent of the AFDC program) is the number of children who are listed on a welfare grant or who are residing in households receiving aid. Thus, 20.5 percent of all children under the age of 5 are living in a home receiving either AFDC, FS, and/or MA. Similarly, 18.6 percent of youngsters aged 5 to 9, and 14.8 percent of children ages 10 to 14, are residing in households receiving income or in-kind transfers.

Table 2 extends the analysis in Table 1, by focusing on household structure. This table allows us to ask: What percentage of various types of households are participating in one or more of the three transfer programs? Married-couple families are least likely to be receiving welfare. Indeed, only 4 percent of such households are receiving aid. There are several reasons for this. First, married couples often are able to generate greater income through the employment of both spouses. Second, it is often easier for married couples to support or arrange (if a wife or husband is not working) for the care of small children. On the other hand, households of two or more individuals headed by a female have a 1 in 2 chance of receiving AFDC, FS, and/or MA. Bradbury et al. (1979) observe that in recent years there has been a rapid growth in
the number of households headed by women and in the proportion of these households receiving public assistance. Or as Sanger notes, "when a woman with children becomes a family head, her chances of becoming poor and going on welfare greatly increase" (1979:51). Our data are consistent with this observation. Again there are several reasons that underlie this relationship. Women earn substantially less in the labor market than their male counterparts. For example, Waite (1981) estimates that for every dollar a male earns in the labor market, a female earns 59 cents. Second, many of these female householders are caring for their children and not participating in the labor force (either by choice or by their inability to find a job outside the home) which creates a greater financial burden upon such households. Thus it is no surprise that married couples and female heads of households represent the extremes in participation percentages shown in Table 2. What may be surprising, however, is the substantial gap between these two extremes.

Finally, Table 3 further refines the analysis in Table 1 by focusing on race, sex, and age simultaneously. Consequently this table addresses the probability over the life cycle of receiving transfer payments by race and sex. Looking first at case heads, the percentage of white males receiving aid is quite low. For black males, those aged 20 to 24 are most likely to be receiving aid. The trend after age 24 is generally downward. Both white and black females display a similar pattern over the life cycle. However, the pattern is considerably more accentuated for black women. During their 20's, over 50 percent of black females are receiving welfare. The percentage steadily drops as they reach their 30's, 40's, and 50's. It is predominantly the black female percentage which is pulling up the overall black percentage found in Table 1. As Kilson (1981) has argued, during the 1970's the slippage of aggregate black family income relative to white family income (from 62 percent in 1975 to 57 percent in 1980) is tied directly to the extraordinary rise in black female-headed households. Kilson points out that low income and high unemployment appear endemic to black female-headed families. Our percentages highlight these difficulties.
Turning to the likelihood of whether an individual is included on a welfare grant, several startling findings are apparent from Table 4. For black children under the age of 5, it is estimated that 79.9 percent of all females and 67.3 percent of all males in the population are included on AFDC, FS, and/or MA grants. While the percentage of white children on welfare grants is substantially less, it nevertheless represents the age category with the highest percentage of individuals on welfare. Likewise, the percentage of children residing in a household receiving aid is also quite high.

CONCLUSION

We have demonstrated that the likelihood of receiving AFDC, Food Stamps, and/or Medicaid clearly differs across demographic characteristics. While our findings are consistent with previous research, what may be surprising is the magnitude of the percentage differences. Clearly, particular demographic characteristics are strongly associated with the likelihood of receiving aid aimed at low income families.

It is also important to stress that these demographic factors are not operating in isolation from one another. For example, we find that participation rates are higher for blacks than whites. However, we also know that black families are more often headed by a female. Similarly, black families in Wisconsin have a higher probability than white families of residing in Milwaukee County. Both of these factors are also related to the chances of participating in one or more of the three transfer programs. Consequently, we need to think of these characteristics in conjunction with one another, rather than as isolated dimensions.

Finally, it is important to mention not only the estimated percentage of the population participating in these programs, but also the estimated number of recipients. For example, although we find that the percentage of blacks who are case heads is higher than the percentage of whites who are case heads (16.1 percent versus 2.8 percent), the actual number of black case heads is much smaller than the number of white case heads (29,600 versus 125,700). The point to be made is not that one number is more appropriate than the other, but rather that both pieces of information are important depending upon the questions being addressed.
1This research was supported by the College of Agricultural and Life Sciences, the College of Letters and Science, University of Wisconsin-Madison, the Bureau of Economic Assistance, Wisconsin Department of Health and Social Services, the Wisconsin Agricultural Experiment Station (project no. 1690, NC-97), and by the University of Wisconsin-Extension. In addition, analysis was aided by a "Center for Population Research" grant, No. HD05877, to the Center for Demography and Ecology, University of Wisconsin-Madison, from the Center for Population Research of the National Institute of Child Health and Human Development. The authors would like to thank Eleanor Cautley, Sheldon Danziger, and Doris P. Slesinger for their suggestions on earlier manuscripts. Also, the assistance of Laura Guy and Stephen Tordella was greatly appreciated. The authors take sole responsibility for any inconsistencies or errors that may remain. Revision of paper presented at the Midwest Sociological Meetings, Des Moines, Iowa, April 7-9, 1982.

2It should be noted that virtually all case heads are also listed on the welfare grant and are residing in the household. Similarly, nearly all individuals listed on the grant are also residing in the household. However, not all individuals residing in the household are listed on the welfare grant. For example, two families may constitute a single household with only one family eligible for AFDC, FS, and/or MA.

3We have excluded individuals in nursing homes and other institutions as constituting one person households.

4We recognize the risk of implying longitudinal trends from cross-sectional data.

5Sampling error may account for the percentage difference between black female children and black male children.
REFERENCES

Bradbury, Katharine, Sheldon Danziger, Eugene Smolensky, and Paul Smolensky

Kilson, Martin

Sanger, Mary B.

Waite, Linda J.
<table>
<thead>
<tr>
<th>Household</th>
<th>Welfare Grant</th>
<th>Heads</th>
<th>Welfare Case</th>
<th>Demographic Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>16.1 (129,600)</td>
<td>6.7 (297,150)</td>
<td>2.8 (129,700)</td>
<td>6.7 (297,150)</td>
</tr>
<tr>
<td>Black</td>
<td>5.2 (82,450)</td>
<td>6.7 (297,150)</td>
<td>2.8 (129,700)</td>
<td>6.7 (297,150)</td>
</tr>
<tr>
<td>Male</td>
<td>12.3 (297,800)</td>
<td>5.2 (82,450)</td>
<td>10.7 (257,850)</td>
<td>5.8 (140,450)</td>
</tr>
<tr>
<td>Female</td>
<td>11.0 (179,650)</td>
<td>3.8 (179,650)</td>
<td>7.8 (179,800)</td>
<td>6.3 (437,650)</td>
</tr>
</tbody>
</table>

Estimated Percentage (and Number) of the Population Who Are:
<table>
<thead>
<tr>
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<tbody>
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<td></td>
<td></td>
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<tr>
<td>Household</td>
<td>11.5 (26.%50)</td>
<td>3.2 (47%0)</td>
<td>2.0 (37%50)</td>
<td>2.7 (55%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
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<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
</tr>
<tr>
<td>Individuals</td>
<td>11.5 (26.%50)</td>
<td>3.2 (47%0)</td>
<td>2.0 (37%50)</td>
<td>2.7 (55%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
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<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
</tr>
<tr>
<td>Welfare &amp; Care</td>
<td>11.5 (26.%50)</td>
<td>3.2 (47%0)</td>
<td>2.0 (37%50)</td>
<td>2.7 (55%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
<td>2.6 (46%50)</td>
<td>2.5 (47%00)</td>
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**Table 1.** (Continued)
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<table>
<thead>
<tr>
<th>Household Type</th>
<th>Male Householder</th>
<th>Female Householder</th>
<th>Other Family</th>
<th>Married-Couple Family</th>
<th>Two or More Persons</th>
<th>All Households (as a percent of Welfare Households)</th>
</tr>
</thead>
<tbody>
<tr>
<td>187</td>
<td>4.9 (67,900)</td>
<td>(NO husband present)</td>
<td>11.8 (4,500)</td>
<td>(NO wife present)</td>
<td>Male Householder</td>
<td>Female Householder</td>
</tr>
<tr>
<td>4.0 (41,050)</td>
<td>Male Householder</td>
<td></td>
<td></td>
<td></td>
<td>Other Family</td>
<td>Married-Couple Family</td>
</tr>
<tr>
<td>5.3 (12,100)</td>
<td>Female Householder</td>
<td></td>
<td></td>
<td></td>
<td>Two or More Persons</td>
<td>Married-Couple Family</td>
</tr>
<tr>
<td>7.5 (10,850)</td>
<td>Male Householder</td>
<td></td>
<td></td>
<td></td>
<td>All Households</td>
<td>Welfare Households (as a percent of Welfare Households)</td>
</tr>
</tbody>
</table>

TABLE 2: ESTIMATED PERCENTAGE (AND NUMBER) OF HOUSEHOLDS RECEIVING AFDC, FOOD STAMPS, AND/OR MEDICAID.
Excludes individuals in institutions (e.g., nursing homes).

1. 1980 Census of Population. See the text for a more complete discussion.
   By appropriate general population figures taken from Summary Tape File 1A,
   (weighted by 2) to estimate welfare population number shown in parentheses
   (weighted by 5) to estimate weighted sample frequencies

<table>
<thead>
<tr>
<th></th>
<th>Female Householder</th>
<th>Male Householder</th>
<th>Non-Family Household</th>
<th>Two or More Persons (Cont'd)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>16.4 (4,950)</td>
<td>14.2 (6,050)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Household Type
   All Households (as a percent of welfare households)
<table>
<thead>
<tr>
<th>Age</th>
<th>Female White</th>
<th>Male White</th>
<th>Female Black</th>
<th>Male Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3 (27,750)</td>
<td>1.1 (1,100)</td>
<td>0.9 (5,300)</td>
<td>1.3 (1,400)</td>
<td>1.1 (1,440)</td>
</tr>
<tr>
<td>1.4 (2,920)</td>
<td>1.4 (2,920)</td>
<td>1.4 (3,250)</td>
<td>1.4 (3,250)</td>
<td>1.4 (3,250)</td>
</tr>
<tr>
<td>3.0-3.9</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>5-9</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>0-4</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>4.0-4.9</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>4.0-4.9</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>5-9</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>10-14</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
<tr>
<td>15-19</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
<td>1.0 (2,150)</td>
</tr>
</tbody>
</table>

Table 3. Estimated Percentage (and Number) of the Population Residing in Households Receiving AFDC, Food Stamps and/or Medicaid by Age, Sex, and Race.
<table>
<thead>
<tr>
<th>Age</th>
<th>3.5' (1.2, 4')</th>
<th>7.7' (1.7, 14')</th>
<th>11' (2.3, 100)</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.3</td>
<td>1.8, 8.4</td>
<td>4.4, 5.5</td>
<td>2.8, 4.9</td>
<td>2.9</td>
</tr>
<tr>
<td>19.6</td>
<td>1.2, 7.9</td>
<td>5.1, 6.1</td>
<td>2.1, 3.5</td>
<td>3.4</td>
</tr>
<tr>
<td>21.1</td>
<td>1.1, 7.8</td>
<td>5.2, 5.7</td>
<td>2.2, 3.9</td>
<td>3.7</td>
</tr>
<tr>
<td>24.2</td>
<td>1.0, 7.7</td>
<td>5.3, 5.7</td>
<td>2.2, 4.0</td>
<td>3.7</td>
</tr>
<tr>
<td>29.3</td>
<td>0.9, 7.9</td>
<td>5.4, 5.7</td>
<td>2.3, 4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>29.4</td>
<td>0.9, 7.9</td>
<td>5.4, 5.7</td>
<td>2.3, 4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>30.1</td>
<td>0.9, 7.9</td>
<td>5.4, 5.7</td>
<td>2.3, 4.5</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Table 2 (Continued)***

**Percentage (and Number) of the Population on a Wellfare Grant**

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Black</td>
<td>White</td>
<td>White</td>
<td>White</td>
</tr>
<tr>
<td>5-9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10-14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-24</td>
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</tr>
<tr>
<td>25-29</td>
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<td></td>
</tr>
<tr>
<td>30-34</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>35-39</td>
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<td></td>
<td></td>
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<tr>
<td>40-44</td>
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<td></td>
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</tr>
<tr>
<td>45-49</td>
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<tr>
<td>50+</td>
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</tbody>
</table>

*Percentage (and Number) of the Population on a Wellfare Grant*
### Table 2.1: Population of Welfare Households by Age and Sex, 1960 and 1970

#### 1960 Census of Population

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>12.3%</td>
<td>11.5%</td>
<td>5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>5-9</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>10-14</td>
<td>5.7%</td>
<td>5.7%</td>
<td>5.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>15-19</td>
<td>4%</td>
<td>4%</td>
<td>4.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>20-24</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>25-29</td>
<td>1.9%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>30-34</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>35-39</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>40-44</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>45-49</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>50+</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

#### 1970 Census of Population

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>12.3%</td>
<td>11.5%</td>
<td>5%</td>
<td>7.2%</td>
</tr>
<tr>
<td>5-9</td>
<td>6%</td>
<td>6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>10-14</td>
<td>5.7%</td>
<td>5.7%</td>
<td>5.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>15-19</td>
<td>4%</td>
<td>4%</td>
<td>4.4%</td>
<td>4.4%</td>
</tr>
<tr>
<td>20-24</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
<td>2.9%</td>
</tr>
<tr>
<td>25-29</td>
<td>1.9%</td>
<td>1.9%</td>
<td>1.9%</td>
<td>1.9%</td>
</tr>
<tr>
<td>30-34</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>1.4%</td>
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<tr>
<td>35-39</td>
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</tr>
<tr>
<td>40-44</td>
<td>0.7%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
</tr>
<tr>
<td>45-49</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
<tr>
<td>50+</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
<td>0.2%</td>
</tr>
</tbody>
</table>

Note: Numbers in parentheses do not sum to total because of the handling of missing data. By appropriate general population figures taken from Summary Tables A.1, (weighted by 50) to estimate welfare population numbers, shown in parentheses (weighted by 50 to estimate welfare population numbers, shown in parentheses), percentage figures are calculated by dividing weighted sample frequencies.

---

TABLE 2. (Continued)
The study of and practice in communities requires a theoretic construct of an overarching conceptualization that can "sweep-in" existing paradigms; variant epistemological foundations and methodological directives for complex community development. The purpose of this paper is to identify and define the existing epistemological and methodological approaches to communities with the objective of coalescing them into a unified system of inquiry. The intent is to first raise the level of abstraction in and about a community that goes beyond the confines of any (or combined) paradigm. In so doing, one can converge a polarity of opposing positions to the study and understanding of communities. This is a social design professional activity: the arrangement of, and the processes of arranging and rearranging the human, social and technical resources of a community to achieved desired results. Secondly, a social design function builds community systems by anticipating human and social needs: developing strategies for realization and tactics for their implementation.

I. Introduction

This paper is based on the notion that all communities, whether in post-industrial societies or less developed countries, are in process of development. The hierarchical levels of complexity in these societies are characterized by structural differentials produced by technological and political development, but the function of planned social change remains the same in all societal systems.
My contention is that community development and social change are mutually interactive processes. Communities ought to evolve towards a desired or envisioned human and societal end (desideratum) through purposeful social change. The means for its realization of an "ideal" end are continuously designed and redesigned. Hence, the social design of a community refers to the arrangement of, and the processes of arranging and rearranging its human, social and technical resources to accomplish a variety of community objectives. A progressive realization of these objectives compel the community as a system to increasingly move toward higher levels of complexity. This, in turn, requires the intermittent resetting of goals that offer new directions for the community in development. Within this context, the role of the professional as a social designer is viewed as that of a centrifugal force within a continuous process of change.

The term "communities in development" as described and defined here differs markedly from the usage of others who do not perceive it as a "centrally planned change" but rather as ... "a non violent approach to organizing people for redressing their grievances." This paradigmic approach advances a Parsonian system of analysis and emphasizes particularly remedial and incremental procedures. "Community in development as a social design function" is distinguished from community action, community organization, community planning and community control because it emphasizes the concept of emergence. Communities are seen as purposefully seeking desired results through a preconceived and predetermined social design. Community planning is purposive in that there are deliberately devised experimental means to pursue goals for a community. Communities in development are purposeful in that the goals are created and they emerge as the means for their realization are designed.

II. Need for a Conceptual Perspective

Social design as a function for communities in development has now advanced to a level of knowledge acquisition and utilization that necessitates the formalization of
a theoretical construct unique to its intellectual, administrative and operational activities. This broad scope of involvement requires a theoretical construct with an overarching conceptualization that can "sweep-in" existing systems of inquiry, variant epistemological foundations, and methodological directives. Such a conceptual perspective should be easily applicable in highly complex urban areas, as well as in less "complex" rural communities.

A brief review, therefore, the major paradigms* responsible for producing knowledge for the field of community studies will enable us to:

(1) Identify existing patterns and traditions in research that can serve as models for community problem solving and decision making.

(2) Describe the relationship between social change in communities with particular relevance to the role of the professional as the user of the knowledge based on these paradigms.

(3) Provide a more creative and rational basis upon which critical decisions can be made in the selection of a particular paradigm relative to its producers (i.e., participants in a variety of spatial and temporal dimensions in which problems of communities are confronted.

Hence, the major purpose of this paper is to describe and identify the alternatives available for inquiry while simultaneously considering the feasibility of coalescing them into a unified conceptualization for a community in development. Second, the intent is to increase the level of abstraction beyond any one exclusive or combined use of these systems of inquiry in the studies of communities. A social design for communities in development is

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*A paradigm in this paper refers to the ontological conceptions, epistemological foundations, methodological directives found in models from which particular patterns, traditions, and practices emerge in community studies.
a function in which emerging human and social needs are anticipated and the means necessary for their realization are prescribed by a social designer. This necessitates and introduces the use of an emerging system of inquiry to provide a broader knowledge base for social and human affairs.

III. Existing Conceptual Perspectives

Four paradigms reflecting contemporary thinking in the social sciences were selected to represent prevailing conceptual perspectives in studies of communities: scientism, adaptations in action systems, control through divergence, and planning in social experimentation. The criteria I used for the selection of these systems of each paradigm contains ontological conceptions, epistemological foundations and methodological directives.

(1) **Ontological Conceptions:** Each paradigm implicitly or explicitly responds to the questions—What is the purpose for which communities exist? Is a community an expression of all the components that comprise it? Or does a community have an existence in and of itself irrespective of the parts that comprise it?

(2) **Epistemological Foundations:** Each paradigm organizes its knowledge, information, resources and experiences. Must they reflect direct observable events and occurrences subject to causal analysis? Or ought they to reflect visions and experiments in heuristic articulations?

(3) **Methodological Directives:** Each paradigm provides a description and explanation for the methods and techniques used that clarify and/or structure the problem (i.e., means/ends relations in causality or finality); each discloses applications of logical principles to concrete problems. Are the available means and ends known to a community in the pursuit of a problem? If not, what alternative strategies can be made available? What do communities do when the means and ends are unknown or in disagreement?
Let us now briefly examine these four paradigms:

(A) **Scientism Applied to the Study of Communities**

A scientific deterministic perspective is in search of knowledge predicted on the assumptions that all human and social behavior can be observed and measured and analytically appraised through the use of objective logic and pure rationality. For example, advancements made in science and technology follow specific physical and mathematical laws that can determine causation and can have replicable and predictable value. A synoptic conception: a comprehensive understanding of a community can be transferred to other communities despite idiosyncratic and subjective values inherent in the communities' cultures and social norms that comprise the foundations for their respective social institutions. In my view, this poses a challenge to the primacy of values which they are supposed to serve, especially when scientific and technological advancements are packaged in their entirety from highly advanced, let us say, industrial and urban technological centers to be applied to less developed areas.

In scientism, objectives for communities are prioritized and quantified to attain the most efficient and effective decisions necessary for their maximization. These objectives are usually decided upon statistically, through elaborate mathematical and probabilistic equations which are formulated on the basis of empirical data of past events and occurrences. Goals are determined and predictions made for social change on the basis of where the social system has been, current thought that governs conditions for classification, and the available quantifiable and mathematical tools advanced for decision-making.

Scientism in studies of communities assumes that:

1. All social problems can be made well structured (means/ends are known and in agreement) so that they can be solved.
(2) Independent and dependent variables can be distinguished, measured quantitatively and controlled under experimental conditions to ensure validation of any findings in community studies.

(3) Analytical reductionism can be used to study communities by an independent, objective analyst whose findings will be replicated and can be predicted in similar situations.

(B) Adaption in Action Systems

A Parsonian perspective proceeds on the assumption that the equilibrium of a social system is both known and attainable, no matter on what structural and functional complexity. This is an inevitable and, incidentally, a desirable prerequisite for a social system's movement towards a preferred steady state. The concept of "equilibrium," on closer scrutiny, comes to represent the selection of choices for a given composite of social values and social norms, perceived as critical for the preservation and maintenance of the social system. These sets of criteria become the basis upon which all decisions in the community are made. All decisions, it is argued, are restricted, omitted or limited to the social values established by a "community of minds." Agreement in a community of minds (known as a "Gemeinschaft" people related by a sense of mutuality, common interest, common bonds, and common destiny) produces commitments, cooperation and coordination in communities. This view of social change in contemporary parlance has come to be known as disjointed incrementalism, comprised of serial, remedial and fragmentary decisions in social development.

Every social system, irrespective of its level of scientific or technological advancement, it is argued, must inherently possess basic functional requisits for the maintenance of its established patterns for equilibrium, the capacity for integrating external environmental value inputs for change, a structural differentiation to adapt to changing external conditions and goals necessary to preserve its perpetual existence and development.
A community, when placed in this perspective, engages in mutual interactive processes within its social system, and between its environment and members. A mutual adjustment is sought whenever the stability in and between these functional requisites is perturbed by external social ills. The functional requisites of a community are to promote and protect the social values that comprise its system. In other words, the system must maintain and preserve a status quo; restore equilibrium whenever it is perturbed by an external force through a variety of coalitions, cooptations and adaptive techniques (i.e., mediate and facilitate; adjust the individual's behavior to the requirements of the system through therapeutic diagnostic treatment modalities; and meliorate social conflicts, issues and problems through the "political" processes of bargaining, consensus and compromises of differences through agreement in a community of minds.

There are no known or agreed upon goals or objectives established for the direction or guidance of the community required in this system of inquiry. The ends of an integrative process that attains accommodation or reconciliation is perceived as more important and critical to the community than the overall purpose and function for existence. Professional activity is required only at points of dysequilibrium. Decisions are reactive to a social perturbation that precipitates action for small change:

1. The reaction to a social perturbation must lead to remedial actions, resulting in short-term benefits with the purposeful avoidance of any long-term commitments.

2. Each incremental decision, it is understood, will resolve a single perturbation as a one-time occurrence without consideration for preceding or succeeding decisions.

3. Participation in the processes of mutual adjustment will resolve (not solve) social perturbation for the purpose of preserving and maintaining the

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system, rather than giving it direction and guidance for the future

This paradigm views "...The changing nature of communities as an understanding of correlates of adaption that should enable anticipation of emerging alienation problems." The assumption is that past experiences can be mirrored into the future for preventive purposes in community planning.

(C) Community Control Through Divergence

The knowledge produced by this paradigm assumes that conflict in social systems is ubiquitous. A multiplicity of values and diversity of interests inevitably generates a polarity of opposing positions that can only be resolved through the creation of an alternative course of action that simultaneously comprises and subsumes the diverging positions. Social change requires discontinuity with the past and can only be advanced through conflict:

(1) There exist in all social systems legitimated authority and a political system which requires leaders to exercise authority in making critical decisions effecting community members. These "chosen few" who make critical decisions can be found whenever authority and power in the community is formally or informally distributed and exercised. They may be a bureaucratic elite who decide on the operationalization of community projects or a technocratic elite who control and decide on the information flow within and outside of the community.

(2) Power elite in society acquire and utilize power to advance specific interests whether political, economic or professional in a conflict ridden climate of adversary relations. Communities striving for "human betterment and social progress" are realized only to the extent that the power elite sanctions them.

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Conflict, power and elitism form a triadic relation in an interactive process by which community control and social change is determined. Leaders are chosen because of their power to guide and direct social programs under conditions that inevitably will generate resistance to change.

Intrinsic to this paradigm is the assumption that those who decide on the nature and quality of change in communities will be in continuous conflict with those who advance opposing ideas as to how a community ought to pursue its ends. Social change in communities is a function and process that evolves in turbulence while striving for a synthesis of diametrically opposing sets of criteria.

Social change for communities within this context is a process that generates tension; stress and strain in that change, purportedly induced by conflict, requires new patterns and relations in the social system. Conflictual relations between those who rule and those who are ruled is an endless process in which a community benefits or is victimized depending on who has authority and control over the setting of goals for social change.

Community Planning in Social Experimentation

This system of inquiry produces knowledge as it learns from experience. Its use is an expression of a social system that is confronted with an unusually new, anticipated or "wicked" social problem in which social experimentation is perceived as the only alternative. Within this context, "community" is perceived as an evolving process in which a great deal of learning and knowledge building will take place to confront an original social problem for which there exists no known or agreed upon solution.

Community planning requires, therefore, learning from experience by introducing alternative courses of action to any chronic or original social problem. It becomes necessary to ascertain and appraise the
alternative courses of action most conducive to the solution of the problem on hand based on the critical variables of cost, time, performance and place of implementation. A number of intermittent social changes are anticipated in sequential development. As the professional solves partial aspects of a problem, immediate changes and modifications are instituted in the functioning of the system (i.e., how it solves its problems) and new goals are pursued in accordance with emerging and changing developments.

Social experimentation in a sequential planning process is committed to social change in:

(1) the restructuring of the social problem, that is, the original problem takes on a different configuration in development;

(2) the amount of knowledge and information made available, as for example, how much learning can take place in a community at any given time;

(3) the degree to which any one alternative course of action can be efficiently and effectively operationalized, as for example, assessing the rate of technology advanced in a given community; and

(4) the amount and quality of resources available to pursue a program or project in development -- given enough resources and time all social problems can be solved. Intrinsic to community planning in social experimentation is the possibility that the professionals and people comprising a community are not always in agreement on what comprises a "good or better" community.

The goal for community planning is to allow the exploring of alternative courses of action so that more viable community decisions can be made in conjunction with everyday experiences in concrete applications.

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The four conceptual perspectives are critical in producing knowledge for studies in and about communities:

(1) Each paradigm has relevant application to the community social issues, problems, needs, etc., at given points in time, place and participants.

(2) Each paradigm broadens the choice over the epistemological and methodological base to communities.

(3) Each paradigm offers its own unique perspective of the community gestalt and its "approximation of reality."

(4) Each paradigm can move horizontally and vertically on a range of disciplinary and interdisciplinary contributions.

Each paradigm, however, is empirically bound to approximate the current reality in describing and explaining that which exists or is bound to arise. None of these systems of inquiry are prescriptive relative to creative action. All lack direction and guidance to move a community from an existing condition towards a planned future goal and thus are not purposefully goal oriented towards a desideratum.

IV. Application of Paradigm

Before proceeding with a discussion about the emerging system of inquiry for studies in communities it is appropriate to first examine the role of participants in the use of existing paradigms. The terms community organization, community action, community control and community planning are often used interchangeably. Distinctions only arise for the user* when specific criteria are

*Producers are members of any perspective(s) in the natural and social sciences, professional groups and researchers. Users are clients, special interest or a community at large.
introduced, as for example, whether the term is being used to describe a process, a task, a method, etc. It seems propitious to place these terms in juxtaposition to the aforementioned paradigm and to note the following significant correlations.

(1) **Community Organization as an Expression of Scientism**

Choices made in the use of knowledge on behalf of a community are relative to the idiosyncratic values of the user. For example, if the user's approximation of the community's reality is an exact replication, that is structure and components parts are well ordered and specified, then the inclination is towards scientism with its logical apparatus and axiomatics.

Community organization is a logical and rational process "... by which a community identifies its needs or objectives, orders (or ranks) them, develops confidence and will to work at them, finds the resources (internal and external) to deal with them takes action in respect to them and in so doing, extends and develops cooperative and collaborative attitudes and practices in the community."\(^1\)

(2) **Community Action as an Expression of Adaptation**

If, the user's value dictates the maintenance and perpetuation of the existing community system, then the choice for usable knowledge is governed by reactive and remedial processes. The community as a social action system "... has both external and internal aspects relating the system to its environment and its units to each other. It can distinguish from its surrounding environment performing a function called boundary maintenance. It tends to maintain an equilibrium in the sense that it adapts to changes from outside the system in such a way as to minimize the impact of the change on the organizational structure and to regularize the subsequent relationships."\(^2\)
(3) **Community Planning as an Expression of Social Experimentation**

If there is no clarity or agreement as to how to resolve a problem in a community and/or for its members, then the only perspective is to experiment with various alternatives. Planning involves "... the process of locating and defining a problem (or set of problems), exploring the nature and scope of the problem, considering various solutions to it, selecting what appears to be a feasible solution and taking action in respect to the solution chosen."¹⁴

(4) **Community Control as an Expression of Divergence**

If change in communities is perceived as a process of agitation for social progress by bringing about new social structures and new social order, then the reality is approximated to be in sets of values committed to stress, strain and tension. The community both in its vertical and horizontal relations engages in adversary exchanges that are a reflection of "... an abiding difference of interests, a challenge to the legitimacy of community decision organization ... and a frank acceptance of contest as a legitimate and necessary method of resolving community issues."¹⁵

In actual applications in studies of communities the aforementioned paradigms can assume the following constellations:

1. Each conceptual perspective can produce knowledge that is highly specialized (i.e., for community organizations, community action, etc.) but is divorced from other perspectives and from the total social wants and needs of a community.

2. Two or more perspectives can offer simultaneously knowledge for the "wants and social needs" of a community, but without making explicit the possible relationships that may exist between them (i.e., knowledge produced for action or planning).
(3) Findings produced by one perspective are imposed upon others as axioms for the same community, thereby compelling a rigid polarization across perspectives toward these axiomatic conditions. The community may actually be left with no choice except to reject these conditions.

(4) Various perspectives can produce knowledge in juxtapositions to one another so as to enhance relationships and bounds between them without involving the community or effecting its direction.

The range of choices for knowledge acquisition is contingent upon the degree and extent of involvement of the producers and users of these systems of inquiry.

Knowledge acquisition and utilization in studies on communities requires a coalescence of these alternative conceptual perspectives for the following reasons:

(a) The range of value choices for knowledge acquisition and utilization in any one perspective is restricted, limited and liable to given sets of premises and internal referents that, taken separately, are far removed from the idealized and actualized "wants and social needs" of a community.

(b) A coalescence approach perceives all contributors to knowledge in whatever paradigms chosen as co-producers to the understanding of a community and that their participation is interconnected and interrelated with that of others. All four paradigms have some potential validity; all must be included.
(c) It requires that producers of these conceptual perspectives purposefully plan and coordinate their efforts in conjunction with existing as well as emerging needs and requirements of a community.*

(d) The producers of knowledge must commit themselves to the overarching goals of a community which give guidance and direction to their studies and community pursuits. This is the most difficult requirement, but I am assuming that agreement, at least on basic "ground rules," is possible.

V. An Emerging Conceptual Perspective for Social Design

With the involvement of co-producers we can begin to formulate a new system of inquiry that engages in a "sweeping-in" process of the contributions of others in knowledge acquisition and utilization for communities. It is both feasible and desirable to begin to formulate a theoretical construct that can accomplish the following:

(1) A system of inquiry for a social design that is macrodeterministic (i.e., comprehensive to encompass a constellation of activities, programs and services in a community, organization, actions, plans and control mechanisms) performed on multiple levels of involvement (i.e., local, state and federal); and concurrently provide guidance and direction in the selection of strategies and tactics necessary for micro-level implementation.

(2) A system of inquiry for social design that can hypothesize "ideal ends" for a community by using the empiricism of past observations and measurements both deductively and inductively derived.

*Because of the relationship discussed above, between paradigms and community roles or functions (organization, action, planning, and control), the involvement of all roles will help to insure the representation of all paradigms.
(3) An inquiry for a social design that can produce the knowledge necessary for a methodology applicable to both community experientials (descriptions and explanations of existing conditions) and community experimentations (prescriptions of what ought to be).

A system of inquiry that pursues knowledge building "in and about" communities in pure rationality, adaptive processes, dialectic and social experimentation can place emphasis of "creating knowledge" for more ideal ends as well as choosing the right means to realize them. This creative activity is in juxtaposition to logic and rationality necessary for realization in specificity. The social designer is involved in human, creative, rational action in which the "being is becoming, the doing requires thinking," etc., resulting in co-producing processes that meet contemporary social needs while simultaneously pursuing "what ought to be."

Second, a social design function distinguishes in thought between different sets of inquiries, role, behavior patterns, and strategies and tactics for social change. This form of inquiry overcomes the inconsistencies of independent findings derived from different systems of inquiries used in conceptual perspectives. The social designer can move the inquiry from analytical reductionism (what each inquiry does independently) to complex synthesis (how a concrescence of these contributions to knowledge produces a new and more complex community perspective). As a result, the social designer can consolidate polarities of positions to be used in studies of communities by moving the inquiry to higher levels of abstraction and complexity.

And finally, a social design function must communicate its program for planned change to the community in such a manner that the community can transform those plans into corresponding actions which, in fact, meet the goals in the same way as the design proposed. The community must be perceived as capable and able of achieving what it wants, so that communities perceived as systems are purposefully goal oriented. Communities still require a rational assessment of what goals have been attained. The social designer must solicit community cooperation in
self-identification expressed through participation in attaining and anticipating common pursuits; in coordinating the multiple levels of structure and processes that must be differentiated and coalesced; must constantly create organizations and institutions to fulfill the wants and needs of the community system.

VI. **Summary**

A social design function and/or process is introduced as an alternative system of inquiry capable of unifying a polarity of conceptual perspectives available to the studies of communities. The social design perspective is viewed as the most advantageous inquiry for a con crescense of social experientials as it is for social experimentations. A convergence in a unified inquiry provides opportunity to describe existing conditions in concrete applications as it does for prescriptions of anticipated events in one overarching conceptualization. This encompasses not only paradigms but also the acquisition and utilization of knowledge as well as an interdisciplinary approach studies in communities. This conceptual scheme offers the professional opportunity to practice in the specificities of communities as it offers opportunity to design future systems.
REFERENCES


2. This concept has been developed as a "syncretic construct." See, Sutherland, John W., Societal Systems. New York: North-Holland, 1978.

3. An epistemological foundation and methodological directive will be available as a companion paper for the social designer in social development. A discussion on contemporary systems of inquiry identified as Leibnitzian, Lockean, Kantian, Hegelian and Singerian can be found in Churchman, West C., The Designs of Inquiring Systems. New York: MacMillin, 1971.


5. Warren, Roland L., Stephen Rose and Ann Bergunder, The Structure of Urban Reform. Massachusetts: Lexington Books, 1974, pp. 163. Note the community decision organization model and finding ... "the more scientifically objective the investigator becomes about quantitative measurement the more naive and unwittingly value laden become the tacit implications of the research design."


15. Ibid., p. 392.
CHILD ABUSE AND MENTAL HEALTH: AN EXAMINATION OF SOME LONG TERM EFFECTS FOR PRISON INMATES

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Abstract

This study examines the effects of childhood abuse on future adult mental health. A statistically significant relationship was found between abuse and mental health problems. This relationship remained even after controlling for parental characteristics and the effects of an abusive environment. These findings suggest that one way to deal with the consequences of abuse would be to develop long term intervention strategies.

Since the early work of Kempe and his associates (Kempe et al., 1962) child abuse and neglect have become major foci for research in the fields of social welfare, pediatrics, child development, psychiatry, and behavioral science. Quite an extensive and informative body of literature has resulted from this relatively recent interest (see Martin et al., 1974 and Taylor and Newberger, 1979 for good reviews of the current literature). The majority of this research provides insight into the social background and present circumstances of the abusive adult (Baldwin & Oliver, 1975; Garbarino, 1976; Gil, 1970; Lynch and Roberts, 1977; Milner and Wimberley, 1979).

A less extensive body of literature focuses on the victims of abuse. The earliest studies (Elmer and Gregg, 1967; McHenry et al., 1963; Schloessner,
1964) focused almost exclusively on the immediate short term physical effects (i.e., lacerations, broken bones, brain damage, death). More recent empirical research has expanded this focus to include the psychological, social, and intellectual development of the abused child. Several of these studies report that abused children exhibit more aggressive behavior than control groups, have a poor self-concept, and have difficulty in developing meaningful interpersonal relationships (Berkeley Planning Associates, 1978; Elmer, 1967; Green, 1978; Kent, 1976; Kinard, 1980; Martin and Beezley, 1976; Martin and Rodeheffer, 1976; Muir, 1976; Sandgrund et al., 1974). These studies, along with the earlier research on the physical problems of abused children, suggest that the neurological, psychological, and social development of these children may be delayed and/or distorted.

Still less developed, however, is theory and research focusing on the long term effects of abuse. A relationship between childhood abuse and future problems as functioning adults is implied in much of the literature. Early theoretical statements (Curtis, 1963; Easson and Steinhilber, 1961; Silver et al., 1969) suggest that abused children are more likely to be aggressive and engage in behavior that is antisocial -- both resulting in conflict with authority and the law. Studies of juvenile delinquents, when commenting on the disproportionate number of children that have been abused or come from a violent family background, tend to reinforce these earlier statements (Button, 1973; Lewis et al., 1979). While this line of research suggests that "violence breeds violence," there is no general consensus on the relationship between abuse and future personal aggression (Muir, 1976).

Research also suggests that abusive adults fail to develop normal parent-child relationships because they themselves were abused as children (Helfer, 1973; Solomon, 1973; Steele and Pollock, 1968). Whether this relationship is due to psychopathological characteristics of the adult resulting from abuse, psychopathological characteristics of the adult independent of abuse, or to the learning of values, attitudes, and behaviors conducive to the use of violence is still debated.
On balance, however, this research seems to provide at least tentative support for the argument that the effects of abuse are likely to go well beyond childhood and adolescence.

Baldwin and Oliver (1975) present findings which further suggest an enduring relationship between child abuse and long term effects on mental health. Their study focused on the family characteristics of abused children. It was found that fifty-eight percent of the abusive parents experienced prolonged mental abuse, forty-two percent experienced severe or moderate physical abuse, and forty-two percent experienced neglect as children. This is consistent with other studies. What is of even greater interest is their finding that significant proportions of the abusive parents had histories of suicidal attempts (30%), psychiatric inpatient treatment (34%), psychiatric outpatient treatment (58%), and various personality and neurotic disorders (76%).

Clearly, the implication of the theoretical work and the findings of empirical research suggest that childhood abuse has long term effects for its victims. The present study examines the mental health of adults who report having been abused and/or neglected as children.

**Data and Description of Variables**

The data for this study were obtained from the Division of Prisons, North Carolina Department of Correction. After being sentenced to an active prison term each new inmate is sent to one of the Department's Reception and Diagnostic Centers. During the first two weeks of admission, data concerning the inmate's background (such as occupation, education, family life during formative years, etc.) are collected. In 1979 there were 10,233 new admissions to North Carolina prisons. Of the new admissions background information was collected on over 5,000 inmates -- the remaining inmates were serving sentences of one year or less and background information is not routinely obtained from them.

The mean age of those individuals admitted during 1979 was 27.5 years. Approximately 94 percent of the new inmates were males and 47% were non-white. The mean education for this group was 9.65 years of
schooling. Over twenty percent were incarcerated for larceny followed by burglary (18.2%), assault (10.5%), robbery (8.7%), and other offenses (42.6%). For those individuals who said that they were abused as children the mean age was 23.7 years, about 84 percent were males and 38% nonwhite. The mean education for this group was essentially the same as the total inmate population—9.67 years of schooling. The most typical crimes for which the abused individuals were incarcerated were also similar (larceny 25%, burglary 23.7%, assault 8.1%, robbery 8.7%), and other offenses 34.5%).

Childhood abuse was constructed from a social history question concerning the inmate's relationship with his/her parents: 1) the inmate felt the relationship was good, 2) felt the relationship was unsatisfactory due to physical abuse, 3) it was unsatisfactory due to mental abuse, 4) it was unsatisfactory due to both physical and mental abuse, and 5) it was unsatisfactory due to negligence. In order to ensure enough cases for analysis categories 2-5 were collapsed into a single category of (being) abused. The dependent variable, mental health problems, was coded as either 1) history of mental problems, or 2) no history of mental problems.

Most research on child abuse utilizes medical, social service, and other official records. By their own admission only the most overt and manifest cases of abuse reach these agencies. Consequently the data are selective and underestimate the extent of child abuse. To gain greater insight into the problems of

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1 This procedure did not significantly alter the results. Separate analyses were run for those who were physically abused, those who were mentally abused, those who were both physically and mentally abused, and for those who were neglected. The overall relationship between abuse and mental health problems remained significant and controlling for parental characteristics or for the abusive environment, when there were enough cases, did not change the basic relationship. These analyses are available upon request from the authors.
child abuse we feel it is necessary to explore and utilize other sources of information that have been neglected previously. Because of the recurring theme of the relationship between child abuse and other antisocial behavior we feel that incarcerated offenders are a critical population in need of study.

We recognize that there might be some limitation to these data. Prison inmates are unique in that they have been formally judged to have violated a criminal law to such extent that they are incarcerated. This certainly stands in sharp contrast to the vast majority of the American public. However, we know of no empirical research that would suggest that criminal offenders are significantly different from others concerning a relationship between childhood abuse and later mental health problems. Additionally, because abuse and mental health were self reported there is no way to determine how severe they were or whether or not the individual was telling the truth. There is ample evidence, however, that self-report data about deviant behavior are both reliable and valid (Elliott and Ageton, 1980; Farrington, 1973; Hardt and Hardt, 1977; Hindelang et al., 1981).

**Findings**

Thirteen percent of the inmates reported childhood abuse. While reliable data on which to determine the true incidence rates for child abuse do not exist (Cohen and Sussman, 1975; Gelles, 1978) the percentage of individuals having been abused is most likely underreported. Incidence rates naturally vary depending upon the operationalization of abuse. But in addition, even if there was complete agreement as to what constitutes abuse our estimates would probably not be much improved. Certainly this is not unrelated to the secrecy of the behavior and our general inability to monitor such behavior prior to cases making their way to physicians, social service agencies, and eventually the official records. As a result of these difficulties many authors contend that cases go unrecognized, undiagnosed, and hence, unreported (Helfer, 1973).

Approximately twelve percent of the individuals reported a history of mental health problems. (At the time of admission 7 percent of the inmates
reported some current mental health problems. Although there is a paucity of empirical studies on the occurrence of mental health problems in prisons there is reason to believe that this percentage is also an understatement. Research investigating prison populations have found, depending upon the definition of mental illness and the methodology used, that the percentage of inmates with mental problems ranges from a low of nine percent (Washbrook, 1977) to a high of seventy-six percent (Yarvis, 1972).

The principal question of our research concerns the relationship between early childhood abuse and later adult mental health problems. Do individuals who have been abused as a child have more mental health problems than others? Table 1 presents the cross-tabulation of childhood abuse with mental health problems. As can be seen, twenty-six percent of the individuals who were abused as a child have mental health problems. Those individuals who were abused have more than twice the rate of mental health problems as those who were not abused. The difference is statistically significant.

Clearly, besides the possible long term physical effects of abuse, such as mental retardation, brain damage, learning disorders, and sensory deficits, the victim may suffer from serious psychological scars. One prevalent view is that abuse is not an isolated event but rather a manifestation of a dangerous and hostile environment to which the child must adapt in order to survive. Unfortunately the defense mechanisms created by the child in order to adapt cause later problems in developing and maintaining interpersonal relationships. Steele (1976) argues that under such conditions a child is unable to develop basic trust. This inability negatively affects the child's perception of personal safety in this world and his/her belief in the general helpfulness and goodness of other people.
TABLE 1
Childhood Abuse and Mental Health Problems

<table>
<thead>
<tr>
<th>Mental Health Problems</th>
<th>Abused</th>
<th>Not Abused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Problems</td>
<td>26.8%</td>
<td>11.0%</td>
</tr>
<tr>
<td>No Mental Problems</td>
<td>73.2%</td>
<td>89.0%</td>
</tr>
<tr>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>(653)</td>
<td>(4474)</td>
</tr>
</tbody>
</table>

p<.0001

At this stage of the analysis it appears that there is a strong relationship between childhood abuse and a late effect of mental problems. A harsh critic, however, would argue that this relationship is not necessarily the true state of affairs. For example, there are numerous studies pointing to a relationship between childhood abuse and poverty (see Pelton (1978) for a discussion of this literature) and also a relationship between mental health and poverty (Dohrenwend and Dohrenwend, 1969). It is possible that the finding reported here is due to an underlying factor of poverty rather than any real association between abuse and mental health problems.

One way to guard against this possible contaminating effect is to introduce a third variable as a test factor into the analysis (Rosenberg, 1968). To test for whether or not the relationship between childhood abuse and mental problems is really due to poverty one needs to control for or eliminate its influence by comparing abused individuals and those with mental problems after the effect of socioeconomic status has been taken out of the relationship. If the original relationship is in fact due to poverty, when one controls for the third variable the relationship between childhood abuse and mental problems should disappear. From a review of the literature on childhood abuse two general sets of test factors were identified: parental characteristics and the abusive environment.
TABLE 2
Relationship between Childhood Abuse and Mental Health Controlling for Parental Characteristics and Abusive Environment

<table>
<thead>
<tr>
<th>Variables</th>
<th>First-Order Gamma</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Abuse and Mental Health Problems</td>
<td>.495*</td>
</tr>
<tr>
<td>A. Controlling for Parental Characteristics:</td>
<td></td>
</tr>
<tr>
<td>1. Parental Situation</td>
<td>.519</td>
</tr>
<tr>
<td>2. Compatibility of Parent's Marriage</td>
<td>.434</td>
</tr>
<tr>
<td>3. Father's Characteristics:</td>
<td></td>
</tr>
<tr>
<td>a. Education</td>
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*Zero-Order Gamma

Controlling for Parental Characteristics

As noted previously there is a large body of information on the background and present circumstances of the abusive parent. Several tentative characteristics have been identified which
can be roughly grouped into demographic characteristics, abnormal psychological traits, early parental history, and parental attitudes toward child rearing (Spinetta and Rigler, 1980). While early parental history and parental attitudes are certainly involved in the etiology of child abuse we are more interested in the first two groups of characteristics because of their possible connection to adult mental health problems irrespective of whether or not one was abused as a child.

Kempe et al. (1962) reported that abusive parents exhibited a high incidence of divorce and separation, unstable marriages, and a history of minor criminal offenses. Other authors have also reported the importance of these demographic characteristics and have extended the list to include such variables as social and economic stress, lack of family roots, social isolation, unemployment, low occupational status, low education, and though disputed, low intelligence (Baldwin and Oliver, 1975; Cameron et al., 1966; Elmer, 1967; Elmer and Gregg, 1967; Gregg and Elmer, 1969; Helfer, 1973; Johnson and Morse, 1968; Pelton, 1978; Schloesser, 1964; Steele, 1976).

The set of characteristics which deals with the presence of abnormal psychological traits among abusive parents has been less clear. Early investigators boldly stated that abusive parents were mentally ill, psychopathic, or displayed neurotic or psychotic behavior (Coles, 1964; Gladston, 1965; Kempe et al., 1962; McHenry et al., 1963; Steele and Pollock, 1968; Wasserman, 1976). More recent studies suggest that the number of abusive parents with severe mental disturbances may be quite small. Kempe and Helfer (1972) for example, found that only 10 percent are psychotic or seriously disturbed. The relationship between less severe mental problems and abuse is no clearer. Gelles (1973) searched the abuse literature for abnormal psychological traits and tabulated 19 different traits. After reviewing the evidence he concluded that the efforts at identifying peculiar psychological characteristics were inconsistent and contradictory. While the severity of the symptoms is still debated it is clear that abnormal psychological traits play a part in the etiology of child abuse.

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Section A of Table 2 presents the results of controlling for parental characteristics on the relationship between childhood abuse and adult mental health. As can be seen from the table, none of the control variables significantly change the original relationship. When parental situation is controlled for the relationship actually becomes stronger (a gamma of .519 versus .495). In contrast, when the compatibility of the parent's marriage is controlled for the relationship decreases (.434 versus .495) but not significantly. (One would expect the relationship to vanish if the original relationship

The following parental characteristics were controlled for: compatibility of parent's marriage was coded as 1) for compatible and 2) for not compatible; father and mother's education were coded as 1) for dropped out of school, 2) high school, 3) some college training; father and mother's occupation were coded as 1) for professional, 2) skilled, 3) semi-skilled, 4) unskilled, and 5) no legally defined occupation; father and mother's employment record, mental health, adequacy of parental care, and disciplinary procedures, employed were all dichotomies: stable-unstable, mentally healthy-mentally problems, adequate-not adequate parental care, and just-unjust disciplinary procedures, respectively; modes of punishment employed by the parents were coded as 1) punished mostly by physical methods, 2) punished mostly by non-physical methods, 3) punished by a combination of physical and non-physical methods.

Gamma, a measure of association for ordinal scales, will have a value of +1 for a perfect positive relationship between two variables and a value of -1 for a perfect negative relationship. It can be viewed in a "proportional-reduction-in error" fashion and interpreted in a manner similar to Pearsonian correlation and other correlation measures. That is, knowledge that one has been abused reduces our error in predicting that he/she also has had a history of mental health problems.
was in fact due to the test factor). Neither the father's nor mother's characteristics of education, occupation, employment record, general health, mental health, adequacy of parental care, disciplinary procedures employed, or modes of punishment employed change the original relationship between childhood abuse and later adult mental problems. These findings indicate a strong and direct relationship between abuse and one's mental health even after controlling for parental characteristics.

Controlling for the Abusive Environment

Like parental characteristics there is a large body of literature on the environment within which abuse arises. A recurrent theme throughout this literature is that a predominant proportion of the reported cases of abuse occur within low socioeconomic families. Gil (1970), for example, found that almost 60 percent of the abusive parents were on welfare. Numerous other studies have had similar results (Baldwin and Oliver, 1975; Bennie and Silare, 1969; Kempe, 1962; Lynch and Roberts, 1977; McHenry et al., 1963; Schloesser, 1964). Critics of such an approach to child abuse argue that the poor are under greater scrutiny by social and law enforcement agencies and thus are disproportionately represented in reported cases of child abuse. Pelton (1978), however, in a review of the evidence on the relationship between socioeconomic class and child abuse counters the critics with three strong points: 1) "undiscovered evidence is no evidence at all," 2) critics cannot explain why abuse is related to degrees of poverty within the same lower class, and 3) they cannot explain why the most severe injuries occur within the poorest families.

Several authors have attempted to refine the global notion of socioeconomic class by looking at parental environmental stresses and abuse. A frequent stressor often found is severe financial problems or unemployment (Gladston, 1965; Gil, 1970). The contention here is that the deprivations brought on by unemployment lead to frustrations which are released on the child in the form of a physical attack. Another stress factor often found is isolation or high mobility (Baldwin and Oliver, 1975; Schloesser, 1964). Here the notion is that
frustrations break out into violence because the individual or family lacks the protection of social support systems. Though the effect of the abusive environment on child abuse has not been closely scrutinized it is quite likely profound and as important as parental characteristics.

The results of controlling for the abusive environment on the relationship between childhood abuse and later adult mental health problems are presented in section B of Table 2. Similar to parental characteristics, none of the abusive environment variables changed the original relationship. Three of the abusive environment variables (source of family income, residence, degree of delinquency) slightly increased the basic relationship between childhood abuse and mental health problems, while the remaining two slightly decreased it.

**Discussion**

Undeniably, abuse leads to severe neurological and physical handicaps in children. Evidence for this has been found in numerous studies which suggest that the development of abused children is often distorted. There is a more insidious and unseen handicap, however, that is less well documented and understood. This invisible handicap is the psychological scar left by the early life experience of abuse. Our study indicates that abused children experience detrimental effects well beyond the initial abuse. In our population, after more than 15

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The following variables which deal with the individual's environment during formative years were controlled for: socioeconomic level of the family was coded as 1) poverty level, 2) subsistence level, and 3) middle and upper income level; source of family income was coded as 1) gainful, 2) social security, and 3) social welfare; residence was coded as 1) city, 2) town, and 3) rural; the degree of delinquency of the residence was coded as either high or low; mobility during the individual's formative years was coded as either no move or one or more moves.
years past the experience, those individuals who were abused had more than twice the rate of mental health problems as those who were not.

Some will argue that the abusive environment, apart from the damage of abuse itself, will account for these findings. Our research, however, indicates that the degree of deprivation within the environment did not influence one's chances of avoiding mental health problems if one had been abused as a child. Obviously, the mental health problems of abused children are chronic in nature and require some type of ongoing support and treatment. Merely removing the child from the abusive environment is inadequate. It also seems that short term treatment and/or interventions are inadequate for dealing with the long term consequences of abuse. A more adequate approach would be extended monitoring and treatment of abuse victims. Without intervention and prolonged treatment the prognosis will remain poor for the unfortunate victims of abuse.

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We would like to express our thanks to the North Carolina Department of Correction, Office of Planning and Research for their cooperation in making these data available to us. This research was supported in part by grant MH15113-03 from the National Institute of Mental Health, Center for Epidemiological Studies and North Carolina State University Faculty Research Grant #00792. The order in which our names appear alternates with each research paper.
A COMPARISON OF CHILD WELFARE CURRICULUM IN UNDERGRADUATE AND GRADUATE PROGRAMS OF SOCIAL WORK

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ABSTRACT

This paper analyzes the differences in child welfare curriculum content of social work programs at both the undergraduate and graduate levels. The findings report little discernible difference in curriculum content in the area of child welfare at either level. These results add to the continuing debate focusing on defining the differences between undergraduate and graduate social work education. An important question resulting from this study is -- what can the consumer of child welfare services or hiring agency expect from the social worker trained in the area of child welfare at either the undergraduate or graduate levels? The answer to this question is far from clear.

Social work, like many other professions, is undergoing major changes. It is experiencing change in educational preparation, in personnel standards, and in a variety of other aspects related to professionalization. One of these major changes in the area of educational
preparation occurred in the last decade. In 1970, membership in the NASW (National Association of Social Workers) was opened to people with social work Baccalaureate degrees from programs approved by the CSWE. In 1974, this program approval evolved into accreditation standards similar to those used for the accreditation of graduate social work programs. As of 1983, there were over 400 undergraduate social work programs and nearly 90 Master's level programs accredited. (1) Many of the graduate programs have combined undergraduate and graduate programs of study.

Some segments of the profession believe that the inclusion of the Baccalaureate degreed workers in the NASW as regular members and the accreditation of undergraduate programs were mistaken actions. Others contend that such actions merely recognize the realities of the social service work force and help to build quality social work practice and to protect those who use social services.

A major dilemma in social work education today is defining the differences between Baccalaureate and Master's level social work education. The undergraduate program is currently being defined by many as a course of study that prepares the student for the beginning practice level so he or she can function in the generalist role (Dinerman, 1981). Educators generally view the Master's level program as being the degree emphasizing specializations in various areas of social work practice. Even though these are the commonly stated differences between undergraduate and graduate level education, there is obvious overlap between the two. This overlap has been particularly irritating to the students going through Baccalaureate programs who decide to seek advanced social
work training (Dinerman, 1981). Adding to the dilemma are the findings that report little difference in functioning and competencies between Baccalaureate and Master's level social workers (Baskind, 1981; Biggerstaff and Kolevzon, 1980; Dinerman, 1982; and Kelly, 1981). Complicating the current situation even more are writings such as Stephens' suggesting that the undergraduate trained workers are much more effective in delivering intense in-home counseling and support to multiproblem families than graduate level workers (Stephens, 1979). Thus it is implied that undergraduate training may better prepare social workers for certain areas of practice than graduate training.

Clearly, several studies suggest that the features that distinguish the undergraduate trained social worker from the graduate trained social worker are difficult to identify. It is also difficult to identify distinguishing features of course content in the programs at both levels. In this study, an attempt was made to see how directors and deans of social work programs define the differences in curriculum content in programs at both levels by focusing on issues related to child welfare content. Even though technically child welfare as a specialization of practice does not exist in undergraduate programs, many of these programs have extensive child welfare content. Child welfare as a specialization in graduate programs is very common. Consequently, much child welfare content exists in programs at both levels; however, it would seem that the content areas stressed at the undergraduate and graduate levels should differ significantly. The directors and deans of such programs would appear to be an excellent source for
defining these differences.

METHOD

The data analyzed in this study is from a large national survey entitled National Survey: The Place of Child Welfare in Social Work Education conducted by the National Child Welfare Training Center, University of Michigan School of Social Work. The data from the national survey was collected during the Spring of 1981.

The data analyzed from the national study are from the Region VI area of the United States. Region VI consists of Arkansas, Louisiana, New Mexico, Oklahoma, and Texas. Within Region VI, there are 34 accredited schools of social work. This figure is based on the 1980-81 academic year. Among these accredited schools are 9 Master's programs and 25 Baccalaureate programs. Seven of the Master's programs responded to the national study and 17 of the undergraduate programs did.

The specific questions analyzed from the national data concerning the Region VI schools dealt with questions focusing on curriculum issues related to the undergraduate and graduate programs. These questions were as follows: (1) How many courses in social work are required of all your students? (2) How would you characterize the content of the courses required in your program? (3) In the set of courses that is required of all students, how much emphasis is given in content areas related to child welfare? The content areas responded to were: a) historical perspectives on child welfare, b) services to adolescents, c) services to unmarried parents, d) in-home services, e) protective services, f) foster family card,
g) adoption, h) racial, ethnic, cultural differences, i) legal knowledge of child welfare, j) administration of child welfare services, k) program planning in child welfare, and l) community work in child welfare. Each of these content areas were rated as follows: "No emphasis" (1), "Little emphasis" (2), "Some emphasis" (3), and "Great emphasis" (4). A comparison of the responses from the directors and deans of the undergraduate and graduate programs on the content areas stressed were analyzed through the use of the Mann-Whitney U statistical test of significance. (2)

FINDINGS

The responses to the questions concerning curriculum and child welfare content were far from expected. The question focusing on the number of courses required reported that on the average the undergraduate programs required 17 courses and the graduate programs 13 courses. Of the courses in the undergraduate programs, 78 percent of the content was generic, 14 percent was specific child welfare content, and the remaining content was indicated as "other". The content of the required courses reported in the graduate courses reported 80 percent generic and 14 percent focused on child welfare; the remaining 6 percent fell under the "other" category. This finding suggests that of the courses required in the undergraduate and graduate programs, the percentage of content related to generic and child welfare content at both levels is virtually identical. (3)

It would appear that of the required courses at both program levels, the undergraduate programs would have a much higher percentage of generic content than the graduate programs. As mentioned
previously, the undergraduate program is viewed by many as a degree that prepares the student to function as a generalist and the Master's program is seen as a program that prepares the student to specialize in an area of practice. It should be noted that the students in the graduate programs may receive some of their specialized training through elective courses. However, many graduate programs supposedly emphasized specialized content among their required courses. It may well be that the graduate programs analyzed in this study are simply an exception to this rule. Even with this possibility in mind, it was surprising to find among the undergraduate and graduate programs virtually the same percentages for generic and specialized course content in the area of child welfare.

Table I reports the findings concerning the directors' and deans' responses to the question concerning content areas. Not one of the content areas emphasized in the field of child welfare at either educational level was statistically significant. The only content area nearing statistical significance was for in-home services (4). The undergraduate programs appear to emphasize this content area more so than the graduate programs. These findings give support to the contention held by many that curriculum content stressed at the undergraduate and graduate levels, at least in the area of child welfare, differs little.

CONCLUSIONS AND IMPLICATIONS

The above findings show little difference in the content areas emphasized at the undergraduate and graduate levels for preparing students for child welfare practice. It was also found that generic
content was equally common to both program levels. Such findings add to the argument suggesting that there is a great deal of overlap among the two programs, with little agreement concerning which content areas are base or specialized in the programs (Dinerman, 1981). Thus the important question still is -- what can the consumer of social services of hiring agency expect from the social worker? In light of this study's findings supporting those who argue for the position of curriculum overlap at both educational levels, the answer to this important question is far from clear.

NOTES

1. The following figures on the number of undergraduate and graduate programs of social work are based on information from a booklet entitled The Many Career Opportunities in Social Work by the NASW, 1983.

2. An analysis of the frequency data suggested a departure from parametric conditions required for the use of the t-test; the test of significance utilized, the Mann-Whitney U test, analyzes only the ordinal features of the data and does not specify the distribution of the research population.

3. One must keep in mind that these percentages do not capture the differences in depth of focus in the courses taught at the undergraduate and graduate levels. Even with this limitation, it is surprising how the course content at both levels was defined so evenly between generic and specific child welfare content.

4. This finding gives some indirect support to Stephens' position that
undergraduates may be more skillful at delivering in-home services. The findings show that in-home services was the only content area nearing statistical significance and was emphasized more at the undergraduate level.

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"America has the most illogical welfare system of any modern nation on earth," Harrell Rodgers declares in the introduction to his timely new book. "It is a huge, complex, inefficient, ineffective failure—and a dreadfully expensive failure to boot." Rodgers asks "How could America spend so much and accomplish so little?" and devotes over 200 tightly argued and detailed pages to answering that query and proposing alternatives to our welfare failure.

Despite the Regan-like language of this declaration and challenge, Rodgers's book is most not definitely not a paen to the economic and welfare policies of the New Right. In fact, Rodgers effectively and repeatedly punctures the myths, miscalculations and misstatements of those currently dismantling the ne'er completed structure of the U.S. welfare state. His most telling arguments are those which refute persistent stereotypes propagated by conservatives and new-liberals alike as to
the nature and size of the poverty population (much larger in Rodgers's view, and more diverse) and the relationship between the economic and welfare systems in the United States (much more interdependent, Rodgers asserts, than generally believed).

Rodgers's own answers, however are only partially satisfying. He concludes "that the American welfare system does about what it is meant to do," that is, provide insufficient benefits to a carefully selected population of "legitimate" poor, "to treat only the symptoms of the continuing crisis caused by society's neglect of millions of citizens," not "to end or to prevent poverty." By his own admission, this is not a controversial view. The flawed nature of U.S. welfare programs has become an article of faith among Republicans, Democrats, radicals and even many social workers.

Nor is Rodgers's second major argument particularly novel. He stresses throughout the book that the success of the U.S. welfare system is predicated upon a healthy U.S. economy, one which competes effectively in the world market, keeps inflation at modest levels and provides "all willing adults with decent employment opportunities while it serves public needs." This view, too, in various forms has been standard U.S. national policy since Kennedy, and, arguably, since the New Deal. Both the Reagan Administration and its critics agree that these should be our country's economic and social goals. No major party or faction thereof, however, has developed a means to achieve these far-reaching goals without compounding the current misery of millions of Americans and writing off the futures of millions of others.
Rodgers's proposals to revamp our welfare system without such economic and social shockwaves also offer little that is new, but present an effective and occasionally persuasive synthesis of the corporatist/social democratic position in the United States as articulated by Felix Rohatyn and Lester Thurow. Rodgers calls for a dismantling of our present reactive system and its replacement with a preventive system consisting of four major components: (1) a viable and broadly defined family policy; (2) an income policy--funded via general tax revenues and an employer/employee tax--which would provide adequate benefits to those who cannot work and those whose incomes fall below a decent financial level; (3) a national health insurance system; and (4) a national housing policy blending public initiatives and subsidies for the private sector.

The success of these proposals rests upon sustained economic growth with improvements in the distributive mechanisms of the U.S. economy, a goal which Rodgers believes can be accomplished by rebuilding the economy along the lines of a Swedish-Japanese hybrid. While he acknowledges that "it would not be easy to adapt such approaches to the American system," he argues that the "serious and systematic" economic problems of the U.S. "cannot be solved easily or without some fundamental alterations in economic policies, business management and government-business relationships." Planning, public enterprise and social contracts, he maintains, "represent realistic alternatives because they would deal with the actual causes of the nation's economic problems."

Rodgers's solutions certainly deserve serious consideration and discussion. They are far more humane than those proposed by

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the Reagan Administration, more creative and far-reaching than the rehashed views of the Democratic party center and more consistent with the principles of the social work profession than either. Yet his search for complementary industrial and welfare policies which deal with "actual causes" ignores certain crucial elements. Briefly, these are (1) the role of militarism—the welfare/warfare state—in creating both the problems of the U.S. economy and precluding many possible solutions is given scant attention. No long-range answers to the multiple problems of the U.S. economy and society can be formulated which do not address this fundamental issue head on; (2) the relationship of sexism and racism to the U.S. economy is presented as if the emergence and persistence of gender and racial oppression were somehow disconnected from the broader political economy. Many studies have shown that nothing could be further from the truth. The problems of racism and sexism go far beyond discrimination and the absence of opportunity. They are directly related to the fundamental processes of U.S. capitalism and are, in fact, two of the "actual causes" Rodgers purports to address; (3) the presentation of alternatives to current welfare and economic policies ignores any ideas of a truly radical nature. Rodgers's conception of a leftist analysis and leftist solutions goes little beyond a moderate social democratic view, suggested by left-liberal politicians and academicians and already practiced in various forms in Sweden, the Netherlands, and France. The perspectives of Marxist economists or analysts of social welfare are not included, nor is there any mention of the attempts by socialist countries to resolve the dilemmas of poverty, illness, and inequality. Until we are able to allow the introduction of such ideas into the
public forum, welfare and economic policies will continue to be debated within a narrow framework which accepts too much as given and ventures too little in the exploration of new ideas with which to tackle our intransigent social and economic problems.


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University of Massachusetts, Boston

This short volume (102 pages of text) does just what its subtitle suggests: it proposes a research agenda to address working class women's issues. In doing so Pamela Roby provides a succinct review of the literature in the field, a useful bibliography and an overview of the problems facing blue collar women. The language is clear and the subject is nicely focussed. Books like this are a delight for graduate students, teachers looking for syllabus references and would-be researchers.

Roby has been thorough, given her self imposed limits. Indeed, the major arguments one could have with such a volume arise from the topics not included. She decides to limit herself to blue collar women, while acknowledging that omitting white collar workers (especially clericals) is a problem—necessitated by the need to "keep the effort within manageable limits." Similarly, she does not highlight the special problems of women of color or of
other women who are multiply discriminated against. She does not seriously discuss or critique differing research methods, so we are not sure what she thinks is the most effective way to actually tackle the wide ranging research problems she reviews. Finally, she omits a full treatment of the research on welfare programs—thereby suggesting that welfare and work are more separate than they are.

But such omissions seem reasonable, if regrettable, assuming the limited focus of the book. The one missing ingredient which does seem significant, however, is any thorough discussion of the spectrum of ideological issues embodied in past research or underlying future research agendas. Here Roby is simply too descriptive, leaving the reader to her own political inferences regarding the underlying values reflected in the different studies. She could easily have supplied such an analysis without being intrusive; it would have been a great help to her readers. Instead, we are left to sift through the topics raised without enough explicit guidance regarding political priorities among topics for research.

Roby has, nevertheless, performed a useful service for anyone concerned with women's condition. Her book is not pretentious and does not claim more than it delivers. Its topic is relevant and its style, accessible. While it breaks no new ground, it is an informative addition to any collection of books on women and work.

The American welfare state is in deep trouble; of that there can be little doubt. And, until recently social policy professionals seemed not to understand the nature of the crisis. The three books under review here are part of an encouraging wave of new work that seeks to refocus social policy by taking a fresh look at some first principles. To discuss them it is first necessary to establish a context.

The problems of the welfare state go far beyond the current conservative onslaught. Consider the tiresome arguments over the impact of the Great Society. It is simply preposterous to assert, as apologists for the Reagan administration have done, that poverty has been eliminated in the U.S. or that recent cutbacks have not hurt the poor. The newly (July, 1983) released Census Bureau report of annual estimates of those living in poverty puts the lie to that position. When all benefits are taken into account, the proportion of the population living in poverty had declined steadily until 1979; since then it has been on the increase. Considering only cash income (from all
sources), the number of people living in poverty rose by about thirteen percent between 1980 and 1982, from about thirty million to about 34.5 million people. The change is even more dramatic when in-kind benefits such as food stamps and Medicaid are factored in. Taking into account all benefits, 6.1 percent of the population were living in poverty in 1979; by 1982, 8.8 percent were. This represents an increase of more than six million people.

It is thus clear that the Great Society programs reduced poverty and that the policies of the Reagan administration have reversed the trend. This information has been widely circulated by the news media. However, it is not the central concern regarding social policy of the general populace—those whose support is essential to the success of any public policy in a democratic society. They are worried that welfare state programs have been designed in ways that undermine such important social institutions as the family and community, and that they run counter to fundamental societal values of mutual aid, personal autonomy, hard work, and the like. For example, it is argued that by subsuming more and more helping functions under formally organized auspices the welfare state has undermined the natural coping mechanisms of families and communities. As a result, these social institutions have been weakened and those the welfare state was meant to assist have been socialized into a condition of helplessness.

Here the numbers are not supportive of the Great Society. To cite only a couple of examples, in 1960, 21 percent of black families were headed by a single parent; by 1981, the figure had increased to 47 percent. As a second example, the black male population increased by 92 percent between
1960 and 1982, but employment among this group grew by only 42 percent; moreover, the proportion of black men "not in the labor force," not working or looking for work, grew from 17 to 28 percent during that period.

Contrary to the belief of reactionaries, the welfare state did not cause those figures, but there is a serious and legitimate concern imbedded in them that social policy professionals have tended to ignore: The conditions these figures describe exist despite the efforts of the welfare state. The black family is deteriorating even more rapidly than its counterpart in the general population. Black males are being excluded at an accelerating rate from work, an activity that in this society provides not only income but self-esteem, autonomy, and a sense of personal efficacy.

In trying to demonstrate that they have not created these conditions, too many defenders of the welfare state have argued that the underlying values and institutions are not important—for example that the nuclear family is an anachronism or that to value work is to fall victim to bourgeois false consciousness. As a result, reactionaries have been able to reduce social policy to a yes-no question: should the American people and their government continue to support the welfare state, considering that its defenders are indifferent to society's basic values and institutions?

The books being considered show a maturing of thought about social policy. They acknowledge the importance of supporting basic values and institutions, not only for political reasons but because the health of society requires it. Social
policy must be sensitive to the intrinsic tensions in society—competition vs. cooperation, the individual vs. the community, equity vs. equality—that sustain these values and institutions.

One of the pioneer efforts in this vein was Piven and Cloward's *Regulating the Poor* (1971). They argued that social policy is shaped by the self-interest of those involved and that most of the time those involved are the privileged and powerful. As a result, social policy is weighted in favor of the powerful and against the common person. They argued that the real purpose (or at least the most conspicuous outcome) of social policy has been social control of common people.

The social control thesis has been a source of controversy and a stimulus to the new wave in social policy. The most recent contribution to the dialogue is *Social Welfare or Social Control?*, the outgrowth of a session by that title organized by Walter I. Trattner for the 1980 meetings of the Organization of American Historians. Trattner's book consists of his Introduction, five essays by social historians examining the social control thesis, and a response by Piven and Cloward. In his Introduction, Trattner describes the social and historiographic background of the social control thesis and outlines the purpose of the book, which is "to test the central thesis of [Regulating the Poor] . . ." (p. 9).

None of the essays supports the social control thesis. John K. Alexander (whose essay is the only one—except for the Piven and Cloward response—not to have been presented at the OAH session), Raymond A. Mohl, and Muriel and Ralph Pumphrey all look at periods not considered by Piven and
Cloward--Alexander at late eighteenth century Philadelphia, Mohl at the abolition of outdoor relief in the late nineteenth century, and the Pumphreys at the widows' pension movement of the early decades of this century. None of them feel that their data support the social control thesis. W. Andrew Achenbaum confronts Piven and Cloward head on. He analyzes the early years of the Social Security Act, a time period covered in *Regulating the Poor*, and concludes that they simply got it wrong.

In an extremely thoughtful essay that is an expansion of his informal remarks as discussant at the OAH session, James Leiby puts his finger on the central issue. He notes that social control does not always have sinister connotations. In addition to its coercive implications, social control describes the processes that support a level of social cohesion necessary for the survival of society. Thus, social control spans the tension between the individual and the community. On one hand it is coercive of individuals; on the other it is necessary for the existence of the community. From a social policy perspective the question is one of balance, of maintaining the tension.

Piven and Cloward add little to the debate in their response. Except for specific responses to the other authors' essays, they have made most of their points elsewhere before. Their position is that social policy responds to the needs of the common person only when civil disorder threatens the status quo. Their critics argue that social policy is a humanitarian response to the needs of the least well-off members of the community. Readers can judge the evidence on each side for themselves. The value of *Social Welfare or Social control?* is that it brings the evi-
dence together in a way that focuses on the intrinsic tensions in society.

Values in Social Policy: Nine Contradictions examines these tensions directly. Jean Hardy is an English social worker and sociologist. Through she writes in a British context, the issues she raises have great salience for the U.S. as well. The nine contradictions of her title are actually value conflicts. Her purpose is not to choose sides but to explicate the necessary tensions in social policy. She deals with her "contradictions" one per chapter: authority vs. liberation; representative vs. participatory theories of government; needs and resources; the family as a basis of society or as the root of society's problems; bureaucracy vs. professionalism; rationality vs. negotiation in decision-making; the individual vs. the community; equality vs. freedom; and the personal vs. the political.

Hardy notes that there are moral, philosophical, political, and social questions underlying the welfare state and that "most legislation, and most administrative practice springing from legislation, is a compromise between conflicting values" (p. vii). She analyzes these conflicting values through what amounts to an extended review of the relevant literature in social theory and philosophy. The result is a major contribution to the social policy literature. Recognizing that the welfare state is not simply a matter of technique, but that it requires us to take seriously the values and institutions of society, Hardy moves us from the ultimately trivial question of "how?" to the central discussion of "why?"

In An Immodest Agenda, Amitai Etzioni brings the question of "why" down from a
theoretical to a practical level. One of our most eminent social scientists, he argues that the failure of the welfare state is not only economic, but that our notions of family, school, and community have also deteriorated. His concern is with social control, but of the sort that Leiby pointed to—the social cohesion necessary for the survival of society.

Etzioni feels that the community is the only viable force capable of holding society together, because only it can adequately describe and direct the shared concerns of its constituent members. He laments the rise of big government through the welfare state, as well as the "Me Generation" reaction to it, ego-centered individualism. Both cut people off from one another and from having viable and effective selves. He argues the need for mutuality—a commitment to others and to shared concerns; and for civility—taking action in the service of shared concerns. Practically, he offers a program for social reconstruction based on these concepts. It might be said that he offers a suggested new direction for social policy, for the American welfare state, sensitive to basic values and institutions.

One might disagree with Etzioni's analysis or with the specifics of his program, but he does respond seriously and cogently to the crisis in social policy. He argues in terms of basic values and institutions rather than techniques.

The common denominator of these books is a recognition that social policy is at least as much an intellectual as it is an economic or political phenomenon. Although they will not resolve the crisis, it is encouraging to know that the discussion is moving in the right direction.

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