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**BOOK REVIEW EDITOR**

James Midgley, Dean, School of Social Welfare, University of California Berkeley, Berkeley, CA 94720

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The Perils of Self-Censorship

ROBERT D. LEIGHNINGER, JR.

EDITOR

Earlier this year, Jim Midgley, until recently Dean of the School of Social Welfare at the University of California, Berkeley, was asked to write a guest editorial for the National Association of Social Work’s (NASW) premier journal Social Work by its new editor Jorge Delva. The topic was international social work and the challenges of globalization. After presenting some of the pros and cons of globalization, Jim chose to focus on “unipolarism,” a foreign policy articulated by neoconservatives like Charles Krauthammer, Paul Wolfowitz, and William Kristol and embraced by officials of the George W. Bush administration, particularly Secretary of Defense Donald Rumsfeld. This doctrine, he argues, works in direct opposition to the positive aspects of globalization which promise greater international cooperation. A unipolar world is one in which the only remaining superpower, the United States, can and should spread its values across the globe, by force if necessary. Confronting the unipolar agenda should be the first order of business for anyone interested in international social work.

This provocative, though hardly incendiary, thesis was designed to start discussion in the two international social work meetings held this summer. But in the headquarters of the NASW it did more than that; it set off alarms. When the copy-edited manuscript was returned to its author, a number of the names of neoconservatives and Bush administration officials had been removed. Thinking this was just capricious editing, Jim asked that they be reinstated. He was told by NASW Press that a “final” decision had been made denying his request. He withdrew the manuscript.

Jorge Delva, the editor, had not been consulted on
any of this and protested. He was told that a staff attorney was concerned about the effect of naming names, Bush administration-connected names, on the association's tax exempt status. The issue was raised at the June meeting of *Social Work*’s editorial board and at a meeting of the NASW Board of Directors. In the course of discussion, it became apparent that this was not an isolated instance of administrative involvement in NASW journal publications. Review by NASW administrative staff, apart from editorial and peer review, is established procedure.

I cannot debate the issue of what threatens the non-profit status of an organization. As I understand it, the impropriety would not be in expressing a political opinion but in backing a particular candidate. Moreover, NASW and its leaders have taken political stands against government policies in the past. Given that, what exactly is NASW afraid of in this case? The Bush administration has a record of attempting to intimidate opponents, so the threat cannot be totally dismissed. Yet is simply connecting its officials with a policy they openly espouse cause for retaliation? And if the state of public debate has become this nightmarish, how should an organization which believes in social justice behave?

We don’t know how long this administrative overview has been going on nor how many other articles have been modified because of NASW concerns. If other authors have been subject to this prior restraint, they have not complained publicly. One purpose in publishing this story is to see if it will bring other examples to light. However, even if this censorship has been imposed only a few times, and even if authors have consented to have their writing altered because of feared political repercussions, it is still censorship. Whether the fears of NASW’s administrators are well grounded, exaggerated, or imaginary, to give into them is to accept a serious compromise with free inquiry and open discussion, all the more pernicious when we inflict it on ourselves rather than have it imposed by the government.
International Social Work, Globalization and the Challenge of a Unipolar World

JAMES MIDGLEY

This summer, two international social work organizations - the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW) - will again host their regular biannual conferences. IFSW will meet in Munich, Germany in July while IASSW will meet in Santiago, Chile in August. These meetings will bring social workers from many different countries together to share ideas and experiences, and to discuss issues of common interest. Social workers have been meeting under the auspices of these two organizations for more than seventy years and today both organizations play a vital role in promoting cooperation among social workers around the world.

As is customary, both conferences will be organized around core themes. The IFSW’s conference theme is *A World out of Balance: Working for a New Social Equilibrium* while IASSW will focus on *Growth and Inequality*. While these themes have been chosen by the conference organizers to give structure and form to the meetings, they also reflect issues of wider interest to the profession. For example, the decision to highlight the problem of inequality at the IASSW meeting in Santiago reflects a renewed interest in the topic. Although inequality has been neglected in economic and social policy debates since the 1980s on the ground that inequality is of secondary importance to the goal of promoting rapid economic growth, it is clear that economic growth over the last twenty years has not brought prosperity to all. Indeed, in many parts of the world, growth has been accompanied by stagnating incomes for many ordinary people. On the other hand, those with high incomes have experienced unprecedented gains. It is highly appropriate,
therefore, that the issue of inequality and growth should serve
as the theme of the IASSW conference.

International issues and concerns such as these have
driven social workers at different times in the profession’s
history. At the time of the First World War, Jane Addams’ paci-
fist campaigns were supported by many social workers in-
volved in international activities. Similarly, in the 1950s, when
rapid industrial development and economic modernization
was believed to offer the best hope of achieving prosperity for
the newly independent countries, some social workers urged
the export of Western social work theories and methods to the
developing world believing that this was compatible with the
modernization process. These ideas were vigorously contested
in the 1970s by social workers from the developing countries
who called instead for the adoption of indigenous approaches
they believed were appropriate to the social and cultural reali-
ties of non-Western societies. Although few social workers at
the time were actively involved in these international debates,
the profession has benefited from addressing these and other
international issues.

Over the last decade, globalization has been a major topic
for discussion in international social work. Articles on the
subject have appeared in many social work journals and the
issue has featured prominently at international gatherings.
Like much of the social science literature on the subject, many
social work scholars have offered a very pessimistic analysis
of globalization. Many have argued that it has created unem-
ployment, weakened traditional family values and community
solidarity, created pressures on governments to cut social ex-
penditures and undermined their ability to implement social
welfare policies and programs.

A more optimistic school of thought that stresses the op-
opportunities provided by globalization for enhancing interna-
tional collaboration, promoting peace and increasing under-
standing between the world’s different peoples and cultures
has also emerged. Social work proponents of this view stress
the multifaceted character of globalization, pointing out that
it not only involves economic but demographic, social, cul-
tural, political and other dimensions. While they are critical
of speculative finance capitalism, exploitative trade relations
The Challenge of a Unipolar World

and the role of international organizations such as the IMF and the World Bank, they believe that it is possible to implement a progressive global agenda that will enhance the welfare of the world's peoples.

International social workers who take a more optimistic view of globalization also believe that globalization can foster greater international political cooperation and strengthen multilateral organizations such as the United Nations. Through the efforts of the United Nations and other international organizations, they argue that it may be possible to regulate economic markets, promote global well-being and address major social problems such as malnutrition, HIV/AIDS, ethnic and religious conflict and the exploitation of women, minorities and children. Above all, they claim that human rights, peace and social justice ideals can best be realized through global cooperative efforts.

These ideals reflect a centuries old cosmopolitan tradition in Western social and political thought that has long believed in the possibility - as well as the necessity - of international collaboration. Rooted in the ancient Stoic belief in a universal natural law that binds people of all cultures and nationalities together, the cosmopolitan ideal has influenced the theologies of Augustine and Aquinas and in the political theories of Machiavelli, Kant and Marx. It found practical expression in the creation of the League of Nations in 1919 and subsequently with the establishment of the United Nations in 1945. More recently it has been restated in the advocacy of admittedly nebulous notions such as "global citizenship", "borderless world" and "global governance".

Many social workers will be particularly interested in the practical implications of cosmopolitan thinking and in the ways these ideas can be implemented. In fact, many are already engaged in the practical task of promoting international cooperation. Many are helping to educate students and colleagues about the need for greater international engagement, and many are actively supporting international organizations, including civil society organizations, that campaign for global reforms. By actively responding to the challenges as well as the opportunities of globalization, they believe that the profession's commitments to promoting global social well-being and
social justice can be realized.

However, there are many who reject the cosmopolitan values reflected in these activities. For example, isolationists believe that international engagement should be minimized and that nation states are better off when they focus on domestic issues and avoid international entanglements. Nationalists believe that national identity (and loyalty) is the most important feature of social life and they have historically used international opportunities to promote domestic interests. Advocates of imperialism believe that powerful states will inevitably dominate weaker nations and that this is a natural and realistic way of organizing international affairs. Their views have been used not only to justify the exercise of diplomatic, military and economic power but the diffusion of values and institutions. These different ideologies pose a serious challenge to the idealistic cosmopolitanism that characterizes international cooperation today.

It is in this regard that the concept of “unipolarism” has particular relevance for international social work. Popularized by the neoconservative journalist, Charles Krauthammer (2004), the term evokes a new global imagery which replaces earlier conceptualizations and classifications of the world’s nation states. These include the bi-polar “East versus West” dichotomy of the Cold War and the tri-polar “Three Worlds” classification advocated by the leaders of the nonaligned movement in the 1950s. For the nonaligned movement, the world was divided into three major spheres of influence or “poles”, namely the Western capitalist democracies, the Soviet Union and the developing countries. Subsequent formulations augmented this classification by adding a “Fourth World” of extremely poor developing countries or by viewing the world as a conglomeration of distinct cultural or “civilizational” spheres such as that envisaged by Samuel Huntington (1996) in his book *The Clash of Civilizations*. For many cosmopolitans, however, the world is best depicted not as a multiplicity of poles but as a community of equal, sovereign nation states bound together by international law and participating on a reciprocal basis in global, cooperative endeavors.

Neoconservative intellectuals and politicians scoff at this notion pointing out that international relations are not
characterized by idealism but by the hard realities of political and economic power. These realities rather than idealistic calls for mutual respect and reciprocity dictate events. The realist view was actively promoted by neoconservative writers such as Norman Podhoretz and Irving Kristol in the 1980s who urged that the accommodationist policies of the Cold War era be rejected, and that the government of the United States be utterly committed to the destruction of the Soviet Union and its communist ideology. Its destruction, they argued, was necessary to secure global peace and promote the social and economic well-being of the world’s peoples. It was the dogged determination of the Reagan administration, they claimed, that brought about the collapse of the Soviet system in 1989. Subsequently, a new generation of neoconservatives including Richard Perle, Paul Wolfowitz, Robert Kagan and William Kristol have articulated a vision for American diplomacy which proposes that the government of the United States accept its new responsibilities as the world’s only Superpower and, in the new unipolar world, tolerate no opposition from any quarter.

Krauthammer’s notion of the unipolar world found expression in the 1992 Defense Department’s policy statement that urged that the Cold War strategy of “collective internationalism” be replaced with a new strategy of “benevolent domination”. Drafted largely by Paul Wolfowitz under the supervision of then Secretary of Defense Dick Cheney, the policy statement urged the administration to declare the global hegemony of the United States and assume sole responsibility for international security. Although the policy statement received a hostile reception when it was leaked to the New York Times, its central premises were aggressively reiterated during the 1990s by numerous neoconservative thinkers with the support of leading right wing think tanks.

In 1997, a group of neoconservatives under the leadership of William Kristol and Gary Schmitt founded the Project for a New American Century which advocates the use of diplomatic, economic and military power to diffuse American values and ideals. Just as the Romans had shaped their world, so the leaders of the Project urged the government to remake the modern world in the American image. In 1998, leading neoconservatives sent an open letter to the Clinton
administration proposing an aggressive military and political strategy for overthrowing Saddam Hussein’s dictatorship in Iraq. Calling themselves the Committee for Peace and Security in the Gulf, the group included present-day luminaries such as Secretary of Defense Donald Rumsfeld, World Bank President Paul Wolfowitz, US Ambassador to the United Nations John Bolton and US Ambassador to Iraq Zalmay Khalilzad. These proposals and the wider ideals they represent have subsequently been adopted by the Bush administration which has frequently declared its commitment to spread American notions of liberal democracy and free-market capitalism throughout the world. Of course, these beliefs were also implemented in the invasion of Iraq as legitimated by the doctrine of preemption. In his recent book, *The Case for Goliath*, Michael Mandelbaum (2005) offers a new and audacious commentary on these developments, arguing that debates about the advantages and disadvantages of American global hegemony have been rendered moot since the government of the United States has now, in fact, emerged (and been widely acclaimed) as the world’s de facto government.

While this argument might be cynically interpreted to suggest that the cosmopolitan ideal of world governance has now been realized, cosmopolitans would be appalled by the idea that one imperial power can effectively represent the interests of the world’s diverse nations and peoples. Unipolarism dismisses the Post-World War II ideal, as exemplified in the United Nations Charter, that the world should be comprised of an egalitarian community of sovereign nation states cooperating with each other and living in peace under international law. Indeed, the advocates of unipolarism in the current administration and in neoconservative intellectual and journalistic circles, have not only ridiculed but campaigned to undermine this ideal. They have successfully urged the Congress to reject a variety of international treaties and human rights agreements and to scorn multilateral organizations such as the International Criminal Court. They are disdainful of the United Nations and other international organizations and have secured the appointment of neoconservative unilateralists to key positions in these bodies. Their attacks have also been directed at international non-profit organizations that pursue
agendas that are contrary to their own ideological preferences, particularly in fields such as gender rights and reproductive health. They have aggressively dismissed dissenters and, on national security grounds, advocated the use of surveillance and other methods that have the effect of suppressing dissent. They have urged the international adoption of values and beliefs that they believe exemplify American culture and have urged that international aid, diplomacy, economic institutions and even military means be used to achieve this goal.

The unipolar agenda presents a major challenge to social workers who believe in the ideals of international cooperation and reciprocity. Much international effort in social work has been based on these ideals. Over the years, social workers have formed national, regional and international professional associations that promote cooperation among social workers in different parts of the world. These organizations and the social workers they represent are respectful of difference and seek to understand and share rather than impose professional viewpoints. When these ideals are again affirmed at the two forthcoming international social work meetings this summer, social workers need to be mindful of the role of unipolarist ideology and the powerful hegemonic global forces that it has unleashed. These forces pose a major challenge to the profession’s historic international ideals and commitments.

References


Dear Dr. Leighninger,

As the co-editor of a human services journal, a social work academic and a social worker of many years, I was shocked when I learned about Dr. James Midgley’s disturbing experiences after submitting an invited guest editorial on international social work to the journal Social Work. The specifics of what ensued are recounted in your discussion, so I will not repeat them here. I do, however, want to raise my voice in protest of how Dr. Midgley’s editorial was treated by the National Association of Social Work (NASW), the publisher of Social Work.

There are several aspects to these events which are particularly disturbing. One is that a thoughtful and well-reasoned critique of foreign policy associated with neoconservative members of the Bush administration would be seen as so threatening by NASW that the names of many of these individuals would have been deleted following their administrative review. Another is that this administrative review and alteration took place without consultation with Social Work’s editor or with the author. Moreover, while editorial and peer review of scholarly professional journals is standard procedure, administrative review by professional associations such as ours should not be. The fears behind NASW’s political censorship can only be imagined. NASW has engaged in political advocacy and critique in the past, so this decision is both confusing and extremely unsettling.

As noted, Dr. Midgley withdrew his editorial from Social Work.
Work after NASW refused to reinstate the deleted names. It is important that Dr. Midgley’s original editorial is being printed in full by Sociology and Social Welfare, along with protests about its treatment by NASW. A forthcoming issue of the Journal of Progressive Human Services (JPHS) will also include a narrative by Dr. Midgley, detailing this experience and calling to the profession to scrutinize and debate just what it means by advocacy and the promotion of social justice.

Sincerely,
Marcia B. Cohen
Journal of Progressive Human Services
Dear Dr. Leighninger,

I have been asked, as the editor of a journal and a member of the National Association of Social Workers (NASW) to comment on the situation relating to Dr. Jim Midgley's manuscript. I approach this state of affairs from a belief in the NASW Code of Ethics, particularly the role of advocacy that is stated there (NASW, 1999).

Advocacy for social justice is one of the key aspects of the profession of social work and one that sets it apart from other helping professions. The NASW Code of Ethics mentions the need for social workers to conduct advocacy to promote social justice many times and in different ways (NASW, 1999). Part of the goal of NASW is stated on its web site as "to advance sound social policies" (NASW, n.d.) which, at its core, must be considered a form of advocacy.

Advocacy, while it means many things, certainly means being able to observe what is going on and to report to an audience what one has observed, as well as making one or more recommendations for what the audience should do. This can be as complex as developing a plan to improve social services, testifying at a legislative hearing and announcing the conclusions at a press conference. Or it may be as simple as talking to colleagues, trying to sway their votes on Election Day.

For academics, advocacy may involve more finely developed research reports, closely reasoned arguments based on a knowledge of history and current events, or even using classes to teach others how to conduct advocacy. Many times, academics, such as myself and Dr. Midgley, write with the hope that our work will be published in the best journals in the social work field, such as Social Work, the largest circulation social work journal in the world. Social Work has a low acceptance rate, and this, combined with the large circulation, means that any article seeing the light of day in this journal has a good chance of being read and thus being influential.

What one says in a Social Work article has a better chance of being used in an effective advocacy effort—that is, that article can be used to share observations and to make recommendations for what social workers across the country
should do. Therefore, it seems incumbent upon the NASW Press, as part of the larger NASW enterprise, to support efforts to report accurately what is being done that is seen as counter to the social justice aims of the profession. Accurately reporting what is going on must necessarily mean that the names of the architects and perpetrators of a social policy disaster should be mentioned.

As long as there are empirical grounds to support such an argument, I believe Dr. Midgley should be able to name the names and try to get their game to end.

But wait, one might say, organizations such as NASW must be careful to stay clear of the Internal Revenue Service, which enforces the rules and law regarding advocacy by nonprofits. If the main journal of the organization tries to take a stand against a certain leader or political party, won’t this potentially bring forth the enforcement division of the IRS, which can revoke any nonprofit status the organization may have?

If this is a valid concern, then the NASW Press may have an obligation to protect the overall organization and remove offending comments from a manuscript. But there is little reason for the press staff to believe such a concern is valid.

First, NASW is not a 501(c)(3) nonprofit, so the need to be careful about advocacy is extremely limited. Second, among the fine print of Social Work’s page of information about the NASW Press, a disclaimer is clearly stated: “Opinions expressed in the journal are those of the authors and do not necessarily reflect the official position of NASW” (NASW Press, 2005, p. 194). Finally, the NASW Press promotes itself as delivering “professional information to more than 250,000 readers through its scholarly journals, books, and reference works” (NASW Press, 2006). What could be more “professional” information than the names of people who helped develop policies with documented negative impacts on vulnerable populations?

In conclusion, if NASW considers itself an organization that demands advocacy from its members, NASW and its related organization, NASW Press, should support the advocacy that emerges, so long as it is well-grounded in facts and falls within other professional parameters. It appears that what has happened to Dr. Midgley’s manuscript is an example where diffusion of professional research and advocacy has been
lessened for invalid reasons. As a result, NASW members have been needlessly deprived of information that would help them in fulfilling their professional responsibilities.

Let us hope that this is an isolated case and one that is not repeated. It certainly is an issue that social workers should be aware of and provided an opportunity to voice their opinion regarding. The Chair of the NASW Publications Committee is Dr. Barbara White, Dean, School of Social Work, 1 University Station D3500, University of Texas, Austin, TX 78712-0358. I encourage readers to engage in some advocacy of their own.

Sincerely,
Richard Hoefer, Ph.D.
NASW Member and
Editor, Journal of Policy Practice

References

Dear Dr. Leighninger,

I do not understand why Professor James Midgley’s guest editorial was not allowed to be published in the journal Social Work. First, it was a guest editorial, and NASW could have printed in the journal that it dissassociated itself from Professor Midgley’s views.

Second it was not clear to me as to who actually made the decision not to publish the editorial? More importantly, was the leadership of NASW involved, e.g., the publications committee in consultation with the editor of Social Work and the author? What was the process in making the decision? If there was no such process, was there censorship by the NASW management rather than by the social work leadership?

Third, Professor Midgley provides an important message for international social workers regarding the issue of unipolarism versus international cooperation and reciprocity.

Fourth, if the editorial was not published due to the fear of offending the government, I have these questions: Is the current management of NASW consistent with the ethical and human rights notions of social workers around the world who are advised to speak out about challenges to human rights? Is NASW maintaining a leadership role pertaining to human rights, or is it reactive to whatever the current views of the government might be?

Tony Tripodi
Moses Visiting Professor
Hunter College School of Social Work
Dean and Professor Emeritus, Ohio State University
Former Editor of Social Work Research
Former Co-editor of Journal of Social Work Research and Evaluation: An International Publication
Editor of Pocket Guides to Social Work Research Methods, Oxford University Press
Dear Dr. Leighninger,

Among the greatest anxieties of those concerned with the erosion of civil liberties under the present administration has been censorship. Under the guise of protecting the populace from terrorists, this administration has used its influence to pass new legislation and rules, reconstitute regulatory commissions and engage in various forms of retribution (such as tax audits) against those who would criticize their actions and positions. Mass media outlets under the ownership of megacorporations have tended to toe the party line to the point that some so-called “news” programs seem more like spokespeople for the administration than neutral reporters.

Although less well known, this administration’s policies have also had a restrictive impact on academic practices. In the education field, several scholars have expressed their concern over the conservative, narrow view of scientific legitimacy promulgated in regulations and laws such as the “No Child Left Behind” legislation. This climate of “methodological fundamentalism” is viewed by some as a reaction to recent approaches (e.g., queer studies, feminist research) whose inquiry practices are openly value-based and critical of current policies.

Together, these developments have produced an environment in which the free expression of ideas has become risky. Yet, if academic journals do not resist such tendencies, they can have a chilling impact on the integrity and legitimacy of such publications. Perhaps most chilling is when, even in the absence of specific regulations, journals begin to exercise censorship of information they believe might be offensive to the administration. The exercise of such forms of censorship is reminiscent of Foucault’s “disciplinary power” in which people become their own overseers. If our professional journals, and in particular social work journals, begin to operate in this fashion, true academic discourse eventually may cease to exist. Yes, it takes courage to print information that may not sit well with those in power and to possibly incur their attempts
at "discipline." But alternatively, if we become domesticated in this fashion can we still call this the social work profession?

Stanley L. Witkin
Former Editor-in-Chief, Social Work
Dear Dr. Leighninger,

The National Association of Social Workers is unique among professional social work associations. As a 501(c)(6) tax exempt organization, in which are housed a Political Action Committee (PAC) and a government relations program with registered lobbyists, NASW has some restrictions and regulations regarding our combined activities, including our publications, that other groups don’t have. While we do encourage a free exchange of ideas, we do so with certain obligations. This has very rarely posed a problem for NASW. Additionally, like any corporation, we always reserve the right to review the content of publications, reports, or correspondence and to request modification if we feel it could have an adverse legal effect.

In the instance of Dr. Midgley’s editorial, the issue centered around requirements regarding reporting of the association’s government relations and PAC activities. After deliberation, we asked Dr. Midgley to make very slight modifications to his editorial, primarily removing the names of government officials. We felt that request was modest and that doing so would not diminish his editorial, but would allow us to stay within the standards and regulations we follow.

Dr. Midgley strenuously objected to the request, and indicated that he would publish his editorial elsewhere if we required any changes. He also contacted several members of our Board of Directors and asked them to intercede on his behalf. We held up publication of the journal until our national Board of Directors met. As requested, the board discussed the situation and concurred with the decision to ask Dr. Midgley to make the necessary modifications. Dr. Midgley withdrew his editorial.

I do feel compelled to say that I believe this issue has been misconstrued. The notion that NASW is reluctant “to take on the administration” or “to stand up to the right” is simply uninformed. We do it every day through our advocacy, through our lobbying, and through our PAC work and grassroots organizing -- but we do it in appropriate ways and within legal and regulatory requirements. With minor changes, we were
ready to publish Dr. Midgley's guest editorial. We're sorry that couldn't happen.

Elizabeth J. Clark
Executive Director, National Association of Social Workers
The need to focus on service and policy barriers to mental health service delivery for African Americans remains critical. The purpose of this article is to review nineteenth century care as a method for understanding contemporary service and policy barriers. A case study strategy is used to compare the efforts of Pennsylvania and South Carolina using primary and secondary sources to document these developments through a political economy perspective. These findings suggest that the prevailing social, political and economic realities have created mental health disparities along racial lines. Existing barriers are likely rooted in this same reality.

Key words: Mental health, African Americans; historical; service; policy; barriers

Mental health service and policy measures often neglect the needs of African Americans. Recognized patterns of misdiagnosis, over reliance on medication and restricted forms of care and disparities in service utilization have been documented for this population (Lawson et al., 1994; Loring & Powell, 1988; Mandercheid & Sonnenshein, 1987; Neighbors, 1985; Neighbors et al., 1989; Segal et al., 1996; Snowden & Cheung, 1990; Zito et al., 1998). Such service patterns produce not only
a sense of mistrust (Brown, et al., 1999; Sussman et al., 1987), but also result in service disengagement and alternate pathways to care (Davis, 1997; Garland & Besinger, 1997). Consequently, the aggregated effect of such experiences may lead to the under-utilization of services (U.S. Department of Health and Human Services [DHHS], 2001). Given the vulnerable status of African Americans, it remains critical that we continue to focus on barriers that detract from and/or prevent access to service. In fact, widely available mental health services did not exist for African Americans until the desegregation of state hospitals in 1965, which was a requirement for funding with the expansion of the Social Security Act that provided health care to seniors (Prudhomme & Musto, 1973). Since then, although managed care has changed the landscape of mental health care, it is imperative that social workers, and all mental health providers, remain vigilant relative to potential barriers.

The nineteenth century for African Americans can be described as a period filled with contradictions. Of course, during this period most were either enslaved or disenfranchised, but some were free and thriving. As the enlightenment movement took hold, most northern states had either abandoned the lawful practice of state sanctioned slavery or at least were phasing it out. Despite these trends, southern states experienced dramatic increases in their slave holdings and thus, wealth (Johnson & Smith, 1998). As a result, the South became more dependent on slave labor and inventories of African Americans/chattel were major asset in the determination of economic wealth. Mental health care historically has always been vulnerable to the social, political, and economic environments, but for African Americans this link is magnified (Turner & Singleton, 1978). As Grob (1994) suggest, social, political, scientific and economic factors stratified service and policy practices along racial lines. Thus, the provisions of mental health care emerged as a function of the society’s racial beliefs and practices (Davis, 1997; Griffith & Bakers, 1993).

A historical review of service and policy barriers can inform contemporary public policy makers and providers of potential problems associated with the legacy of neglect to African Americans who need mental health services (President’ Commission on Mental Health, 1978). A two state case study
of 1800s mental health service and policy strategies in the states of Pennsylvania and South Carolina is presented as an expression of care through the lenses of a political economy perspective. Information was collected from primary and secondary sources in the form of published literature and The 19th Century African American Newspaper collection database. From this special collection, key words such as "negro", "lunatic", "asylum", "mania" and "idiocy" were used to access relevant content.

Mental Illness amongst African Americans in the 1800's

During the 19th century, the prevailing diagnostic system centered on four main syndromes, -- melancholy, mania, dementia, and idiocy; however, geography and race of clients often combined to create a different typology. In the Pennsylvania State Lunatic Hospital in Harrisburg, melancholia and acute mania were the most common diagnoses for all patients (Morrison, 1992). However, in the South an alternate taxonomy emerged that incorporated ideological thought relevant to chattel slavery within existing practice and service delivery. In 1851, Dr. Samuel A. Cartwright in the De Bow's Review observed two "diseases of the mind" which he associated with slaves: drapetomania and dysaethesia aethiopica (as cited by Stampp, 1961). Specifically, drapetomania was defined as "sulky and dissatisfied" behaviors that usually resulted in slaves running away. Dysaethesia aethiopica was a pattern of "mischief" that appeared "intentional" concerning work habits, which resulted in poor attention to their work and destruction of equipment (e.g., plow, hoe). Both diagnoses were culturally and contextually bound to the institution of slavery and reflected the intrusion of social, political, and economic views into psychiatry.

The cause and treatment of mental illnesses for African Americans were viewed differently from that of whites. Although environmental stress was widely believed to cause mental illness for the general populace, as one of the "uncivilized races", mental illness for African Americans was seen as having a different etiological premise. For example, views of biological defect, social inferiority, and political
subjugation underpinned notions of their pathology (Deutsch, 1944; Thomas & Sillen, 1972). At one extreme, some even suggested that slavery provided a "guard" against mental disorders (Dewery, 1906). This phenomenon resulted in different critiques not only about the prevalence but also causes of mental disorders among African Americans. Most notably was the perception that the regional nature of slavery caused different outcomes since it provided structured daily activities including meals and lodging, however harsh and minimal. The causes of mental illness attributed to African Americans took on a unique departure from that of their white counterparts due, in part, to the disparities uncovered in the U.S. Census of 1840.

Presumptions of low risk of mental illness were fueled by census returns and treatment rate reports to asylums. The 1840 U.S. census, for example, established disparities in rates of "insanity and idiocy" from a high rate of 1 in 14 in Maine to a low rate of 1 in 4,310 in Louisiana. In comparison, the states of Pennsylvania and South Carolina had a high of 1 in 257 to a low of 1 in 2,477, respectively (Litwack, 1961; Prudhomme & Musto, 1973). After reviewing the returns, John C. Calhoun, the Secretary of State from South Carolina advanced the notion that "science" (the tabulation of returns) had demonstrated that the protected condition (e.g., slavery) of blacks would decrease their risk of becoming "idiot" or "maniac" (Prudhomme & Musto, 1973). Moreover, others attributed these differences to their lack of engagement in daily routines of ordinary life and civic responsibilities (Babcock, 1895; Dewery, 1906). Following along the earlier decade, the 1850s returns found disparities in the rate of "insanity" noting 1 in 1,290 for whites, 1 in 1,350 for free African American's and 1 in 11,014 for enslaved African Americans. Before 1861, African Americans were rarely admitted into Southern asylums because they presumably exhibited "milder forms" of mental illness (Babcock, 1895) that justified lower treatment rates. These assumptions would not go unchallenged.

The black press raised concerns about both the interpretation and utilization of the census findings. In 1853, The National Era, a Washington, D.C. newspaper urged caution regarding the inference by suggesting there was a danger in using such
evidence as supporting oppression. It was explained that "we trust this fact will not be alleged as an argument to show the inferior organization of our race". This critique was extended by suggestion that if "slavery" provides protection against mental disorders, then "whites would be the gainers by being reduced to slavery".

Two claims emerged to explain disparities (lower rate) in mental illness found among African Americans. First, geography, regional differences, led to the consideration of climatic conditions as an influential factor in the prevalence of mental illness. In 1857, Bouldin, a French psychiatrist, concluded the cold climate of the North was destructive to the mental health of blacks (as cited by Prudhomme & Musto, 1973). Second, biological inferiority also fueled claims of disparity. Notably, leading social scientists of the time suggested that the lower brain functioning protected African Americans from "higher order" mental disorders, such as melancholia and mania (Babcock, 1895). This critique was consistent with the Darwinian view of the time, which suggested that Africans and their decedents were less evolved than Europeans. This alleged rarity and its causes justified the neglect of services to African American's. Further analysis of the 1840 census discovered significant problems in the returns, which led to concerns regarding errors in enumeration and suspicion of fraud by proponents of slavery.

As the mental health asylum movement grew, governing bodies at the state level became concerned about the extent of mental illness in their population. In response, counties, states, and federal agencies began developing strategies to document service demands of African Americans. In 1837, the county census of almshouse residents of Philadelphia County, PA found that African Americans were more than 20 percent of those characterized as "lunatics and defective" (DuBois, 1899). Hence, they were disproportionally represented, some three times more likely to be labeled as such. In 1840, federal government enumeration efforts would constitute the first, albeit primitive, epidemiological survey to gauge the prevalence of mental illness in the country. Subsequently, the United States census returns found higher rates of "insanity and idiocy" in Northern blacks than Southern blacks, free vs. enslaved blacks,
and white vs. black populations.

The Political Economy of Mental Health Service and Policy

The theoretical political economy literature has argued that service and policy formation can be modeled as the outcome of a process in which competing groups vie for the favor of policymaker. From this framework, a growing body of work has provided a better sense into how economic and political interests are translated in outcomes by the intervening political institutions (Alston & Ferrie, 1984; Becker, 1984; Brock & Mage, 1978; Collins, 2000 & Schneider & Moon Ji, 1990). However, relatively few studies in economics have explicitly examined race-specific government policy formation (Collins, 2000; Roback, 1986; Wright, 1990). Of the economics studies that have been done, most focused on the South in the early twentieth century. Few compare the regional efforts between North and South, suggesting that this area is underdeveloped. Empirical studies in political science and sociology have investigated race-specific policy formation several times, but the emphasis has been slanted toward federal legislation.

This paper expands this line of inquiry by drawing on previous works in examining the history of mental health service and policy barriers in the nineteenth century at the state level. The mental health service system was viewed as a part of the social welfare network based on the interweaving dynamics of social, political and economic influences of that time. First, a contextual overview of the social, political and economic footing of African Americans during the period is proffered.

The Confluence of Factors

Despite the promise of enfranchisement by the late eighteenth century, African American communities in Pennsylvania and South Carolina remained marginalized. The religious revivalist movement of the late 1700's and early 1800's, in part, helped direct the prevailing northern view of slavery from that of a utilitarian institution to one of moral sin. To the South, the institution of slavery was woven into the fabric of southern society. The social reform movement experienced dissention
because it failed to reconcile beliefs regarding the existence of social inequity across the country and that the loss of civil liberties dealt a blow to both free and enslaved African Americans. Many northern states eventually abandoned the practice of slavery, some abruptly and some gradually (DuBois, 1899). In contrast, the South became more dependent on slavery as a source of free labor that undergirded much, if not most of the region's wealth. These issues played out in the social, political, and economic environment of the nineteenth century. For example, although relegated to segregated/separate status in the larger society, a self-contained business and civic class emerged in some urban African American communities.

Despite the thin veil of social respectability, in Philadelphia and Charleston, African Americans lived socially on the periphery of society. These communities were relatively small and posed little threat to whites. Although a black middle class was emerging, it lacked real social clout, with few exceptions. Racial tensions erupted into violent riots in a number of areas including Philadelphia and Columbia, Pennsylvania over the issue of employment between blacks and whites and caused deep social division (Shirk, 1993). In South Carolina, where the black population was larger than that of whites, concerns were associated with the personal safety and economic security of whites at the expense of free and enslaved African Americans. In response to these tensions, communities in both states began to enact a series of ordinances that would restrict personal liberties of blacks. After becoming suspicious of municipal fires in the 1820's, the Harrisburg, Pennsylvania borough council enacted statutes developing "citizen patrols" and "requiring the registration of free people of color" (Eggert, 1991). Similarly, South Carolina, as other southern states, enacted a series of laws restricting many practices concerning African Americas' movement, emancipation, education, gatherings, religious practices, and many other activities of daily living (DuBois, 1903; Gordon, 1929). In the face of such challenges, African Americans organized mutual aid societies that would address facets of individual and communal needs (e.g., religious, churches, trade, educational) as sources of support and protection. They often targeted advertisements in black newspapers to crystallize community support, plan for and
provide respite and increase public awareness and spotlight the curtailment of rights and the punitive efforts of asylums.

As evidence in the emerging African American press suggests, both direct and indirect initiatives were made to comfort and support those suffering from “different” mental conditions. In 1848, for example, the National Era in Washington, D.C. carried a direct appeal, “To the Friends of the Poor Colored Orphan”, for purpose of soliciting funds for support of an orphanage in Cincinnati, Ohio. The article mentioned that this method of fund raising was used in order to provide asylum care for those less fortunate. In 1851, The North Star of New York, New York reported the efforts of the Nightingale Minstrels in providing a concert to entertain the “inmates” of the Utica, New York Insane Asylum. The Christian Recorder of Philadelphia, Pennsylvania carried stories discussing the dangers of “morbid nervousness” and the efforts of the New York Asylum for Idiots in 1861 to treat the disorder. In particular, the press characterized morbid nervousness as a debilitating illness that is hastened by multiple stresses. These fund raising initiatives demonstrated both recognition and concern relevant to mental health service issues.

With the role of African Americans as a centerpiece in a national public policy debate, political tensions mounted concerning their relationship to whites. Because Pennsylvania and South Carolina were on opposing sides of the Mason-Dixon Line, both free and enslaved African American communities were exposed to similar and different dilemmas. Outcomes of the 1837 Pennsylvania Constitutional Convention represented a devastating turn away from the principles of liberty and equality. The convention ratified a ‘new state constitution restricting the franchise only to white freemen (Smith, 1998). Thereby, the right of black men to vote was removed. In response to disenfranchisement, opposition was launched by two critical monographs, Memorial of the Free Citizens of Color in Pittsburg, 1837 and The Appeal of Forty Thousand Citizens, Threatened with Disenfranchisement, To the People of Pennsylvania, Philadelphia, 1838 (as cited by Smith, 1998). Despite protest and appeals, voting rights of African Americans would not be restored until after the Civil War. As attacks on the institution of slavery mounted, free and enslaved African Americans
became increasingly repressed politically and socially. In particular, "southern race relations required that Negroes be powerless, submissive, and dependent" (Berlin, 1974, p. 316) as their growing resistance in the courts, through the media, and via insurrection escalated tensions. The converging political protest threatened the social caste assumptions of both the North and South.

The development of the independent black church provided political leadership outside the control of whites; the African Methodist Episcopal (A.M.E) Church was launched in Philadelphia, PA in 1794 and a charter to establish a church in Charleston, SC was secured in 1810 (Berlin, 1974). This expansion to the South provided a platform to import the liberating tenets of African Methodism to free and enslaved African Americans. From 1813 to 1837, the number of A.M.E. churches grew from two to eight with almost three thousand members (Nash, 1988). After being implicated in 1822 as staging liberating activities in a failed insurrection in Charleston, the A.M.E. church was expelled from South Carolina, having become regarded as a social, economic and political threat to the status quo.

The economic implications of the demise of slavery weighted heavily, particularly in the South, on the debate concerning the future of African Americans. The north minimized the economic impact because of its reduced investment from the practice, while the South had serious misgivings because of its relationship to the institution, culture, and style of living. In some states in the South, dependence on slavery as an institution was enormous. For example, by 1860, South Carolina had established an enslaved population 30 percent larger than the free white population (Berlin, 1974). In particular, this slave population had grown from just over 146,000 in 1800 to over 402,000 in 1860. Over the same period, the free white population grew from slightly more than 196,000 to over 291,000. Dependence on a labor-intensive enterprise (e.g., agriculture) required a stable workforce. The investment in slavery represented a significant portion of the white population's wealth making them vulnerable to rebellions by slaves and threats by external suggestion that slave ownership was immoral and sinful. In the North, free blacks often filled lower tier jobs
usually considered less desirable by whites. An examination of the African American population in Harrisburg, PA during the 1800's reported that they primarily held lower level occupations (Eggert, 1991). Mindful of African Americans menial existence, the ability to afford and have access to asylum care is doubtful.

The Birth of Service and Policy Barriers

The North and South both recognized the need for mental health services for African Americans in the Colonial era. Services then focused around local jails and almshouses. By the nineteen century, a new movement concerning the delivery and organization of health care dramatically changed mental health care by propelling national efforts to develop state-funded asylums for the care of the mentally ill. Notably, Virginia and Pennsylvania led others by becoming the first states to develop specialized hospitals exclusively for the care of the mentally ill in 1773 and 1813, respectively (Deutsch, 1946; Morrison, 1992). Specifically, the combined efforts of scientific developments, the social reform movement, economic demands, and the failure of communal almshouses gave rise to the innovation of institutionally based “moral treatment”, which consisted of specialized care for the mentally ill.

Although states established institutional facilities, the accessibility and quality of mental health care left considerable room for improvement. By 1849 thirteen states had initiated state-funded asylums for the care of the mentally ill (Grob, 1994). Aside from these developments, most mentally ill people remained in almshouses, which meant that their treatment options were within the framework of public welfare (Katz, 1996) and corrections. After observing the poor system of care, school teacher turned social reformer, Dorothea Dix, energized a nationwide reform effort to improve and expand institutional care for the “insane”, but only for white people (Gollaher, 1995, Trattner, 1994). This effective reformer suggests that mental health care for slaves and free blacks should be the preview of black advocates. In the South, where most African Americans lived, care for the insane was generally
thought to be more deficient (Wisner, 1970), but the quality of care in the North was arguably no better (Prudhomme & Musto, 1973). With most African Americans living in bondage, this new form of care was rarely accessible; therefore, the tide of institutional reform did little to change the status of mental health.

The delivery of mental health services became increasingly more segregated during the mid 1800's, which affected the funding and public attitude toward those receiving care. The availability of moral treatment (i.e. specialized care) for the mentally ill was often limited to white citizens (Drewey, 1906, Grob, 1994), which forced alternate paths to service for most African Americans, meaning that almshouses and jails remained their primary providers of institutional care (Babcock, 1896; Prudhomme and Musto, 1973; Trattner, 1994). In 1860, Dr. Langdon of the Longview Asylum of Ohio underscored this reality. He explained that:

many of them [the colored population] pay heavy taxes, but their insane are compelled to herd with rogues and thieves and vagabonds in our county jails. This is an outrage upon justice, humanity, and common decency... that we now almost despair of accomplishing anything in the future” (as cited in Babcock, 1895, p.178).

Segregated admissions practices developed in both the North and South. For example, the Worcester State Hospital in Massachusetts, which was organized in 1833, quickly established separate quarters for the “races” (Grob, 1994). Due to the lack of separate facilities, prior to 1848, the state Lunatic Asylum outside of Columbia, South Carolina refused to admit African Americans. Replicating the racial tensions found in the larger society as they did, asylums’ provided services in keeping with what was considered to be the best treatment approach (McCandless, 1989; Prudhomme and Musto, 1973). Segregation sometimes did improve the condition of white inmates, who moved to new facilities while blacks languished in their old ones, which usually left the latter worse off than before, for once isolated in separate facilities white officials rarely bothered to improve services (Berlin, 1974). Vestiges of
denied services, as well as segregated and unequal services, remained anchored in policy practice for generations.

Regional differences provided some contrast, but did not account for major distinction in policy approaches regarding African Americans’ mental health care. Local sensibilities were influential in provision of services and therefore, the context of care operated within those understood social practices. The South was not alone in its exclusionary practices; some northern states also excluded African Americans from asylum care. The states of Mississippi, North Carolina, Indiana and Ohio excluded African Americans, free or enslaved, from state financed asylum care. In 1856, these policy restraints were visibly evident-based on a legislative report. In a discussion on care, the superintendent of the Mississippi Asylum explained that there was no provisions under existing laws for the reception of slaves nor free persons of color in the asylum (as cited by Babcock, 1895).

Exclusionary practices in the South also recognized the different legal status held by African Americans. Dr. Galt of the Williamsburg Asylum explained:

> the colored insane of Virginia may be divided into two classes: first, those who are free; and second, slaves ... Patients of the first class have been received into the asylum from the date of its opening .... [F]ree people of color ... have been ... placed upon the same footing as to the right of admission ... as white people (as cited by Babcock, 1895, p.170).

Such statements demonstrate the policy restraints placed upon the asylums by the state legislature though there is no evidence that many administrators would have delivered services even if required by law.

State mental health policy regarding admission of free and enslaved mentally ill African Americans mainly took three directions. Policy practices can be defined as exclusive, inclusive or contradictory to state’s legislative mandates. With the majority of African Americans in bondage, exclusionary policy practices refer to laws that prevented their admission into mental health care. Inclusive policy practices refer to those state
policies that permitted their admission to the state asylum, which were generally the exception, not the rule; however, a number of southern and northern states were progressive in this regard. Contradictory policy practices refer to policies permitting admission, but such mandates were neutralized or not enforced.

A Case Study of Two States Efforts

Pennsylvania

Pennsylvania's practices regarding the care of mentally ill African Americans were representative of the general practices in northern states where the African American population was small permitting such services. Because of the size of this cohort and lack of political clout, mental health service needs were of little concern for most (Grob, 1994). In 1837, the Philadelphia County, Pennsylvania, almshouses' census found that 14 percent of the residents were African Americans, while they only accounted for 7.4 percent of the population. Of these residents, more than twenty percent were characterized as "lunatics and defective" (DuBois, 1899). The conditions in almshouses throughout the state, and all of the North, were generally dismal for all occupants (Morrison, 1992). New York city and Cincinnati created separate jails and almshouses to prevent the mixing of races (Grob, 1994).

Limited details are known about the kind or range of practices in Pennsylvania regarding the delivery of asylum care to African Americans. What is known suggest some attempt at inclusion; the Friends' Asylum for the Insane in Philadelphia actively solicited admissions in the Black press. In 1851, an ad in the National Era, characterized the service offered by this agency as providing a family like care that combined kind and efficient moral and medical treatment. Of note is that the state asylum in Williamsburg, Virginia accepted its first African American patient considerably earlier in 1774, although such care was typically only provided to free citizens. In 1846, the Virginia legislature even permitted the treatment of enslaved individuals after a petition from the asylum's board of directors (Babcock, 1895).
South Carolina’s policy practices regarding the care of mentally ill African Americans were contradictory. In 1821, the state passed legislation authorizing the construction of a state funded "lunatic asylum" with no exclusionary provision (Bellows, 1981). However, the lack of segregated facilities resulted in socially sanctioned denial of services to free or enslaved African Americans. It would be 1848 before the legislature approved funding for separate quarters to accommodate the needs of both the free and enslaved “insane” cohort (Bellow, 1981). Over the next ten years, Babcock (1895) recounted that thirty free African Americans were admitted to asylums, but no more than five at one time. However, those enslaved were generally expected to be provided care by their “owners”, unless the latter were unable to afford care. In such cases, provisions were supposedly provided locally through general parish funds dedicated for poor people (Wood, 1974). Punitive services where “solitary confinement and near-starvation diets were the standard means of discipline were provided by Charleston’s Columbus Street Almshouse; however “the needy poor refused to apply” (Eggener, 1997). Across the South, access to almshouses was generally not available due to local policies and practices driven by the prevailing culture which neither sanctioned nor supported admission of African Africans to such institutions (Curry, 1981).

Because of the lack of constitutional protection for African Americans coupled with regional culture, customs and services, policies usually reflected the ideology of the host community. Relative to services for free African Americans, under utilization of institutional care and over utilization of almshouses and jails as “care” were the norms. Although South Carolina had laws to restrict the use of jails for the mentally insane (Babcock, 1895), the implicit policy practices suggest that they were assigned to jails for longer periods with little concern for the consequences of such action. Mentally ill slaves, as noted above, were generally the responsibility of their “owners”, which signaled wide discretion for “treatment” options (Drewery, 1906) that ranged from contracting services to local physicians to employing corporal punishment to control behavior. Tom Whiteside, a slave owner from
South Carolina, hanged an old slave woman who had "loss her mind" after exhibiting bizarre behaviors and burning down the barn (Botkin, 1973). In cases where slaves displayed symptoms of drapetomania, owners were advised to identify and remove those who were discontent. When no cause for certain behavior was determined, "whipping the devil out of them" was the appropriate "preventive" service against progression of the illness (Stampp, 1961).

A number of state policy mandates were contradictory regarding these earlier practices. South Carolina first expressed concerns for "lunatic" slaves in the Negro Act of 1751 which required local parishes to make provisions to relieve poorer slave owners for the cost of confining and maintaining "slaves that may become lunatic" (Wood, 1974). Similarly, the states of Virginia, Kentucky, Maryland, Tennessee, and also the District of Columbia had policies that permitted asylum-based services; however, social practices restrained any substantial delivery of care. In 1821, the South Carolina legislature authorized the building of a state funded "lunatic asylum" (Bellows, 1981). Although service access was denied by laws due to requirement of separate facilities, by no means did the legislation negate the need for care. In 1848, appropriations were made available for separate facilities, but the failure to account for a significant increase in services for African Americans raises serious doubt if care was made available. At other times, policy practices emerged that provided care only when accommodations for all mentally ill white citizens was secured (Wisner, 1970).

Enduring Vestiges of the 1800’s Mental Health Care

Although major socio-political, scientific, policy advances and service delivery have occurred in the mental health care into the millennium, care for African Americans continues to be plagued by barriers that emanate from their precarious history. This circumstance begs the question: What vestiges of the nineteenth century mental health care system for African American still exist – even into the 21st century? Arguably, remnants of mental health service and policy barriers found in the 21st century for African Americans are manifest in the form of on-going service disparities as well as the lack of access to
Despite improvements, the marginal socio-political status of African Americans impacts access to care. African Americans today exercise more political power than ever before with more than 8,000 elected and appointed officials nationwide (Smith, 1999). Major Civil Rights victories of the 1950s and 60s supported increased access to health care through the expansion of public insurance (Prudhomme & Musto, 1973), but African Americans’ continuing underutilization of mental health care is associated with their family income and level of wealth (Brown, Ahmed, Gary, & Milburn, 1995; Corenlius, 2000; DHHS, 2001; Lowe & Hopps, in press, U.S. Census Bureau, 2000). Disparities also continue to persist in the form of over-representation of African Americans as crime victims, under “state supervision”, such as in prison, on probation (Federal Bureau Investigation, 2004; William & Jackson, 2000) reflective of past asylum care. As a result, public funded health programs like Medicare, Medicaid and other state supported efforts are critical components in the response to address service barriers. In particular, on-going socio-cultural, political and economic practices continue to underpin service and policy practices that mimic their early predecessors.

Claims of African Americans’ racial inferiority permeate our popular culture, as structural barriers often mask this reality. Racial prejudice currently looms as an overarching reality in the delivery of psychiatric care for African Americans (Corrigan, 2004; Gary, 2005; Hollar, 2001). Findings from the Epidemiologic Catchment Area and the National Co-morbidity Survey studies in 1980s and 1990s, respectively, found that African Americans were less likely than whites to suffer from major depression and more likely to suffer from phobia (DHHS, 2000; Zhang & Snowden, 1999). Studies also have documented consistent patterns of misdiagnosis (that is, over-diagnosis of schizophrenia and under-diagnosis of depression) and disparities in quality mental health care for African Americans (Barnes, 2004; Lawson et al., 1994; Loring & Powell, 1988; Neighbors, 1985; Neighbors et al., 1989; Segal et al., 1996; Snowden, 2003; Snowden & Cheung, 1990; Strakowski, Hawkins, Keck, et al., 1997; Zito et al., 1998; Zhang & Snowden, 1999). These ongoing disparities are complicated
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by socio-cultural and economic realities that suggest African Americans, who are in need of mental health care and are less likely to receive the necessary help. This phenomenon parallels the effort found in the nineteenth century (Cohen, 2002).

Discussion

Given the marginalized status of African Americans during the 1800s, the caliber of mental health care provided them emerged as a function of barriers relative to their position in society. The political economy perspective suggests that social, political and economic factors underpinned prevailing service and policy practices that disproportionally shaped, developed and inhibited access to mental health care. These interlocking factors also contributed to racial stratification, which continues to persistent. Mental health providers and social scientists participated in aiding the development of a “scientific” rationalization (or “scientific racism”) of oppression. Prevailing views of mental health illness among African Americans were predicated on co-relative assumptions of White supremacy and Black inferiority that retarded the development of adequate care. Although the institutional care movement created an improved system of care for many suffering from mental illness, it failed to cause significant changes in the quality and level of mental health care for African Americans. The context of their mental health services were relegated to the county almshouses and jails; neither of which provided substantive “care”, often meaning the absence of any such service.

This review demonstrates that arguably barriers are ultimately based in American social culture. It follows that such barriers to mental health care are human in origin and only by moving away from the notion of the faceless “system” as the perpetrator of policy and service barriers can we ever expect to address enduring problems. If this assumption has currency, two strategies come to mind: first, owning the history of policy and service disparities and second, attacking any remaining vestiges of racism and unprofessionalism in policy and practice via education, values clarification and cultural competence. This can quicken the pace of substantive improvements in the mental health care of this population, along with
others, thereby reducing disparities and providing hope for an even better legacy at the turn of the next decade—instead of the next century.

References


In this article, the authors consider the socio-historical conceptions of childhood in relation to Black children and their unique relationship with child welfare institutions. Against this background we apply models of childhood to issues of race and social agency and argue that these elements have been inadequately addressed in developmental models of childhood. Following these concerns, we present a social model of childhood and consider how these distinct and different ways of understanding children might be applied to child welfare practice. This child centered approach presents a unique opportunity to incorporate the differential positioning of Black children in the wider society by engaging with their everyday lives as a framework for child welfare practice. This framework allows for a greater participation of children and specifically, Black children in decision making processes. In the final section we suggest possible outcomes of integrating this approach into child welfare practice.

Key words: Black children, social agency, marginalization, child welfare
Introduction

Child welfare holds a central place in the history and development of social work since its inception over a century ago. The history of childhood studies closely parallel the profession's development of therapeutic interventions with children. The models identifying what constitutes 'childhood' use conceptualizations of child development as an established professional discipline that informs current child welfare practice. This academic interest in child development proposes that biological and social development through children's language, play, and interactions are important markers in the developmental progress of children (James & Prout, 1997).

In recent years sociologists have employed 'new' approaches to our understanding of childhood as a social and cultural construct that is attentive to the variables of gender, race and culture. These approaches question the dominant epistemological explanations of childhood as a neutral distinct stage in the human life cycle and rather adopt representations of children as knowledgeable and competent, with abilities to construct their own perspectives of daily lived experiences (James, Jenks, & Prout, 1998). This knowledge widens our understanding of childhood and raises concerns about the dominant place of developmental psychology in childhood studies which tends to position children moving through ages and stages as if children were solely adults in the making. Many critics argue that these approaches are inadequate in describing children's ordinary lives or their active participation in social life (Burman, 1994; Hogan & Tudge, 1999; Woodhead, 1999).

With significant changes in the way children are perceived, scant attention has been paid to how these distinct and different ways of understanding children and their everyday lives might be applied to child welfare practice. The focus on children's social agency has important resonance with the profession's responsibility to listen to children and take their experiences and views seriously across a range of practice modalities. The increased interest in children's everyday lives is closely linked to international trends in promoting children's rights, as evidenced in conferences and literature, building the case for children to be more involved in decision-making.
activities.

In this context, several authors have suggested a balanced model of child development which includes children's active participation in developing policies regarding the welfare services they receive. This modified approach presents the socio-cultural aspects of children's lives from a 'social child' perspective (Thomas & O'Kane, 2000; Hogan, 2005; Winter, 2006). Here, this approach offers insights and understanding of children as their own agents recognizing childhood as socially constructed through differing social relations and contexts. This perspective provides a counterbalance to abstract individualized developmental models by presenting a perspective that examines the way children experience their lives through specific social, historical, and cultural arrangements.

Understanding children's ordinary lives in a wider social context can provide opportunities and strategies for children to voice their experiences, social achievements, and competencies. This focus allows children to communicate their social realities and experiences mediated through the social categories, of race, gender, disability, and the differences among children, rather than using reductive approaches that are based on sameness and generalities (Taylor, 2004). Besides generating a better understanding of children's thoughts, feelings and aspirations, these narratives can uncover the complex ways in which oppression and discrimination are powerful markers of experiences. Although 'listening to children' is regarded as an important aspect of professional knowledge in developing appropriate methods of interviewing, valuing subjective experiences in other areas of practice raises difficult issues as an overall strategy in addressing complex problems. Nevertheless, by adopting these strategies to promote the involvement of children in public child welfare, and in particular for Black children, we can unravel some of the complexities and identify barriers that seem to have a direct impact upon their life chances as a first step towards improving their situation and their well-being. In addition, this approach allows for a greater engagement with the participation rights of children in disadvantaged circumstances.

This article is organized into three broad sections. First, we chart the historical development of child welfare in relation to
Black children. This discussion offers insight into models of childhood through ideological constructions of race and the relationship between Black children and welfare institutions. In the second section, we apply models of childhood to issues of race and social agency and argue that these elements have been inadequately addressed and as a result of this process, Black children’s subjective realities and views have been marginalized as an important feature of practice. We maintain that by integrating their lived experiences from their vantage point can assist in shifting emphasis away from ‘problem’ children towards a deeper understanding of their everyday lives, and their social achievements and competencies. In the final section we suggest possible outcomes of integrating this approach into child welfare practice with children in public care and specifically, with Black children.

Historical Discontinuities – Different Childhoods

The history of childhood as a social construct has been the starting point and focus of analysis in generating new paradigms about the historical and culturally specific nature of childhood (Aries, 1962; Heywood, 2001; James & James, 2004). Aries (1962) is credited with stimulating debate and interest in the history of childhood by asserting that the notion of childhood emerged in Europe during the fifteenth to eighteenth centuries. Prior to this historical period, the idea of childhood did not exist – children were perceived as miniature adults. Aries (1962) claims that the gradual removal of children from everyday activities with adults through organized schooling led to the discovery of ‘childhood’ as a determined stage in preparation for adulthood (James & Prout, 1997). These historical markers have framed the development of professional and academic research in the field of childhood studies and culminating in defining the 20th century as “the century of the child.” The historical development of childhood outlined by Aries (1962) has been subject to intense scrutiny by several social historians. These critiques have stimulated a wider understanding of childhood which produces diverse perspectives rather than common perspectives of childhood over time (Heywood, 2001; Pollock, 1983; Pufall & Unsworth, 2004).
In a similar vein, the history of childhood in relation to Black children has particular relevance in marking the social status of Black children and their identities in contemporary society. In many respects these historical markers rupture the constituents of an idealized childhood and produce multiple discontinuities in the nature and experience of childhood. Black children have experienced a unique and different kind of childhood, situated exclusively within the context of formal and legitimized enslavement from the 17th century to the middle of the 19th century, and of on-going marginalization, sometimes extreme and in other cases just barely perceptible well into the 21st century.

Enslavement by its very nature constituted a form of extreme child cruelty. Unfortunately, however, very little is known about the lives of Black children who were enslaved. The narratives available are mostly adult recollections which give shocking glimpses of terror, the witnessing of horrific incidents of cruelty and barbarism at an early age (King, 1995). The legacy of enslavement and its impact upon social welfare in the US has been well documented (Billingsley & Giovannoni, 1972; Gutman, 1976; McRoy, 1990). DuBois (1956) reported on the peculiar ways in which the institution of enslavement provided minimal levels of board and housing for Black people including Black children (however, exclusively in the interests of slave owners). These criteria established patterns of diswelfare, segregation and exclusion culminating in the differential treatment of Black children as formal child welfare policy and practice emerged.

Billingsley and Giovannoni (1972) suggest that slavery was the embodiment of the ideology that race encapsulated decisive factors about human worth. Thus enslavement of Black children became the baseline or social marker for hierarchical models of social welfare service provision. In this regard, Black children were positioned as the minimal benchmark for any dependant child. In other words, no dependent poor White child would receive less support than the enslaved Black child. These criteria allowed for the maintenance of a racial hierarchy codified through patterns of social relations.

The abolition of enslavement did not change the status of Black children in regard to social welfare but instead, the
institutional patterns of exclusion, segregation, and discrimination became entrenched over many decades. Civil rights legislation in the 1960s transformed social welfare policy and established access to programs for all without regard to race. However, as child welfare services developed there was a gradual shift towards the overrepresentation of Black children. Several commentators suggest that these shifts are related to the development of child welfare services compounded by public and professional concerns about child welfare generally (Courtney & Skyles, 2003; Smith & Devore, 2004; Stehno, 1982).

Billingsley and Giovannioni (1972) identify three factors that explain the increase in the number of Black children in the public welfare system during the 1950s and 1960s. The first factor was the migration of Black families from the South to the North. The second being the rediscovery of poverty and the greater surveillance of poor families; and the third being the civil rights movement and the concomitant federal legislation mandating integration. The shifts in child welfare from exclusion to over-inclusion have been the subject of intense debate and discussion among child welfare professionals and policymakers for several decades (Courtney & Skyles 2003; Needell, Brookhart, & Lee, 2003). These discussions have sought to account for the over-representation of Black children in child welfare. For example, it is suggested that disproportionate representation is linked to differential treatment ascribed within the child welfare system. Other explanations cite high levels of poverty, unemployment and single motherhood as contributory factors. There are a series of complex relationships between these factors which require a sophisticated understanding of the interlocking nature of discrimination and oppression (Bernard, 2002).

However, for the purposes of this article, the historical information about Black children concerning their relationship to child welfare provide indications of the ways in which welfare institutions and policies have been defined primarily largely by race, rather than by class or gender. Black children have been subjected to a particular conceptualization of childhood which has shaped and framed institutional neglect and the lack of responses to their needs. These considerations have
ongoing implications for contemporary social relations. For example, Black children were integrated into public welfare provision based upon an individualized, liberal, ethnocentric notion of children's welfare and well-being. In these institutional formulations, the focus is directed toward the needs of individual children largely divorced from their social contexts which not only disallows their collective identities, but also promotes their shared processes of exclusion, historical neglect, and differential treatment as irrelevant or non-consequential (Krieken, 1999). Thus, childhood as an integral part of society is shaped and prescribed by social forces which frame the "complex relations between children and institutions and the formal and informal hierarchies that influence children's lives" (Christensen & Prout, 2005, p.54).

Black children have a unique historical relationship with child welfare institutions to which their marginal position in society is firmly linked (Smith & Devore, 2004). Incorporating socio-historical factors in this analysis is essential to understanding the disparities in childhood experiences through modes of stratification and social hierarchies. Moreover, in considering any social group which is subordinated in the social order it is crucial to acknowledge the weight of the past bearing down on the group's social position and its ability to negotiate, improve, or transform (Mayall, 2002). Consequently, it is important to take seriously the impact of history in the longstanding racialized conceptualizations of child welfare institutions.

Bringing Race into Models of Childhood

Although the social category of gender has received considerable academic interest in childhood studies, as well as uncovering the gendered nature of social work practices in child welfare, the issues of race and social difference have received much less attention (Graham, in press; Scourfield, 2003). Established models of childhood have largely ignored these considerations as irrelevant or insignificant (Boushel, 2000; Chand, 2000; Williams, 1989). There has been scant attention paid to the key dimensions of social differentiation and the ways in which Black children experience childhood within the broader context of society. This neglect is largely
associated with the social concept of race which is an unsettling issue in the public discourse and more specifically in childhood studies where a color blind approach has been adopted as a popular way to deny or avoid recognition that any race privilege exists. These attempts to present a 'raceless' society fail to acknowledge that this social belief is afforded only to the majority society (Dei, 1999a; Graham & Robinson, 2004).

The denial of race as a social relational concept has appeared in social work literature in recent years, through the intense focus on its meanings and the problems in relation to social theory (see O'Hagan, 2001). These debates and discussions have sometimes denied the importance of race and the subsequent discrimination as a function of denial through engaging in semantics and over theorizing. As Dei (1999a) explains "race is more than a theoretical concept. It is also an idea that governs social relations . . . race hierarchies shape and/or demarcate our schools, communities, workplaces, and social practices and lived experiences" (p. 24). This discussion recognizes the shifting nature of identities and the different ways of being 'Black' in an era of "difference" but we insist that social relations are raced, gendered and classed. This means race, gender, and class are not simply identities but sites of power and difference (Dei, 1999b). Other authors have referred to the interlocking nature of oppression and the ways in which the trilogy of race, gender, and class are articulated in various contexts and situations (Dei, 1999a; Hill-Collins, 1991). However, race can also be an entry point for relational aspects of difference and in this context, Essed (1991) provides an account of everyday racism which emphasizes the processes through which racism is experienced in daily encounters. These processes of racism can operate in gendered ways which require a complex reading of the interlocking nature of oppression and power relations in the wider society.

Drawing upon a postmodern frame, social models of childhood tend to assign privilege to the social construction of identities, rather than to issues of power in racialized contexts. However, as Scourfield, Evans, Shah, and Beynon (2005) concede "identities are being negotiated in a clearly racialised context" (p. 222). In light of these concerns about the social character of childhoods, there is a pressing need to openly
acknowledge the differential position of Black children in the broader social and political aspects that inform their lives. These concerns allow for space to give voice and agency to diverse accounts of childhood experiences.

The histories of Black children in child welfare reveal patterns of exclusion, neglect, segregation, and social constructions of 'otherness.' These patterns are subject to various contexts and situations which continue to have an important influence upon the character and quality of the childhood experiences of Black children (Billingsley & Giovannoni, 1972; Graham, 2002; Smith & Devore, 2004). This means that various social mechanisms often marginalize Black children and as a consequence of these experiences, Black children are silenced and excluded from the few opportunities to speak, to be heard and to participate in decision-making processes. Giving voice to these diverse childhood experiences can elicit new questions and lines of inquiry to reveal useful practice approaches. These concerns are particularly relevant in child welfare practices because Black children are over represented in child welfare institutions and often find themselves in stressful circumstances where they struggle to find opportunities to develop competence and confidence (Smith & Devore, 2004). Consequently, rather than being able to articulate their specific circumstances, Black children's social experiences are mediated through their differential positioning in relation to race, gender and class (Dei, 1999a). These social markers characterize their realities and define the context for social relations.

While it appears that children's agency and their differential positioning in relation to society has received some attention in recent years, these considerations have attracted new research agendas in connection with social institutions. These frames of reference seek to uncover insights into complex power relations between black children and institutions in society's social arrangements which are often inscribed by formal and informal hierarchies (Christensen & Prout, 2005). In the context of schooling, this literature presents an analysis which explores the role of educational institutions in producing and reproducing racial, gender, and class-based inequalities in society (Dei, 2000; Gillborn, 2004; Graham & Robinson, 2004). These research agendas include giving voice to young Black
people by illuminating the everyday experiences that frame their social context. There is an expectation that the narratives of Black children will reflect their experience in the broader social context and has critical effect upon their subjective experiences. For example, Dei (2000) suggests in his research into race and schooling that some young people have a sophisticated understanding of social difference and the ways in which powerful stereotypes frame and sometimes limit their educational experiences and opportunities. These insights give voice to the experiences of discrimination and the realities of power which once acknowledged allow for the revitalization of the processes in which education facilitates the development of tangible equity and opportunities.

Child Centered Approaches – Implications for Practice

In the social work context, applying the social child perspective presents a unique opportunity to incorporate the differential positioning of Black children in the wider society resulting in more inclusive theoretical perspectives and approaches to practice. These multiple lived experiences can provide fresh insights into what it means to be a Black child in societies where adverse power relations based on race, gender and class are etched into everyday experiences. We place emphasis upon the social category of race because this form of inequality has been accorded marginal significance in mainstream paradigms of childhood.

Many authors share the view that Black children live in a society that not only devalues their personhood, but Black children are also subjected to overt and covert experiences of racism and discrimination (Bernard, 2002; Courtney & Skyles 2003; Graham, in press; Graham, 2004). Following these concerns, it is clear that there is a need for a model of childhood which draws attention to their agency, social competences and diversity among children for child welfare practice. Another related but different point is that children in out-of-home placements are by definition at a disadvantage and in most cases their life chances have already been limited by factors outside their control. A key issue for child welfare practitioners must
be to understand patterns of disadvantage in the wider society as well as the ways in which children are sometimes discriminated against by the very services that have been organized to protect their best interests.

In applying a social model of childhood to child welfare practice, we have identified the key areas where useful professional knowledge can be drawn. The involvement of children and young people as active participants in decision-making activities has widely been recognized as an important trend in promoting children’s rights. These developments question the wholly paternalistic approach to welfare, based upon the assumption that by involving parents or concerned adults the best interests of the child will automatically be served (McNeish & Newman 2002). One of the drives towards acceptance of children’s participation has been increased understanding of children as active participants in the everyday world who are contributing to its events as equal to members of society. Several commentators have argued that children’s participation is essential for a healthy society because participation promotes democratic processes as children become active members of their community (Lansdown, 1995; Sinclair, 2004). Even though children’s participation holds potential risks; for example, imposing responsibilities onto children for which they are ill prepared, there are many benefits for welfare organizations as well as benefits for children themselves.

Cashmore (2002) outlines several reasons why children in public care should have their views taken seriously and treated with respect. First, the participation of children in decision-making activities has the potential to accord children both recognition and protection. This is particularly important for children who have been abused or neglected because rather than being victims of adult agendas, this approach would give them some sense of being active agents engaging with processes in relation to their own care generally. Second, the decision-making processes for children living at home and those in public care are quite different. For children living at home, decisions are generally made by one or two adults with whom the child has daily or regular contact. This is not the case for children living in public care where decisions often involve many adults, some of whom may not have even met the child
or know what is important to this child. Third, as children in public care experience fewer opportunities to participate in decision-making, they are often ill prepared for independent living and making decisions for themselves. Children learn about decision-making activities through support and guidance as well as practice by example.

Another important prerequisite for effective participation is providing good information to children and young people in order for them to make informed choices about services or decisions about their lives. A social model of childhood helps to modify professional knowledge which tends to view children as passive recipients or as adults in the making, lacking social competence. From this perspective, children are socially competent in different ways and opportunities for genuine participation involves a two way process built upon trust developed over periods of time which allows children to properly understand the issues and to take part in their own care. In child welfare there has been some caution or even reluctance to involve children wholeheartedly in the decision-making processes that affect their lives because caseworkers sometimes interpret involving children in decision-making as allowing them to get their own way. As Cashmore (2002) maintains, children 'are not seeking self-determination or to control the decision-making; they do, however, want to be informed and involved in the process. They want to “have a say” rather than “their own way” (p. 845).'

What would we know if we applied our proposed child centered approach to practice with Black children? We suggest that there might be no immediately discernable outcomes, yet in the longer term there would be a qualitative difference in children’s experiences of public care. Black children would be less likely to feel alienated from decision-making processes and instead have a sense of active participation in the decisions made about their lives. There is some evidence that suggests children are more stable in out-of-home placements where the child is consulted and their views taken into account. This is because out-of-home placements are likely to be more appropriate and acceptable to children if they have had a real role in the decision-making process regarding a specific placement (Cashmore, 2002; Lindsay, 1995). Equally
important, giving voice to Black children can be empowering in the context of societal racism where their views and perspectives are often marginalized or ignored. This understanding can enhance a child’s perception that they are important and what they have to say matters to the adults involved in their care.

Professional knowledge about children in public care largely stems from developmental models which tend to focus upon pathology specifically, ‘problem’ children. Sandbaek (1999) believes that this orientation towards children is biased because it does not include knowledge from children themselves about their lives which, in turn can cast light on their social achievements, competence and important people in their life. Moreover, there is little attention given to how children perceive the welfare services they receive. Some of these gaps in our professional knowledge are addressed by Sandbaek (1999) and premised upon sociological models of childhood. This research takes a participatory approach by engaging children in a deeper understanding of their interests, successes and important persons in their lives. By integrating this method into practice, children are perceived as active agents and are encouraged ‘to have a say’ through active participation in decision-making activities.

Conclusion

The general aim of this article has been to explore the marginalized position of Black children and their unique historical relationship with child welfare. Another aim has been to apply social models of childhood to sketch out a framework for social work practice with Black children. By providing opportunities for children to voice their experiences of everyday lives, this approach can assist to shift emphasis away from the aggregate problems of children and grasp a deeper understanding of individual everyday lives. This is particularly important for children from socially stigmatized groups who are subject to majority representations and stereotypes in the wider society. We maintain that by integrating the lived experiences of Black children from their vantage point in the decision-making process can help to shift emphasis away from
deficit models of ‘problem’ children to a deeper understanding of the social achievements and competencies of Black children. This approach can strengthen positive elements of their lives as well as help raise self esteem.

The trends towards greater participation of children in the decisions that affect them have gathered pace in recent years. These important developments have begun to direct attention to the minority group status of children in society and raise concerns about the need to give children a voice in key areas of public policy and service provision (Mayall, 2002; Thomas & O’Kane, 2000). These sociological models of childhood have generated research agendas that seem to respect children’s competence and value their views and perspectives. Rather than children’s competence being considered in comparison to adults’ competence, children are perceived as being socially competent in different ways. Further, as outlined above, these new conceptualizations have significant implications for Black children.

Social work has an important role to play in facilitating children’s active participation and in reframing direct practice with children, specifically by raising their profile and status. This requires a re-conceptualization of our thinking about children to widen our professional knowledge. The social child perspective offers research agendas that bring the voice of children to the center of professional knowledge as a source of data to better understand children’s needs and interests. By employing participatory approaches children can be empowered to provide their own accounts of their lives. This acknowledgement is a first step towards ensuring better outcomes and quality of life for children, and particularly in the long term ensuring better outcomes for Black children in the care of public child welfare agencies.
References


In the time of HIV/AIDS, epidemics for which we have no vaccination or cure, public health is bound entirely to depend on the traditional health education strategies to stop or contain this disease. This reality demands that we travel extra miles and thoroughly employ every health promotion tool at our disposal. The Ottawa Charter for health promotion stressed the need for public policy to create supportive social conditions for health. This necessitates a commitment to enduring social conditions for health and raises topics that have been neglected by the traditional public health scholars. A close examination of the colonial language policy of Ethiopia reveals that language is not value free and is intermingled with power and has significant public health impacts. In this paper, I critically examine Ethiopian language policy within the framework of health promotion and demonstrate the ways in which such policy creates a barrier for the Oromo people in making life choices. Additionally it hinders them from ensuring the conditions in which they can be healthy. This paper addresses a gap in the research literature on the impacts of colonial language policies on health promotion.

Key words: public health, Ethiopia, health policy, health education, Oromia, colonial language policies

Introduction

The impact of the Ethiopian language policy on health promotion in Oromia can best be examined if we define the terms.
"health promotion" and "health." According to the World Health Organization (WHO) Health Promotion Glossary (1998), health promotion is the process of enabling people to take greater control of their health and improve it. Health promotion is intended to strengthen the skills and capabilities of individuals to take action and build the capacity of groups or communities to act collectively to exert control over the determinants of health and achieve positive change (Ottawa Charter, 1986). This means health promotion is not something that is done to people; it is done by, with and for people either as individuals or as groups. Indeed, health promotion represents a comprehensive social and political process, and knowledge of community members is essential to achieve the desired health goals.

According to the WHO "health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (Bull World Health Organ, 2002). The Ottawa Charter for Health Promotion (see Ottawa Charter, 1986) declared: "The fundamental conditions for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity" (Terris, 1994). It is also known that health determinant conditions include socio-economic status, income, education level, environmental conditions and biological factors (Ballantyne, 1999). In fact contemporary health promotion is working with a concept that portrays health as a part of everyday living and one of the essential dimensions adding to the quality of our lives. Health is thus envisaged as a resource, which gives people the ability to manage and even to change their surroundings. This view of health recognizes freedom of choice and emphasizes the role of individuals and communities in defining what health means to them. No matter how health is defined or measured, the Ethiopian language policy has significant effects on the freedom of choice in life.

Language makes events and ideas meaningful and often defines our reality. According to Dei and Asghazadeh (2003) language plays a crucial role in the maintenance of individual and collective ways of living as well as in the development and maintenance of individual's and group's identity and their aspirations. Languages provide meanings, relations and
interrelations and it also foster self-reflection of the past and critical thought into the learning process. Language plays a guiding role in the maintenance or alteration of the community's social fabric.

Language is potentially converging with the intellectual resources of centuries human endeavor and thus, it plays significant role in community stability and social transformation. When it comes to information human beings never depended on his/her own experience alone. Due to the limitations of his/her own experiences and knowledge, instead of having to discover what others have already discovered, instead of spending time and resources to make trials they can go on from where their ancestors left.

The primary objective of this paper is to raise awareness about the impact of Ethiopian language policy on health promotion in Oromia and explain the mechanism by which it affects the health determinant factors. This paper explores a range of topics that are linked to the Ethiopian language policy: (a) the exclusion of Oromos from formal schooling; (b) deaths resulting from the misdiagnoses of diseases; (c) Oromo avoidance of modern health care; and (d) the wider consequences of the language policy such as the loss of property, shelter and social status.

Social Construction of the Ethiopian Empire

Ethiopia is a multi-national empire formed at the beginning of the last century when Abyssinia clustered big and small nations in the North Eastern Africa (Holcomb & Ibsa, 1990). The formation of the empire, the maintenance of the border, and power relations were not achieved by peaceful means (Holcomb & Ibsa, 1990; and Bulcha, 2002; Jalata, 2005). Since its formation, Abyssinia dominates the political life in Ethiopia. The impact of Ethiopian language policy on health promotion cannot be analyzed without reference to power relations and the social construction of the Ethiopian Empire. In the Ethiopian case, it is important to critically look at the social structure of the Empire in terms of language and education policy, because these socially constructed conditions limit the capacity of individuals and groups to make choices in life.
Oromos are indigenous African people who constitute a significant portion of the population in the Horn of Africa. Oromo constitute about 39 million of the 73 million inhabitants in Ethiopia and they are also found in neighboring countries such as Kenya, Somalia and Uganda. The Oromo language (Afaan Oromo) is categorized as a Cushitic language, similar to that of the ancient Nubians, and it shares a common vocabulary and grammar with Afar, Sidama, Somali and other Cushitic languages. Afaan Oromo has the second most speakers among African indigenous language, next to Hausa (Bulcha, 1994).

However, the Oromo people are being denied the right to develop their own literature (Bulcha, 1997). This affects the rights of Oromo people to enjoy the highest attainable standard of physical and mental health set forth by WHO constitution (see, Bull of World Health Organ, 2002) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (See, ICESCR).

Until recently the Ethiopian government was not willing to recognize the socio-cultural diversity of the people in the empire. From the perspective of public health, culturally diverse societies have distinct social and health problems and each of them requires a specific strategy to address their problems. The denial of cultural diversity is a denial of opportunities in addressing these social problems.

The population of Ethiopia is about 73 million (WHO, 2004) and it is one of the poorest countries in the world. In Ethiopia, twenty six percent of the population gets less than $1 a day. The Ethiopian government spends as much as 50% of its GDP on its military while they allocate only 6% to health care. Ethiopian life expectancy is one of the lowest in the world—even lower than neighboring countries such as Kenya and Sudan (see the World Bank Group). The life expectancy at birth is 47 years for men and 49 years for women. The maternal mortality ratio ranges from 560 to 850 per 100,000 live births. Infant mortality is 114 per 1000 children born. Only 24% of the populations have access to sanitized water (WHO, Statistics, 2004). Though there are no data available along ethnic lines, it seems logical to assume that the disadvantaged groups like the Oromo people have significantly poorer health and a higher
prevalence of disability (Dugassa, 2003). Thus, from a health promotion perspective it is critical to examine conditions that increase the risks and vulnerability of people and how these risks and vulnerabilities can be reduced and/or avoided. This goes beyond a simple biomedical concept of health and takes into account politics and social justice.

Ethiopia is one of the countries in the world most severely hit by HIV/AIDS. The incidence of HIV/AIDS (ICG, 2001) and malaria (Babaniyi, 2005) has been increasing steadily. Political instability, lower socio-economic conditions, widespread human rights violations and famine accelerate the transmission of HIV/AIDS. Currently over 2.2 million people live with HIV/AIDS (UNICEF, 2005).

In absence of vaccination and treatment against HIV/AIDS, raising awareness about AIDS is the only means of prevention. Data collected by the Ethiopian Statistics Authority make it clear that the number of Oromo, Afar and Somali women who have heard of the existence of HIV/AIDS lags behind women in the Amahara and Tigray regions. Not only that, among those women who have heard of the existence of the disease, many are reluctant to believe the information (see, Ethiopia Demographic and Health Survey (2000). This reflects the Ethiopian language policy and power relations. One of the major reasons for differences in knowing about the disease is lack of access to the Amharic language that dominates the media. The other explanation for the discrepancy is that the state-controlled media and public health institutions are seen as state agents and viewed as police and security forces which have no respect for the peoples' rights and dignity.

The recent WHO (2005) report revealed that in Ethiopia the coverage of DPT3 immunization rate varies between regional states. The Tigray region, the home of Ethiopia's dominant political party, DPT3 immunization coverage is over 80%, while it is less than 5% in the Somali and Afar regions.

Currently, the Ethiopian adult literacy level is 47% for men and 31% for women. In the year 2000, 72 percent of children still had no access to formal education (ENA, 2000). Accessibility to education is not equally distributed. The Ethiopian official language policy is one of the tools used to discriminate against non-Amharic students.
Emmanuel Abrah (1995), an Oromo man who served as a Director General in the Ministry of Education from 1944 to 1947, was at one point accused of educating only the "Galla." Galla is a derogatory term for Oromo. Without Abraham's knowledge, King Haile Selassie directed the headmaster of a school that had the largest number of students to make a list of the pupils in various ethnic groups; and he found, out of a total of 991 pupils, that 701 or about 71 percent of them were Amahara nationals and the rest came from the various ethnic groups. Then the Emperor commanded Abraham to get a list of all the pupils in the Addis Ababa schools by ethnic groups and Abraham came up with an exact figure in a few days. Accordingly, it is known that in April 1947, 4,795 students attended schools in Addis Ababa. Of those, 3,055 or about 64 percent were Amharas and the remaining 1,740 were from the other ethnic groups. Of these, only 583 or about 12 percent were Oromo nationals (Abrah, 1995). The allegation against Abrah was fallacious. Arguably, the motive of the allegation was two fold: first, the Abyssinian elite wanted Abraham out from the position he holds, since, he is an Oromo in an Abyssinian dominated circle; second, they did not approve even a handful Oromo students attending school.

Twenty years after Emmanuel's Abrah data were collected, Hultin (2003) recorded that from 1967 to 1969, of the students who reached grade 12 and sat for the final exam, 60 percent were Amharic speakers. In 1970 there were 4500 students in Haile Selassie University and only 10 percent of the students were Oromo nationals (Balsvik, 1985). It is very clear that there is overt and covert discrimination against the Oromo people. However, only recently, the Ethiopian education system acknowledged that one of the major contributing factors for the high illiteracy level is its language policy (WIC, 2002).

Ethiopian language policy has its basis in conquest, military and political subjugation, and economic exploitation as well as socio-economic exclusion (Holcomb and Ibsa, 1990, Bulcha, 2002; Jalata, 2005). The contemporary status of English, French, Portuguese and Russian indicates how successfully and ruthlessly the principle of language imposition was applied (Phillipson, 1999). Colonizers claimed their colonial motives as "a civilizing mission." Correspondingly, they claimed that
language is neutral and thus, imposing the colonial language on the colonized would have no social, political and/or health consequences. However, a close examination of the contemporary Ethiopian language policy reveals that language is not value free and it is intermingled with power (Wright, 2001); hence, implicated to the social well being of people.

Colonialism and Language Policy

Colonizers explain their colonial agenda as a 'civilizing' mission; but for the colonized people, colonialism is a 'disease'. Colonialism affects the socio-economic status, knowledge construction and way of life of the colonized people (Watts, 1997). The problem of colonialism goes beyond the exploitation of human and natural resources (Said, 1994). Colonialists used language for social regulation, imposing their moral, cultural and hierarchical social norms on the colonized peoples. Soon after Oromia fell under Abyssinia, Abyssinia slowly imposed its language and culture upon the Oromo people. Though the Amharic language has fewer native speakers than the Oromo language in Ethiopia, it is the working and official language. Knowledge of the Amharic language is used to screen individuals and groups from accessing education, information, and well-paying professional jobs (Dugassa, 2005). This creates an enormous socio-economic barrier for the Oromo people.

Language is one of the most complex tools that the colonizers use for control, exploitation and suppression. Amharic is the official language in the Ethiopian empire (Bulcha, 1997) and it is required for employment and promotion in the public services and other well paying jobs. Success of students is measured on their knowledge of Amharic. For over a century, the Oromos have been forced to communicate with Amharic-speaking lawyers, teachers, judges, police, doctors, security guards and others. Very often the Oromos have to pay for translators.

This language policy denies the Oromo people the right to have access to information and to develop their own literature, so they have been excluded from literature, art, science, and music. Oromos have no choice but to purchase Abyssinian books, magazines and newspapers and even listen
to Abyssinian music, thus creating jobs and business opportunities for the Abyssinians.

According to Hassen (1993), Hodson, (1927) during the nineteenth century, Afaan Oromo was the major language of trade, the main lingua franca in the Horn of Africa. It was the language of government, business and education within the Oromo states. After Oromia was colonized, slowly the Oromo language was legally banned (Bulcha, 1997). After a long struggle, in 1991 the Oromo people achieved a partial victory for the use of Afaan Oromo in the work place and as a language of instruction in school. However, in several parts of Oromia, Afaan Oromo is still not used in workplaces or schools. For example, in the province of Wallo, in the district of Wonbera, in the cities of Dire-Dawa and Harar, as well as Finfine (Addis Ababa) this right is still denied. In addition, the current government of the Tigray People’s Liberation Front (TPLF) is planning to deny language rights in several cities and towns in Oromia.

Similar language policies have been used under several colonial rules. For example, the famous Macaulay Minute on Indian education argued that the intent of colonial education was to create a class of Indians who were so in name but otherwise English in everything else through linguistic engineering. This was clearly a theory that had emerged from practice. Indian bodies with English minds are expected to see the world in the same way as their white engineers. The re-formed Indians would become efficient and trusted interpreters between the colonizers and the millions whom they ruled (Ascroft et al, 1995). The French elaborated this into a system they called “assimilation,” in which some Africans could become French citizens through the same process of linguistic and cultural engineering. The French created a vast army of Macaulay-type interpreters to help them homogenize French subjects. The Portuguese in Angola, the Belgians in Republic of Congo and the Abyssinians in Oromia used the same approach.

Language transcends the reality of everyday life for the given community (Berger & Luckman, 1967). Students learn based on their former experiences. As such, language affects the learning process of children through construction of meaning. If the subject they are about to learn is not comparable to what they know, they do not learn, as they should (Bishop, 1998).
For that reason Ethiopian language policy implicated to educational underachievement. For example, for the Oromo people black and blackness represents purity and holiness; however, for most of European and Amharic languages black represents crime, sorrow and evil (Dugassa, 2006). Oromo children who have been denied the rights to learn in their native language are forced to integrate into their thinking the dominant concepts and symbols, which I call “imperialism of mind”.

Language and Health Promotion

In health promotion and medicine the language barrier has significant effects. Doctors diagnose the patient’s health problems based on her or his narrative. If doctors cannot communicate with patients they are not likely to make proper diagnoses. If they cannot make proper diagnoses there will not be appropriate medical prescriptions and no patient education about their health. In fact, a communication barrier between patient and doctor can be fatal.

When a patient does not fluently communicate with her or his health care provider, several adverse effects can happen. A patient may not comprehend the education the health professional provides, often resulting in poor patient satisfaction and poor compliance to health advice. Health education that is intended for the maintenance of good health and preventive measures can be totally ineffective if there is a language barrier. According to Timmins (2002) and Flores et al (1998) poor patient outcomes attributed to language barriers between patients and providers include: (1) increased use of diagnostic tests, (2) increased use of emergency services and decreased use of primary care services, (3) poor or no patient follow up and (4) misdiagnosis, negative outcomes and malpractice. According to David and Rhee (1998) language barriers affect patients’ compliance with medication and their satisfaction to the service.

There are several solid pieces of evidence that show a language barrier could adversely affect quality of care. Liao and McIlwane (1995) reported that the health needs of Chinese populations in Glasgow are not fulfilled. This report suggests that the main barriers to the effective use of health services
and gaining benefits from health promotion and health education programs are language difficulties. A similar situation was also reported among the Spanish, speaking population in New York State (David and Rhee (1998).

According to the reports made by Committee on Perception and Communication (See, National Cancer Institute, 1989), health communication is used as a tool to let the public know about the health threats and influence to individual and community decisions to enhance the individual’s and the public’s health. The report also suggests that effective communication helps community leaders and policy makers become allies with health professionals to influence change in existing socio-economic and health policies. This also includes increasing awareness of health issues among community members by insisting on changes in attitudes and beliefs, and obtaining group or institutional support for desirable health goals. Very often, effective communication leads to a structural change in the community, which encourages health behavior changes. In turn, this can influence individual behavior by affecting norms and values and attitudes and opinions by creating better physical, economic and cultural environments. Effective communication can be achieved if, and only if, the communication is done in the language the community fluently speaks.

Several studies have examined the healing rituals used by religious institutions (Freedman, et al. 2002). Their findings showed that healing depended on a meaningful and convincing discourse that transformed the patient. This transformation did not necessarily remove the symptoms; it did change the meaning a patient attached to the illness or changed a patient’s lifestyle (Gesler, 1997). Verbal language allows the patients to bind themselves to the past and to the future and help them develop positive abstract concepts (Emmert & Donaghy, 1981). By connecting ourselves to the past and the future we learn from the mistakes, accomplishments and the wisdom of our ancestors and also transmit these and, our current experience to the incoming generation. This means that through language we learn from the knowledge produced in the past and teach the future generation and so bind our selves to the past and present.

The Ethiopian language policy is contrary to the principles
of health promotion. For example, according to Alma-Ata declaration (1978) the attainment of the highest possible level of health (social wellbeing) should be the most important social goal. The realization of this goal requires not only the actions of health sector but also the participation of several social and economic sectors. The Sundsvalle statement (1991) on health promotion emphasized the need of assembling the physical, the social, the economic and the political environment in supporting health rather than damaging to it. Access to information is essential to achieving effective participation and empowerment of people (See, Jakara Declaration, 1997).

Let me share my personal observations. One day I was sitting in a small teashop not far from a hospital in Finfine (Addis Ababa) and I saw an old brave man carrying a woman crossing the road toward the teashop. He put the woman very close to the entrance door and came into the teashop and bought bread and tea for himself and for the woman who was sick and not able to walk. A few minutes later he came back to the teashop and asked the cashier to read the prescriptions, which he had gotten from a doctor in the hospital. The shopkeeper could not communicate with this Oromo man. When I spoke to him in Afaan Oromo, he was relieved and shared with me his concerns. He showed me two prescription drugs, which he had put in separate pockets hoping to identify them later. One of the drugs was for his wife and the other was for himself. Since he could not read, he wanted to know which drug was for whom and how and when they had to take these drugs.

It is obvious that this man and woman did not understand the Amharic language. There was no way for them to communicate competently with the Amharic speaking doctors, nurses and pharmacists in the hospital. There is no mandate for health professionals to provided translators for their patients. If that is the case, how could the doctor make proper diagnoses of diseases in this man and woman? How could they educate the couple about their health problems? If I had not been in that teashop to help him to understand the instructions of the doctor, he may have taken the medication that was supposed to be for his wife and vice versa. One can imagine the tragedies that might result from such communication problems.
The second case is about HIV/AIDS. In 1996 a friend introduced me by telephone to his friend from Finfine. A year later, I learned that this person had died. To express my condolence I called his wife. In our conversation she told me that she was also sick. I asked her what was happening, hoping to know whether or not she was aware of the AIDS/HIV epidemic. I asked her whether or not she watched television and listened to the radio. She said, “I do not understand Amharic. The Afaan Oromo program soon after it has started you will find it is finished.” During the television show in Afaan Oromo she said, “they talk about their propaganda, who is going to listen to their lies? In our coffee gathering I heard about a baleful shadow that is going around.” I asked her what the baleful shadow was. She answered, “it is the shadow of evil, that is flying around. If that shadow passed on your clothes that you put to dry in the sun you will catch the disease. The person who is caught by the disease would die a year later and there is no medication for the disease “Waaqni haan akkas namaa habaasu”. (Let God forbid such tragedy)”. She passed away a year later.

I raise these issues not as separate accidental cases, but as realities that the Oromo people have been facing throughout the country for over a century. How many such cases are known? How many people die from such a preventable tragedy and how many more are going to die from them in the near future? The man and woman I mentioned above are not in a foreign country, they were born there, their ancestors lived there and their children are going to be there. Why are these people treated inhumanely? Why are their lives considered less important than others?

The most basic component of an effective form of communication is to establish trust. In education we know that students' learning processes are influenced by not only where and when the subject is presented but also who presents the subject. Credibility in health promotion is as important as it is in teaching and learning. According to Hilliard (2000) full communication involves earning and sustaining trust, listening actively, mastering timing, conveying a sense of sincere caring, formulating ideas clearly and succinctly, and transmitting sympathy or empathy as needed. Before reasoned
actions take place, the public should have evidence, which has
to be provided to them from reliable sources in oral, written
or visual forms, or they have to see it themselves. Generally,
the public trusts information that is coming from an institu-
tion that they trust, that belongs to them, where they can be
involved in collecting the data and in educational planning as
well as in implementation. In Ethiopia, public health education
has failed (Ethiopia Ministry of Health, 2002). Lack of trust in
the information provided by government agencies is one of the
contributing factors for the failure (Dugassa, 2005).

Knowledge of a society is embedded in language. Reliability of health information depends on how and who has
provided them. For example, the Oromo people consider their
language as a their treasure. These treasures are the collected
wisdom of ages; the knowledge that has been established over
a long period of time, which guides and monitors the Oromo
peoples’ very lives today and in the future. The Ethiopian lan-
guage policy, which is practically designed to dismantle and
disrupt these treasures, significantly affects the information
delivery system. Packaging information in Afaan Oromo is the
perfect delivery mechanism for informing the Oromo people
about health risks.

The Ethiopian government that has imposed this language
policy and discriminatory practices in all social structures of
the Empire State has created two categories of people. On one
hand there is the Ethiopian government and its agencies, includ-
ing public health agencies and on the other hand the general
Oromo public. The government agencies represent the interests
of the institution to which they belong. They are therefore, not
in a position to address the true needs of the Oromo people;
in response, the public has lost trust in these agencies. Such a
long-term colonial power relationship between Abyssinia and
Oromia has created a condition in which the general public
does not trust the public health agencies and the government
media. As a result, in Ethiopia, public health education is con-
sidered state propaganda (Dugassa, 2003). That is one of the
reasons that Ethiopian public health education has failed to
stop or contain the HIV/AIDS epidemic (Ethiopia Ministry of
Health, 2002). To bring health behavioral changes, the credibil-
ity of public health agencies must be established. Credibility
can be established and public skepticism, or indifference, to information about health risks will be addressed if the public health agencies are seen to belong to the people.

The Ethiopian government language policy slowly expropriated the socio-economic, cultural and political power. Slikkerveer, (1990) made an intensive survey in the town of Babile in Eastern Oromia. According to the report, the Oromos and Somali people use traditional medicine more than the Amaharas. Most of the government employees are Amahara nationals. The economic status of Amahara is much better than the others.

Information is knowledge and knowledge is power (Foucault, 2001). Information access determines one's social status during the information age. From a health promotion perspective, providing information empowers the public. Hence, language is used as a tool to empower the public so that the public acts upon the advice to achieve the desired health goals. Knowledge about disease-causing agents or conditions and their means of transmission or control, is a powerful tool to combat epidemics. For example, in Canada, in health professionals' qualifications, the ability to communicate with patients is considered the second most important skill for health professionals (The Royal College, 1996). This document suggests that communication between practitioners and patients is essential in understanding and solving patient's health problems.

The Ethiopian language policy is one of the major obstacles in health promotion in Oromia. Such a language policy has disempowered the Oromo people and denied them access to information in science, health and farming techniques. Because they are denied the use of their language in school, they are deprived the ability to develop their own knowledge at the local level and also access to knowledge produced elsewhere. These conditions have resulted in the Oromo society continuing to lead a sluggish socio-economic-health-cultural life style for over a century. To improve the social wellbeing of the Oromo people, the rights of the people to use their language in school, court, health care and at the work place are essential.

Control of language is an instrument of power. Information and education are essential tools to effect behavioral changes and preventative actions, as well as joint problem-solving and
conflict resolution. Language proficiency skills are essential to increase public awareness of specific disease risks through organized education, information, and communication (Tinker, 1996).

The motive behind making laws and the intent of policy making in general has never been neutral. As such, the Ethiopian language policy is intended to improve the Abyssinians' quality of life at the cost of the Oromo people. The Ethiopian language policy should be seen in parallel with other colonial language policies that are intended to monopolize, control and disempower (Kasuya, 2001). From a health promotion perspective, the Ethiopian language policy should be seen as a social construct that limits the Oromo people's choices in life and in some cases condemns them to death.

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References


Health Care Poverty

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This paper introduces and describes health care poverty. Underinsurance and its consequences for access to health care are highlighted. Definitions of underinsurance and its prevalence are presented. Groups that experience disproportionate barriers to obtaining medical care are identified. Manifestations of underinsurance are explicated and their relationship to receipt of medical care, such as vaccinations and medications is discussed. A reframing of the health care debate is suggested with emphasis moving from uninsurance to access to health care.

Key words: access to health care, underinsurance, unmet needs, social justice

Introduction

In the debate on health care in the United States, one might conclude that being poor and uninsured are the sole determinants of access to and utilization of health care. The effect of poverty on health insurance status, access to health care and health outcomes has long been established. But that dialogue is driven exclusively by economic status. It emphasizes both the relationship between poverty (as defined by the Federal Poverty Level, FPL) and the complete lack of health insurance (uninsurance), and, subsequently, the relationship between being uninsured and having access to health care.
instance, it is well-documented that individuals living in poverty experience higher rates of uninsurance (Holahan & Cook, 2005; Kaiser Commission on Medicaid and The Uninsured, 2004a) and consequently, a lower likelihood of having a usual source of care (Families USA, 2003; Kaiser Commission on Medicaid and the Uninsured, 2004b).

While it is vital to recognize the scope of health care consequences for those living in poverty without any health insurance, this paper contends that there are additional factors critical to the examination of health care in the United States. It introduces a different application of poverty in the health care debate – health care poverty – which significantly broadens the focus. Health care poverty expands examination of issues related to health insurance and access to health care to additional, and significant, groups of individuals who are disenfranchised not solely due to poverty status and a complete lack of health insurance. It includes those who have private health insurance that is inadequate to meet their needs, regardless of their income level. In other words, the term refers to poverty of access to health care. This situation has been labeled underinsurance, and includes, but is not limited to: yearly and lifetime limits on benefits, lack of coverage for medication and other ancillary services, daunting premiums and deductibles, and levels of copayments and/or coinsurance that inhibit ability to obtain health care.

Individuals in this predicament do not meet the criteria for inclusion in counts of the uninsured nor are they represented in discussions of access to health care. They are invisible because the focus of such discussions is on the presence or absence of health insurance, as if the presence of health insurance is synonymous with access to health care. However, this assumption is naive. Healthy People 2010 acknowledged multiple factors that contribute to problems with access to health care:

Financial, structural, and personal barriers can limit access to health care. Financial barriers include not having health insurance, not having enough health insurance to cover needed services, or not having the financial capacity to cover services outside a health plan or insurance program. (Healthy People 2010a)
This paper addresses the situation in which health insurance coverage is "not enough" to meet health care needs. It contends that the insured/uninsured discussion, while important, neglects the critical issue of underinsurance. Consequently, identification of the extent of unmet need is precluded. This paper describes the nature and degree of underinsurance and discusses implications for access to health care for individuals and families. Thus, the focus is moved from whether one has health insurance to whether one has access to needed health care. These represent two very different, although related concerns. This paper submits that the presence of health insurance should not be considered the ultimate goal, because it is only a means to the desired end – access to health care.

Examination of underinsurance is particularly important as cost sharing has replaced managed care as a strategy to control the rising costs of health care. Cost sharing occurs when patients are required to pay for part of the costs of their medical care (Hsu et al., 2004). It is believed to promote efficient use of medical services by raising patient awareness of medically related costs (Hsu et al). Hence, "...cost sharing is aimed directly at consumers" (Wong, Andersen, Sherbourne, Hays, & Shapiro, 1989, p. 892). This relatively recent increased emphasis on cost sharing as a cost containment strategy directs the "...focus away from the supply (physician) and toward the demand (consumer) side of the health care market and from uniformity toward variety in products and prices" (Robinson, 2004, p. 1880). In some markets, consumers are given choices regarding the type of health insurance product they desire. Whether by consumer choice or employer/insurer mandate, the consequences of underinsurance are problematic. The potential for more negative health outcomes due to cost sharing has been identified because individuals reduce their use of needed medical care due to financial concerns (Wong et al.). This paper asserts that cost sharing represents another manifestation of underinsurance with consequences that must be identified and quantified.

Poverty Defined

Poverty has been described as an indicator of deprivation
with both absolute and relative dimensions (Karger & Stoesz, 2006). Absolute poverty identifies a distinct point (i.e. dollar amount) below which individuals and families are deemed poor. Determinations of eligibility for benefits from social welfare programs are based on the federal poverty guidelines (also known as the FPL) which are determined every year by the Department of Health and Human Services (U.S. DHHS, 2005). The FPL represents an absolute indicator of poverty. The existence of governmental social welfare programs for individuals deemed “poor” underscores an acknowledgement of governmental responsibility for the welfare of its citizens.

Relative poverty compares the wealth of members of a society to one another. It has been described as a representation of social inequality (Karger & Stoesz, 2006). It is possible that individuals may not meet the criteria for absolute poverty but experience relative poverty, nonetheless, that is deprivation compared to the condition of others within their environment. There is no clear mandate that the government, or any other entity, holds responsibility for the welfare of those experiencing relative poverty, despite evidence of a clear level of need.

This paper contends that the framework used to define poverty - incorporating absolute and relative - should be applied to analyzing the health care system in the United States. Two reasons exist for this position. The first addresses the need to understand the true prevalence of the lack of access to health care. The current strategy, which emphasizes primarily the “absence or presence” of health insurance during a certain period of time is insufficient to reveal the true prevalence of problems with to access to care. A clearer picture of the magnitude of health care poverty would be revealed through identification of individuals with health insurance who lack access to the needed services. Thus, consideration of “absolute” poverty of health care would examine those who have no health insurance (and presumably no access) while “relative” poverty would include underinsurance and its effect on access to health care and utilization of medical services.

Health Care Defined

“The enjoyment of the highest attainable standard of health
is one of the fundamental rights of every human being without
distinction of race, religion, political belief, economic or social condition” (World Health Organization, 2005). This definition underscores the importance of health to individuals in a society. However, in the United States there is no agreement on the basic level of health care to which all individuals should be entitled. Although the medical establishment has provided goals for health and the provision of health care, related both to prevention and treatment through initiatives like Healthy People 2010, the current system of financing medical services impedes their implementation. Healthy People 2010 identified two goals for improving health in the United States: 1. extending life expectancy and increasing quality of life and, 2. eliminating health disparities among subgroups of the population (Healthy People 2010b). The first of the 28 focus areas directed at these primary goals is “access to quality health services” (Healthy People 2010b). It is addressed in chapter one and includes a number of corresponding objectives. Health insurance coverage for 100% of the population is objective 1-1 (Healthy People 2010c). While this objective can be supported universally, it does not necessarily equate with access to health care services. This is the point at which considerations of underinsurance become relevant. Even if the goal of 100% of the population having health insurance is reached, it does not guarantee that the overarching goals of increasing length and quality of life and eliminating health disparities will be achieved. Interestingly, objective 1-6 in Healthy People 2010 identifies the goal of reducing the percentage of those who delay or do not obtain required medical care from the 12% reported in 1996 to 7% (Healthy People 2010d). The inclusion of objective 1-6 despite the presence of objective 1-1 could be interpreted to reflect an understanding that the presence of health insurance coverage does not always translate to access to needed medical services.

It appears that the broad goals identified by the government in Healthy People 2010 are not accompanied by social welfare policies to ensure their achievement. Specific areas do exist in which the government has intervened to assure a certain level of compliance with medical recommendations (e.g. immunization of children) and even those have not achieved the desired
goals. However, aside from Healthy People 2010, there appears to be no consensus on the level of health care or amount of health services that should be “normative.”

Underinsurance and Cost Containment

In recent years, concern for rising health care costs has resulted in various cost containment strategies. Two strategies used by employers to control escalating health care costs have been to increase either the employee share of the insurance premium or other health care related costs (Trude, 2003). Cost sharing has been frequently used to address medication related costs (Anis et al., 2005; Reed, 2005). Examples of costs that are shared by employees include deductibles, copays and coinsurance (Goff, 2004; Trude). A copay is a predetermined amount paid by an individual at the point of care, regardless of the actual charge of the service. A cost to the individual that is based on the actual charge for care at the point of service represents coinsurance (Goff). This increase in out-of-pocket expenses (cost sharing) is driven by the presumption that greater expenses will moderate the use of health care services by individuals who share the financial risk of obtaining medical care (Chernew, Rosen, & Fendrick, 2006; Trude). In other words, “...the purpose is to sensitize consumers to the financial consequences of their choices” (Goff, p. 7). Cost tiers have been established in areas such as prescription drugs and hospitals that result in differential costs to the employee based on preferred status of the medication or provider (Goff).

Prescription drugs provide an example of the prevalence and consequences of underinsurance. Nine percent of a national sample of individuals between ages 19-64 had no prescription drug benefit despite the fact that they had private health insurance (Schur, Doty, & Berk, 2004). As previously stated, prescription drug coverage is an area that has been targeted for cost containment strategies. One such strategy, benefit-based copayment, occurs when the use of medications with more documented benefit is encouraged by lowering its required copayments and raising those of less effective medications (Goldman, Joyce, & Karaca-Mandic, 2006).
Underinsurance: Definitions and Prevalence

Underinsurance occurs when health insurance is insufficient to cover all needed health care services (Moniz & Gorin, 2003). Although it receives relatively less attention than uninsurance, it is not a new phenomenon. Thirteen years ago, four components of underinsurance were identified that included: “a) too few services are covered or the coverage is inadequate; b) amounts of out-of-pocket expenditures, with or without regard to family income, are excessive; c) insurance is perceived to be inadequate; or d) some combination is present” (Bashshur, Smith, & Stiles, 1993, p. 202). More than 15 years ago, the Pepper Commission identified “inadequate coverage” as health care costs that exceeded 10% of income (as cited in Bodenheimer, 1992).

A recent classification of categories utilized in previous research on health insurance coverage identified: economic, structural and attitudinal perspectives (State Health Access Data Center). Studies from an economic perspective investigate the relationship between out-of-pocket expenses and total individual/family income. Examination of which health care benefits are omitted from benefit packages that should have been included is the focus of structural studies. Finally, attitudinal research considers health care coverage from the perspective of the beneficiary. These studies investigate individuals’ feelings about the adequacy of their coverage. Each of the three strategies has strengths and limitations and reflects a different perspective on the adequacy of health insurance coverage. (State Health Access Data Assistance Center). This typology of studies appears consistent with the components identified in earlier works.

Similar to uninsurance, estimating the incidence of underinsurance has proven challenging due to varying definitions and measurements (Kogan, Newacheck, Honberg, & Strickland, 2006; Oswald et al., 2005). Estimates of underinsurance have ranged from 7%-53% (Beebe as cited in Kogan et al.). A national study of insurance coverage in 2003 reported that approximately 16 million individuals age 19-64 were underinsured (Schoen et al., 2005). This represented 12% of those who reported having health insurance during the entire year.
Data from the National Survey of Children with Special Health Care needs was used to estimate the prevalence of underinsurance, both at the national and state level. The percentage of uninsured children with special health care needs nationally was estimated at 32.3% (Kogan et al.). Additionally, the underinsurance rate of 680 children with special health care needs residing in Virginia was estimated at 25.6%, 2.9%, and 28.9% using the economic, structural and attitudinal strategies, respectively (Oswald et al.).

Another manifestation of underinsurance is coverage that does not include behavioral health care (Wu & Schlenger, 2004). Data from the National Household Survey on Drug Abuse during 1995-1998 reflected that 38% of the 36,214 privately insured adults age 18-64 either did not have behavioral health insurance or were uncertain of their coverage (Wu & Schlenger). Underinsurance also has been identified for mental health and substance abuse services among 434 managed care organizations nationwide (Hodgkin, Horgan, Garnick, & Merrick, 2003). More than 66% of the sample required copayments for substance abuse and mental health services, with payments of $20.00 or more per visit at 42.6% for substance abuse treatment and 45.8% for mental health services. Coinsurance was less prevalent at 28.8% of substance abuse services and 29.6% of mental health services. However, a coinsurance payment of 50% of the charges was required by 15% of the managed care products (Hodgkin et al).

African Americans (Reed, 2005), Hispanics (Kogan et al., 2006; Wu & Schlenger, 2004), those living in poverty (Kogan et al.; Oswald et al., 2005; Schoen et al., 2005; Schur, Doty & Berk, 2004; Wu & Schlenger), individuals living in single-adult households (Oswald et al.), individuals age 18-25 (Wu & Schlenger), and those without a high school education (Wu & Schlenger) are more likely to be underinsured.

Underinsurance and Access to Care

Underinsurance has been associated with less access to health care. A recent study of 3,293 nonelderly adults nationwide reported that those who were underinsured were significantly more likely to forego medical care due to concern for
costs than individuals who had sufficient insurance (Schoen et al., 2005). Furthermore, nearly 33% of underinsured individuals reported not seeking attention from a physician for a medical problem due to concern for costs (Schoen et al.). It is particularly important for individuals with chronic illness to obtain timely health care. A national study of 1,700 adults with chronic illness reported that cost sharing (i.e. the amount of copayment) was significantly associated with reduced likelihood of seeking medical care (Wong et al., 1989). Despite being chronically ill, individuals with high copayments were significantly less likely to pursue medical care for serious symptoms than those with low or no copayments (Wong et al.). Additionally, individuals with chronic illness with any required copayment (low or high) were significantly less likely to seek care for minor symptoms than individuals without a copayment (Wong et al.). Thus, cost sharing reduced the use of medical services by individuals already at increased risk for adverse health outcomes. An association exists between cost sharing and utilization of health care in an emergency. Hsu et al. (2004) reported a relationship between patient beliefs regarding the copayment amount of an emergency room visit and likelihood of pursuing treatment from an emergency department. Individuals were significantly less likely to pursue treatment in an emergency room if they believed that their copayment was $20.00 or more. The percentages of those who delayed or decided gave up emergency room care related to belief about copayment were 20% (believed copayment $20 or more) and 6% (believed copayment was less than $20) (Hsu et al.).

The relationship between underinsurance (cost sharing) and obtaining prescribed medication also has been documented. A study of 1997-2000 claims data of 526,969 employees at 30 U.S. employers, including predictions of the effect if their current copayment for medications, was doubled (Goldman et al., 2004). The reduction in percentage of spending for eight classes of medications ranged from 25% to 45% in response to a 100% increase in copayment. Furthermore, decreased spending of 8% to 23% on the same classes of medications was predicted for a subsample of chronically ill individuals (Goldman et al.). Foregoing prescribed medications due to cost concerns was
reported by 15.2% of a nationally representative sample of individuals who were ages 18-64 and had private insurance (Reed, 2005). The aforementioned study found that privately insured, working age adults constituted 40% of individuals with chronic conditions who expressed difficulties obtaining medications due to cost concerns. Once again, this underscores the increased risk of adverse outcomes for individuals with chronic illness. It is noteworthy that 35% of low-income adults reported cost issues concerning prescribed medications. Financial barriers to obtaining prescription medications significantly increased between 2001 and 2003 to 12.8% (Reed). Not only were non-elderly insured adults who did not have a prescription drug benefit more likely to forego obtaining needed medication than those with prescription coverage (28% and 16%, respectively), and significantly more likely to forego obtaining other needed medical services, such as obtaining ordered medical tests, they were also significantly more likely to report having problems paying for medical bills (Schur et al., 2004). Additionally, 38% of underinsured adults reported not obtaining a prescribed medication due to financial concerns. This percentage was identical to that of individuals who completely lacked health insurance, suggesting that, in this area, individuals with inadequate health insurance were more similar to the uninsured than to individuals with sufficient coverage. Finally, although a literature review of 30 studies published between 1974 and 2005 regarding medication and cost sharing reported mixed results with regard to impact on the utilization of health care services, it did show that increased amount of cost sharing was associated with lower rates of initiation of prescribed therapies and discontinuation of prescribed medication (in some cases) (Gibson, Ozminkowski & Goetzel, 2005). Moreover, three of four examined studies reported a relationship between higher cost sharing and lower adherence to prescribed drug regimens. The authors concluded that although cost sharing has been effective, in some cases, at achieving its goals “It is also becoming clear that cost sharing is not always a benign instrument, and at times it may come at a price.” (Gibson et al., p. 739).

Children represent a population for which goals for care have been identified (in some specific areas) and social welfare policies have been created to extend access to health care.
Receipt of vaccinations is an important area in which underinsurance has severe implications for access to care. The vaccination rates for children and adults remain below the goals set by Healthy People 2010 (Davis & Fant, 2005). The Institute of Medicine (IOM) evaluated the current system of making vaccines available to children and adults and offered recommendations for improving access (Institute of Medicine, 2003). It reported that 11% of children age 5 or under and 59% of adults are underinsured for vaccinations, and noted that increasing cost sharing by insured individuals has been occurring (IOM). Similar to adults with chronic illness, children with special health care needs who were continuously, but inadequately, insured experienced significantly more problems with access to health care than those with adequate coverage (Kogan et al., 2006). Consequences for these children of inadequate coverage included delays or skipping care, unmet needs for medical services, difficulty obtaining referrals for specialty care and the occurrence of financial strain on the family due to the child’s medical status (Kogan et al.).

As expected, income level is associated with access to health care among underinsured individuals. Reduced use of health care services by those in a lower socioeconomic status has been documented, despite having health insurance (Fiscella, Franks, Gold, & Clancy, 2000). Data from the 2001 Medical Expenditure Panel Survey (MEPS) suggested that low income families with private health insurance experienced significantly more out-of-pocket financial burden related to health care than uninsured families or families with public health insurance (Galbraith, Wong, Kim, & Newacheck, 2005). One-fourth of insured adults under age 65 with incomes less than $20,000 indicated that financial concerns caused difficulty obtaining medical care, visiting a physician when they experienced a medical problem, and filling a prescription (Donelan, DesRoches, & Schoen, 2000). These individuals were three times more likely than insured individuals with incomes $60,000 or greater to forego obtaining needed care or skip completing recommended tests or treatment (Donelan et al.). Finally, despite being insured, low-income women did not receive preventive care that was medically recommended, including Pap tests, breast exams and dental visits (Almeida, Dubay, & Ko, p. 44). The
relationship between reduced access to care for low income individuals, despite the presence of health insurance also has been reported for dental care (Kenney, McFeeters, & Yee, 2005). Data on 9,714 children from the 2002 National Survey of America’s Families suggested that children living in families with private health insurance that did not include dental coverage had similar percentages of unmet dental needs to those living in families without any health insurance 12.9% and 13.7%, respectively (Kenney et al).

Although access to health care is more financially burdensome for low-income individuals and those who are uninsured, the presence of health insurance does not assure that health care will be received, regardless of economic status. A national study of 1,771 bankruptcy cases filed during 2001 found that more than half (54.5%) were a consequence of medically related expenses (Himmelstein, Warren, Thorne, & Woolhandler, 2005). The assumption that individuals who experienced medically related bankruptcy did not have health insurance coverage is erroneous. More than three-fourths (75.7%) of those whose medical problems led to bankruptcy reported that they had health insurance, primarily private, at the time they, or their family member, became ill (Himmelstein et al). A study that included a nationally representative sample of about 25,400 families reported that 14% experienced problems paying for medical bills during the previous year (May & Cunningham, 2004). More then two-thirds (68%) of those for whom paying medical bills was problematic had health insurance. Also, 12.4% of families with incomes between 300%-400% FPL and 7.4% of those with incomes more than 400% FPL experienced cost related problems (May & Cunningham).

A national survey conducted April-June 2005 of 1,531 adults reported that 23% expressed problems paying for medical bills; of those who identified problems, 61% had health insurance (USA Today, Kaiser Family Foundation, & Harvard School of Public Health, 2005). Notable as well, 28% of respondents indicated the inability to pay for medical care during the previous year; 62% of whom had health insurance (USA Today et al.).
Conclusion

While we never can lose focus on the health care dilemma faced by the poor, we must recognize that health care is a challenge – even an insurmountable obstacle – for countless others in our society. Drawing together data from various studies conducted in the field allows a complex picture to emerge – one markedly different from that created through common misconceptions. We discover a phenomenon that can, and should, be called health care poverty. Rather than being tied to a simple insured/uninsured template, it is more far reaching. In analyzing the traditional poor/poverty case, we apply both absolute and relative criteria. By using the same approach to the total health care picture, we reach some striking conclusions.

- Underinsurance can be as crippling as uninsurance. Nearly one-fourth (23%) of a nationally representative sample of adults surveyed during spring, 2005 reported problems paying their medical bills; 61% who reported problems had health insurance (USA Today et al., 2005). The percentage of individuals with health insurance, who indicated being “very worried” was 40% regarding paying medical bills when elderly, 37% regarding paying for costs related to a serious illness or accident, 31% regarding affording prescribed medications (USA Today et al.).
- The regressive nature of out-of-pocket costs (cost sharing) must be acknowledged and addressed (Bodenheimer, 1992). Individuals with lower incomes experience relatively greater barriers to care.
- Although more burdensome for individuals with lower incomes, underinsurance poses barriers for individuals above the poverty level, as well. More than one-fourth (26%) of non-elderly insured individuals with annual incomes < $75,000 reported problems paying for medical bills. However, so did 5% of insured individuals with yearly incomes ≥ $75,000 (USA Today et al.). Furthermore, 13% percent of individuals with annual incomes ≥ $75,000 reported that they did not obtain a medical test or prescribed medications or took less than the prescribed amount of medication due to financial concerns (USA Today et al.).
- The potential for worse health outcomes due to
decisions made by patients involved in cost sharing should be acknowledged and addressed proactively (Lee & Zapert, 2005). Plan adjustments that reduce financial disincentives to obtaining needed health care for individuals who are low income should be introduced and complete coverage for appropriate preventive care should be provided (Lee & Zapert).

- It has been suggested that the very existence of the concept "underinsurance" assumes consensus regarding an expected amount of "protection against health care expenditures" (Bashshur et al., 1993, p. 205). Dialogue must occur in the public and private arenas that results in measurable goals for access to health care against which the current system can be evaluated. The insured/uninsured dichotomy is not appropriate to achieve the goals of Healthy People 2010.

The macro picture becomes clear and compelling. These inequities are created by the absence of a national mandate for the type of universal health care present in most other industrialized nations. Our government spends billions on health care, but the funding lacks coherence. It is not allocated based on the realities explicated in this paper. Unless and until there is recognition of this unacknowledged challenge – and the will and wherewithal to solve it – health care poverty will expand, enveloping increasing numbers of victims.

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References


Foster Parents’ Reasons for Fostering and Foster Family Utilization

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Better utilization of foster families might be linked to parents’ reasons for fostering. This study used data from the National Survey of Current and Former Foster Parents to examine relationships between reasons for fostering and types of services and length of service foster parents provide. Top reasons for fostering were child-centered. The least endorsed reasons were self-oriented. Those who fostered to help children with special problems were more likely to have a child placed, had more children, and had fostered more types of special needs children. Parents who fostered because their children were grown were more likely to have a child placed, had more children, and were more likely to intend to continue fostering. Conversely, parents who wanted to be loved or who wanted companionship fostered fewer children. Implications for improving foster family utilization are discussed.

Key words: foster parent, motivation, utilization

Foster families have a critical role in child welfare as resources for children who need temporary out-of-home care and as resources for adoptive children. Approximately 70 percent of the estimated 532,000 U. S. children in foster care live with foster families (U. S. Department of Health and

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Even with the rise in kinship care, 65 percent of foster home placements are with non-relative foster families. Foster parents adopt the majority of children adopted through foster care (DHHS, 2004) and 20 percent of adopted children live in family foster homes (Barth, Gibbs, & Siebenaler, 2001).

Child welfare agencies face continual challenges to maintain adequate numbers of family foster homes (DHHS, 2002a, 2002b). Underutilization of licensed foster homes creates additional demands on systems already straining to recruit families. One-fifth of foster families provide 60 to 80 percent of placements (Gibbs, 2004). Approximately one-third of homes do not have placements at any one given time (DHHS, 1993; Gibbs, 2004; Kriener & Kazmerzak, 1995; Maine Foster Parent Association, 1994). Many foster parents never accept placements because they are unwilling to care for children with special needs or teens (Cox, Orme, & Rhodes, 2002; DHHS, 2002a). Twenty to 25 percent of foster parents quit each year (Casey Family Programs, 2000; Gibbs, 2004) and another quarter express uncertainty about continuing (Iowa Foster Recruitment and Retention Project, 2002; Denby, Rindfleisch, & Bean, 1999; Rhodes, Orme, & Buehler, 2001; Rhodes, Orme, Cox, & Buehler, 2003). Almost half of foster parents quit within a year of their first placement (Gibbs, 2004).

Part of the problem is engaging and encouraging foster parents to stay as long-term partners with agencies and to care for the types of children who need foster care placements (DHHS, 1993; DHHS, 2002b). However, little is known about how foster parents' reasons for fostering relate to foster home utilization. That is the purpose of this study.

Foster Family Utilization

The National Survey of Current and Former Foster Parents (NSC&FFP) (DHHS, 1993) provides the most extensive data on foster families from a national probability sample. The NSC&FFP (DHHS, 1993) estimated that there were approximately 131,100 licensed family foster homes in 1991 when the survey was conducted. The average family was licensed to care for 3.1 foster children, and so theoretically there were place-
ments available for 406,400 children. At approximately the same time there were 404,000 foster children (Tatara, 1997).

While these estimates suggest an adequate number of family foster homes, closer examination of utilization patterns tells a different story. At the time of the survey, 35 percent of foster families did not have any children placed. Foster families who did have children placed had an average of 2.2 foster children, although the average licensed capacity was 3.1 foster children. Sixty-three percent of foster families were operating below licensed capacity, 25 percent at capacity, and 11 percent above capacity. Twenty percent of families indicated that they planned to quit fostering within three years.

Initial analysis of the NSC&FFP data indicated some patterns in foster home utilization (DHHS, 1993). Location of the foster home was one factor. More families living in urban areas indicated that they were at licensing capacity than families in non-urban communities. Only 27 percent of urban families had no children as compared to 42 percent of rural and 39 percent of suburban families. Also, 23 percent of urban families had three or more children placed compared to 21 percent of suburban families and 17 percent of rural families. Race also was a factor. Only 30 percent of European-American foster families were operating at or above their licensing capacity, compared to 40 percent of African-American families and 45 percent of Hispanic families. Further, only 22 percent of African-American foster families did not have foster children as compared to 39 percent of European-American families. Finally, anecdotal evidence suggested that to some unknown extent under utilization might be due to the fact that agencies sometimes license, but do not place children with families about who they have concerns.

In her secondary analysis of the NSC&FFP data, Cox (Cox, Orme, & Rhodes, 2002) found that families more willing to foster special-needs children and teenagers had fostered more children and more types of special-needs children, had more children in the homes, were licensed to care for more children, had fostered longer, and were less likely to consider quitting. Specifically, utilization was predicted by willingness to foster children with physical handicaps or serious illness, children with serious behavioral or emotional problems, or children
who were sexually abused. Similarly, in a survey of 142 foster parent applicants, Cox et al. (2003) found that families willing to foster children with emotional or behavioral problems were more likely to have children placed within fourteen months after pre-service training.

Reasons for Fostering

Authors of the NSC&FFP survey (1993) developed a comprehensive list comprised of 28 stated reasons for becoming a foster parent derived from previous research on motivation for fostering. The survey asked foster parents to endorse reasons for fostering by indicating "yes" or "no" if a reason described why they wanted to foster.

Initial analysis of the NSC&FFP data (DHHS, 1993) reported that parents had multiple reasons for being foster parents. Most respondents wanted to provide a child with love and with a good home. Two-thirds of parents indicated that they wanted to provide a home for a child who would otherwise be in an institution and because they wanted to help children with special problems. Over half of parents believed fostering was a way to do something for their communities. Approximately one-fourth of parents gave one or more reasons related to parenting a child, such as being unable to have children, wanting a larger family, wanting to adopt, or wanting to parent after their children were grown. Parents licensed after 1985 were more likely to foster because they knew a child and because they were interested in adoption, than those approved earlier, reflecting increased emphasis on kinship care and permanency planning.

The NSC&FFP survey and other studies yielded fairly consistent descriptions about reasons for fostering (Anderson, 2001; Baum, Crase, & Crase, 2001; Kirton, 2001). Several studies examined how reasons for fostering related to placement outcomes for children. Kraus (1971) and Hampson and Tavormina (1980) found positive relationships between child-centered reasons for fostering and placement duration. Placement disruptions were more frequent in families motivated by wanting companionship for their children (Kraus, 1971). Foster parents motivated by altruism, being childless, and
Reasons for Fostering

identifying with the child received high performance ratings from foster care workers while those motivated by wanting to look after children were rated as barely adequate (Dando & Minty, 1987).

Two studies considered how reasons for fostering related to retention. Triseliotis, Borland, and Hill (1998) found no differences between reasons for fostering and continuation, except for families who started fostering as an avenue to adoption. Rindfleisch, Denby, and Bean's (1998) study of closed and open foster homes found that wanting to adopt and not being able to do so increased the likelihood that a foster home closed.

None of the aforementioned studies address how reasons for fostering relate to foster parents' activity levels as service providers. The present study uses data from the NSC&FFP to extend understanding of utilization by examining how reasons for fostering are associated with foster family utilization. It limits the analysis to non-kinship foster families because nationally this is the most prevalent type of foster care, because the vast majority of caregivers sampled by the NSC&FFP were non-kinship foster families, and because kin and non-kin families have different reasons for fostering (Le Prohn, 1994). Also, it will use both inferential and descriptive statistics. Principal research questions include what reasons for fostering are associated with:

- the total number of the number of children fostered, whether or not any foster children were placed in the home at the time of the survey, and the number of children in the foster home at the time of the survey?
- licensing capacity?
- the number of types of special needs children fostered and if parents foster children from more than one racial group?
- whether or not respondents adopted children and adopted foster children?
- retention as evidenced by the number of years fostered and the intention to continue fostering?

Methods
The NSC&FFP was conducted in 1991, and it is the only study of current and former foster families based on a national probability sample (DHHS, 1993). The purpose of the NSC&FFP was to collect extensive information potentially useful in agency and public policy planning regarding recruitment and retention of foster parents. This rich data set provides an opportunity to examine these and other important issues concerning family foster care.

The NSC&FFP used a multistage stratified sampling design with probability sampling at each stage so that the findings generalize to the 1991 U. S. population of approved, licensed, or certified foster families. States were stratified by level of foster care payment. Counties were stratified by residence and by level of unemployment. Foster parents were stratified by their current and former status. Current foster parents were stratified by their length of service. Ultimately, data were collected from foster parents living in 27 counties in 9 states. The unweighted sample contains 1048 current (116,964 weighted) and 265 former foster families (63,823 weighted).

Only data from current foster families were used in the present study because the full range of foster home utilization measures used in this study were collected only from current foster families. Also, families approved to provide kinship care, group care, or unspecified “other” types of foster care were excluded. Of the total sample of 1048 current foster families, 876 families (108,592 weighted) met these criteria.

The population-weighted sample was used in order to obtain representative national estimates. Estimates were computed using the Jackknife (JK1) replication approach. The replicate and full sample weights were used in the analyses. Data were analyzed using WesVar (Version 4.0, SPSS 2001). WesVar PC is used to analyze data collected using complex sampling designs such as the NSC&FFP (Johnson & Elliott, 1998).

For descriptive purposes, family-level characteristics include income, marital status, number of children, whether they adopted children, geographic location, and number of years fostering. Individual-level characteristics include race, age, educational level, and employment status.

Respondents were asked to indicate why they wanted to be foster parents by checking “yes” or “no” to a list of 28 reasons. In addition, a count variable was created for the total number
of endorsed reasons for fostering, and this variable has a potential range of values from 0 through 28.

Respondents were asked whether they had fostered the following types of special needs children: (1) developmentally disabled/mentally retarded child, (2) physically handicapped or seriously ill child, (3) drug-exposed infant or newborn, (4) child born with Fetal Alcohol Syndrome or other alcohol-related disorders, (5) child born with AIDS virus, (6) mentally ill or emotionally or behaviorally disturbed child, or (7) sexually abused child. A variable for each type of special needs child was coded 0 for "have not fostered" and 1 for "have fostered." A count variable was created for the total number of the types of special needs children respondents had fostered, and this variable has a potential range of values from 0 through 7.

Another measure of foster family utilization used was whether a family fostered children from multiple racial groups. Respondents to the NSC&FFP also were asked if they had fostered children with the following identified racial backgrounds: (1) American Indian or Alaskan Native; (2) Asian or Pacific Islander; (3) Black, not of Hispanic origin; (4) Hispanic (including Mexican American); (5) White, not of Hispanic origin; and (6) "Other." A dichotomous variable was coded 0 for "fostered from one race group" and 1 for "fostered from multiple racial groups."

Retention was considered as a utilization variable because foster parents have to remain licensed in order to provide placements for children. Indicators of retention included the number of years as a foster parent and if they planned to continue fostering. Respondents were asked what year they were approved to foster. Because data were collected in 1991, number of years fostered was calculated by subtracting the year of approval from 1991. An expressed intention to continue fostering was used as an indicator of foster home utilization since foster families who discontinue fostering can no longer accept foster care placements. Respondents were asked if over the next three years they intended to continue to foster. A response of "yes" was coded 1 and "no" was coded 0.

Results
Descriptive statistics appropriate to the level of measurement and distributional characteristics of the variables are reported (e.g., medians are reported for skewed distributions). Bivariate linear regression was used to analyze quantitative dependent variables, and $R^2$ is reported to quantify the strength of these relationships. Bivariate binary logistic regression was used to analyze dichotomous dependent variables, and odds ratios (OR) are reported to quantify the strength of these relationships. In all analyses two-tailed tests were used with a .05 level of statistical significance.

The majority of information in the present study was provided by foster mothers (65%) or jointly by foster mothers and foster fathers (28%). Foster fathers (7%) provided a small percentage.

As shown in Table 1, three-fourths of families included married couples or couples living as married couples. Income levels were fairly diverse, with 42% of families with incomes less than $25,000, 32% with incomes from $25,000 to $39,999, and 26% with incomes of $40,000 or greater. Seventy-seven percent of families had at least one birth child. Thirty percent of families had adopted children and 22% of families adopted foster children. Approximately 40% of families lived in suburban areas, 36% in urban areas, and 24% in rural areas. Foster families on average had 6.6 years of fostering experience ($SD = 6.4$) with a median of 4 years.

Table 2 shows the demographic characteristics of foster mothers and fathers. Racial diversity was found, with 29% of foster mothers and 22% of foster fathers being minorities. Specifically, 22% of mothers and 13% of fathers were African-American. In terms of education, 84% of mothers and 86% of fathers had at least a high school education. Seventeen percent of mothers and 23% of fathers had a bachelor’s degree or higher. Most (83%) fathers were employed full-time, whereas only 35% of mothers were employed full-time. Forty-eight percent of foster mothers were not employed outside of the home. The mean age of mothers was 44.2 years ($SD = 10.6$) and the mean age of fathers was 45.1 years ($SD = 11.0$).

Table 1. Demographic Characteristics of Foster Families
## Table 2. Demographic Characteristics of Foster Parents

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total families (n=108,592) %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
</tr>
<tr>
<td>Married or living as married</td>
<td>75.1</td>
</tr>
<tr>
<td>Divorced</td>
<td>10.7</td>
</tr>
<tr>
<td>Separated</td>
<td>2.6</td>
</tr>
<tr>
<td>Widow/Widower</td>
<td>6.5</td>
</tr>
<tr>
<td>Never married</td>
<td>5.1</td>
</tr>
<tr>
<td><strong>Number of Birth Children</strong></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>23.3</td>
</tr>
<tr>
<td>1</td>
<td>14.5</td>
</tr>
<tr>
<td>2</td>
<td>22.0</td>
</tr>
<tr>
<td>3</td>
<td>18.1</td>
</tr>
<tr>
<td>4</td>
<td>11.1</td>
</tr>
<tr>
<td>5 or more</td>
<td>11.1</td>
</tr>
<tr>
<td><strong>Adoptive Children</strong></td>
<td></td>
</tr>
<tr>
<td>Adopted children</td>
<td>30.3</td>
</tr>
<tr>
<td>Adopted foster children</td>
<td>21.8</td>
</tr>
<tr>
<td><strong>Annual Family Income</strong></td>
<td></td>
</tr>
<tr>
<td>&lt; 15,000</td>
<td>15.7</td>
</tr>
<tr>
<td>15,000-19,999</td>
<td>12.8</td>
</tr>
<tr>
<td>20,000-24,999</td>
<td>13.4</td>
</tr>
<tr>
<td>25,000-29,999</td>
<td>12.8</td>
</tr>
<tr>
<td>30,000-34,999</td>
<td>10.4</td>
</tr>
<tr>
<td>35,000-39,999</td>
<td>9.2</td>
</tr>
<tr>
<td>40,000-49,000</td>
<td>8.2</td>
</tr>
<tr>
<td>&gt; 50,000</td>
<td>17.5</td>
</tr>
<tr>
<td><strong>Geographical Location</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>36.4</td>
</tr>
<tr>
<td>Suburban</td>
<td>39.8</td>
</tr>
<tr>
<td>Rural</td>
<td>23.8</td>
</tr>
<tr>
<td><strong>Number of Years Fostering</strong></td>
<td></td>
</tr>
<tr>
<td>M = 6.6, Md = 4, SD=6.4</td>
<td></td>
</tr>
<tr>
<td>&lt; 2 years</td>
<td>14.1</td>
</tr>
<tr>
<td>2 - 3 years</td>
<td>28.3</td>
</tr>
<tr>
<td>4 - 5 years</td>
<td>17.1</td>
</tr>
<tr>
<td>6 - 10 years</td>
<td>20.5</td>
</tr>
<tr>
<td>&gt;10 years</td>
<td>20.0</td>
</tr>
</tbody>
</table>

Note. The percentage of missing data ranged from .9 to 5.2%.
### Total families (n=108,592)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Mothers (n=107,033)</th>
<th>Fathers (n=83,541)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race</td>
<td></td>
<td></td>
</tr>
<tr>
<td>European-American</td>
<td>69.8</td>
<td>77.9</td>
</tr>
<tr>
<td>African-American</td>
<td>22.0</td>
<td>12.9</td>
</tr>
<tr>
<td>Other</td>
<td>8.2</td>
<td>9.2</td>
</tr>
<tr>
<td>Highest Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;HS</td>
<td>16.0</td>
<td>13.6</td>
</tr>
<tr>
<td>HS/GED</td>
<td>24.2</td>
<td>25.9</td>
</tr>
<tr>
<td>College, No Degree</td>
<td>32.8</td>
<td>27.4</td>
</tr>
<tr>
<td>Two-Year Degree</td>
<td>9.6</td>
<td>10.1</td>
</tr>
<tr>
<td>Bachelor's Degree</td>
<td>6.1</td>
<td>10.6</td>
</tr>
<tr>
<td>Grad work, no grad degree</td>
<td>5.6</td>
<td>5.1</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>5.7</td>
<td>7.3</td>
</tr>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full-Time</td>
<td>35.3</td>
<td>82.9</td>
</tr>
<tr>
<td>Part-Time</td>
<td>16.6</td>
<td>2.5</td>
</tr>
<tr>
<td>Not employed outside home</td>
<td>48.1</td>
<td>14.6</td>
</tr>
<tr>
<td>Age</td>
<td>44.2 (10.6)</td>
<td>45.1 (11.0)</td>
</tr>
</tbody>
</table>

Note. The percentage of missing data for mothers ranged from 2.3% to 3.6% and for fathers ranged from 3.1% to 4.9%.

### Reasons for Fostering

Table 3 shows foster families' reasons for fostering in order of endorsement from most endorsed to least endorsed. Top reasons for fostering tended to be child-centered, such as: "to provide a child with love" (89.9% of families); "to provide a good home for a child" (89.4%); "to provide a home for children who otherwise would be in an institution" (62.3%); and "to help a child with special problems" (58.9%). In addition a majority of families (52.4%) "wanted to do something for the community / society." Among the least endorsed
**Reasons for Fostering**

<table>
<thead>
<tr>
<th>Reason for fostering</th>
<th>% endorsement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanted to provide a child with love</td>
<td>89.9</td>
</tr>
<tr>
<td>Wanted to provide a good home for a child</td>
<td>89.4</td>
</tr>
<tr>
<td>Wanted to provide a home for children who would otherwise be in an institution</td>
<td>62.3</td>
</tr>
<tr>
<td>Wanted to help a child with special problems</td>
<td>58.9</td>
</tr>
<tr>
<td>Wanted to do something for the community/society</td>
<td>52.4</td>
</tr>
<tr>
<td>Wanted to be loved by a child</td>
<td>39.6</td>
</tr>
<tr>
<td>Wanted a larger family</td>
<td>29.9</td>
</tr>
<tr>
<td>Thought about adopting and thought fostering was a good way to start</td>
<td>26.1</td>
</tr>
<tr>
<td>Could not have any, or any more, children of my own</td>
<td>25.0</td>
</tr>
<tr>
<td>My own children were grown and I wanted children in the house</td>
<td>23.3</td>
</tr>
<tr>
<td>Wanted companionship for my own child</td>
<td>14.8</td>
</tr>
<tr>
<td>Wanted to care for a child but did not want permanent responsibility</td>
<td>14.5</td>
</tr>
<tr>
<td>Wanted to adopt but couldn't get a child</td>
<td>12.5</td>
</tr>
<tr>
<td>Wanted a certain kind of child (e.g., a girl or a five-year old)</td>
<td>12.3</td>
</tr>
<tr>
<td>Wanted companionship for myself</td>
<td>11.5</td>
</tr>
<tr>
<td>Wanted to fill time</td>
<td>11.3</td>
</tr>
<tr>
<td>Religious beliefs</td>
<td>11.2</td>
</tr>
<tr>
<td>Knew the foster child of the child’s family and wanted to help</td>
<td>11.1</td>
</tr>
<tr>
<td>Was abused or neglected myself</td>
<td>6.9</td>
</tr>
<tr>
<td>Wanted to increase family income</td>
<td>6.6</td>
</tr>
<tr>
<td>Did not want to care for an infant</td>
<td>5.7</td>
</tr>
<tr>
<td>Was single and wanted a child</td>
<td>5.0</td>
</tr>
<tr>
<td>Had a child who died</td>
<td>4.2</td>
</tr>
<tr>
<td>Am related to child</td>
<td>2.1</td>
</tr>
<tr>
<td>Was a foster child myself</td>
<td>1.9</td>
</tr>
<tr>
<td>Thought a child might help my marriage</td>
<td>.8</td>
</tr>
<tr>
<td>Wanted a child to help with chores or work in family business</td>
<td>.6</td>
</tr>
</tbody>
</table>

Note. The percentage of missing data ranged from 4.3 to 6.7%. Families endorsed a mean of 6.6 (SD = 2.8) and a median of 7 reasons for fostering. Reasons for fostering were approximately normally distributed.

Table 4. Number of Children Fostered, Licensed Capacity, and Racial Diversity of Children Fostered
Number of children fostered

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>% of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>2.3</td>
</tr>
<tr>
<td>1-2</td>
<td>22.3</td>
</tr>
<tr>
<td>3-5</td>
<td>19.4</td>
</tr>
<tr>
<td>6-10</td>
<td>19.3</td>
</tr>
<tr>
<td>11-20</td>
<td>16.6</td>
</tr>
<tr>
<td>&gt; 20</td>
<td>20.1</td>
</tr>
</tbody>
</table>

*M = 19.1, Md = 7, SD = 42.1*

Number of foster children in the home

<table>
<thead>
<tr>
<th>Number of Foster Children</th>
<th>% of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>33.5</td>
</tr>
<tr>
<td>1</td>
<td>20.5</td>
</tr>
<tr>
<td>2</td>
<td>25.3</td>
</tr>
<tr>
<td>3</td>
<td>10.8</td>
</tr>
<tr>
<td>4 or more</td>
<td>9.9</td>
</tr>
</tbody>
</table>

*M = 2.2, Md = 2, SD = 1.2 (for families with at least 1 child in the home)*

Number of children family licensed to foster at one time

<table>
<thead>
<tr>
<th>Number of Children</th>
<th>% of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>11.6</td>
</tr>
<tr>
<td>2</td>
<td>32.9</td>
</tr>
<tr>
<td>3</td>
<td>22.4</td>
</tr>
<tr>
<td>4</td>
<td>18.1</td>
</tr>
<tr>
<td>5</td>
<td>5.9</td>
</tr>
<tr>
<td>6</td>
<td>7.9</td>
</tr>
<tr>
<td>7 or more</td>
<td>1.1</td>
</tr>
</tbody>
</table>

*M = 3.0, Md = 3.0, SD = 1.5*

Number of types of special needs children fostered

<table>
<thead>
<tr>
<th>Number of Types</th>
<th>% of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>12.6</td>
</tr>
<tr>
<td>1</td>
<td>20.8</td>
</tr>
<tr>
<td>2</td>
<td>26.8</td>
</tr>
<tr>
<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>4</td>
<td>10.1</td>
</tr>
<tr>
<td>5</td>
<td>6.5</td>
</tr>
<tr>
<td>6 or 7</td>
<td>4.4</td>
</tr>
</tbody>
</table>

*M = 2.3, Md = 2.0, SD = 1.6*

Number of different racial groups fostered *(n=106,592)*

<table>
<thead>
<tr>
<th>Number of Groups</th>
<th>% of Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>.6</td>
</tr>
<tr>
<td>1</td>
<td>56.0</td>
</tr>
<tr>
<td>2</td>
<td>22.9</td>
</tr>
<tr>
<td>3</td>
<td>12.1</td>
</tr>
<tr>
<td>4</td>
<td>5.9</td>
</tr>
<tr>
<td>5 or 6</td>
<td>2.6</td>
</tr>
</tbody>
</table>

*M = 1.7, Md = 1, SD = 1.05*

Note 1. Data were missing for number of children (9.3% of families), number of foster children in the home (.3% of families), licensed capacity (4.2% of families), and number of types of special needs children (3.8% of families).

Note 2. Data were missing for 2.5% (of all families) for the number of different racial groups children fostered belonged.

Note 3. Families were considered “European-American” if both parents were European-American, otherwise families were coded as non-European-American.

motives were more self-centered reasons such as: “wanted to increase family income” (6.6% of families), “was single
Reasons for Fostering

and wanted a child” (5.0%); “had a child who died” (4.2%), “thought a child might help my marriage” (.8%), and “wanted a child to help with chores or work in family business” (.6%).

Foster Family Utilization

The number of children fostered was positively skewed and the median number of children fostered was 7 (see Table 4). Ninety-eight percent of families had fostered at least one child, and approximately 75% had fostered at least three children. However, at the time of the survey 34% of families did not have foster children in their homes. The median number of foster children in the home at the time of the survey was 2 for families with at least one child in the home. Forty percent of families had fostered at least three types of special needs children and the median number of types of special needs children fostered was 2.

The median number of children families were licensed to care for at one time was 3 (see Table 4). Only 28.4% of foster homes were filled to capacity at the time of the survey.

The median number of different identified racial backgrounds fostered was 1 (see Table 4). A majority of families (56%) had only fostered children from one racial group. Almost one quarter of families (23%) had fostered children from two racial groups. The remaining 21% of the families had foster children from three or more racial groups.

Families had fostered for a median of 4 years (see Table 1). Fourteen percent had fostered for less than 2 years and 41% of families had fostered for 6 years or longer. Seventy-two percent of foster families reported an intention to continue fostering over the next three years.

Thirty three percent of families had adopted children and 22% of families adopted foster children (see Table 1).

Table 5. Reasons for Fostering and Foster Family Utilization
<table>
<thead>
<tr>
<th>Desired Outcome</th>
<th>( t )</th>
<th>( B )</th>
<th>( p )</th>
<th>( R^2 )</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Number of Children Fostered</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to be loved by a child</td>
<td>2.36</td>
<td>-5.00</td>
<td>.031</td>
<td></td>
</tr>
<tr>
<td>Wanted companionship for my own child</td>
<td>2.52</td>
<td>-6.14</td>
<td>.023</td>
<td></td>
</tr>
<tr>
<td>Wanted companionship for myself</td>
<td>2.34</td>
<td>-6.14</td>
<td>.033</td>
<td></td>
</tr>
<tr>
<td>Was single and wanted a child</td>
<td>2.95</td>
<td>-9.08</td>
<td>.009</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Foster Children in the Home at Time of Survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to help a child with special problems</td>
<td>2.84</td>
<td>.31</td>
<td>.012</td>
<td>.011</td>
</tr>
<tr>
<td>Thought about adopting and thought foster parenting was a good way to start</td>
<td>-2.25</td>
<td>-.37</td>
<td>.039</td>
<td></td>
</tr>
<tr>
<td>My own children were grown and I wanted children in the house</td>
<td>3.28</td>
<td>.53</td>
<td>.005</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Children Licensed to Foster at One Time</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to provide a home for children who would otherwise be in an institution</td>
<td>2.12</td>
<td>.20</td>
<td>.050</td>
<td></td>
</tr>
<tr>
<td>My own children were grown and I wanted children in the house</td>
<td>2.22</td>
<td>.42</td>
<td>.041</td>
<td></td>
</tr>
<tr>
<td>Wanted to fill time</td>
<td>2.75</td>
<td>.42</td>
<td>.014</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Types of Special-Needs Children Fostered</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to help a child with special problems</td>
<td>2.82</td>
<td>.61</td>
<td>.012</td>
<td></td>
</tr>
<tr>
<td>Wanted a larger family</td>
<td>2.40</td>
<td>.49</td>
<td>.029</td>
<td></td>
</tr>
<tr>
<td>Was abused or neglected myself</td>
<td>2.35</td>
<td>.73</td>
<td>.032</td>
<td></td>
</tr>
<tr>
<td>Wanted to increase family income</td>
<td>3.09</td>
<td>.62</td>
<td>.007</td>
<td></td>
</tr>
<tr>
<td>Had a child who died</td>
<td>2.46</td>
<td>.85</td>
<td>.026</td>
<td>.011</td>
</tr>
<tr>
<td>Was a foster child myself</td>
<td>2.46</td>
<td>.74</td>
<td>.026</td>
<td></td>
</tr>
<tr>
<td>Wanted a child to help with chores or work in family business</td>
<td>-2.24</td>
<td>-1.11</td>
<td>.040</td>
<td></td>
</tr>
<tr>
<td><strong>Number of Years Fostered</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to provide a home for children who would otherwise be in an institution</td>
<td>2.53</td>
<td>.92</td>
<td>.022</td>
<td></td>
</tr>
<tr>
<td><strong>One or More Foster Children in the Home at Time of Survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to help a child with special problems</td>
<td>2.17</td>
<td>.046</td>
<td>1.40</td>
<td></td>
</tr>
<tr>
<td>Wanted to fill time</td>
<td>2.41</td>
<td>.028</td>
<td>1.63</td>
<td></td>
</tr>
<tr>
<td><strong>Foster Children from Multiple Racial Groups</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanted to be loved by a child</td>
<td>-2.95</td>
<td>.009</td>
<td>.56</td>
<td></td>
</tr>
<tr>
<td>Wanted a larger family</td>
<td>2.31</td>
<td>.035</td>
<td>1.64</td>
<td></td>
</tr>
<tr>
<td>Was abused or neglected myself</td>
<td>2.41</td>
<td>.028</td>
<td>3.65</td>
<td></td>
</tr>
</tbody>
</table>

*Intention to Continue Fostering*
Endorsed Reasons for Fostering and Foster Home Utilization

Table 5 summarizes endorsed reasons for fostering and foster home utilization. Reasons endorsed associated with utilization in the following ways:

- Families who endorsed “wanted to be loved by a child,” “wanted companionship for my own child,” “wanted companionship for myself,” or “was single and wanted a child” fostered fewer children than families who did not endorse any of these reasons.

- Families who endorsed “wanted to help a child with special problems” or “my own children were grown and I wanted children in the house” had more foster children in their home at the time of the survey than families who did not endorse either one of these reasons.

- Those families who endorsed “thought about adopting and thought foster parenting was a good way to start” had fewer foster children in their home at the time of the survey than families who did not endorse this reason.

- Families who endorsed “wanted to help a child with special problems” or “wanted to fill time” were more likely to have one or more foster children placed at the time of the survey than families who did not endorse either one of these reasons.

- Those who endorsed “wanted to provide a home for children who would otherwise be in an institution,” “my own children were grown and I wanted children in the house,” or “wanted to fill time” were licensed to care for more children than families who did not endorse any of these reasons.
Families who endorsed "wanted to help a child with special problems," "wanted a larger family," "was abused or neglected myself," "wanted to increase family income," "had a child who died," or "was a foster child myself" fostered more types of special-needs children than families who did not endorse any of these reasons. Conversely, families who endorsed "wanted a child to help with chores or work in family business" fostered fewer types of special-needs children than families who did not endorse this reason.

Families who endorsed "wanted a larger family" or "was abused or neglected myself" were more likely to foster children from multiple racial groups than families who did not endorse either of these reasons. Conversely, families who endorsed "wanted to be loved by a child" were less likely to foster children from multiple racial groups than families who did not endorse this reason.

Families who endorsed "wanted to provide a home for children who would otherwise be in an institution" had fostered longer than families who did not endorse this reason.

Families who endorsed "my own children were grown and I wanted children in the house" were more likely to report an intention to continue fostering than families who did not endorse this reason. Conversely, families who endorsed "knew the foster child of the child’s family and wanted to help" were less likely to report an intention to continue fostering than families who did not endorse this reason.

Families who endorsed "could not have any, or any more, children of my own," "thought about adopting and thought foster parenting was a good way to start," or "wanted a larger family" were more likely to adopt children than families who did not endorse any of these reasons. Conversely, families who endorsed "wanted to provide a good home for a child" were less likely to adopt children than families who did not endorse this reason.

Discussion
The chronic shortage of family foster homes is exacerbated by underutilization of existing foster families. Better utilization might be linked to the reasons that parents foster. This study used data from the National Survey of Current and Former Foster Parents to examine this question.

Agencies routinely include questions related to interest and reasons for fostering as part of the foster home study interview. Questions such as what families anticipate and count on from their experiences as foster parents help to make expectations clear and to assure that applicants have realistic views about fostering. Yet, some families may not be able articulate fully their reasons to foster, as this is complicated and complex issue. Agencies may miss important information needed to plan training and support of foster parents. Findings from this study suggest that agencies would benefit from information obtained through systematic standardized assessment of reasons for fostering.

The study’s results supported that people foster for many different reasons. Most foster parents want to provide a child with love and a good home. Yet, the most frequently endorsed reasons did not predict higher utilization. Families averaged six reasons for fostering. Even families with reasons for fostering that were incompatible with the goals of child welfare were likely to have other, more compatible, reasons for fostering as well. In addition to having a comprehensive list of reasons, it would be beneficial to expand the measurement of reasons for fostering from a nominal to an ordinal scale to indicate the extent of a particular reason.

Key findings from this study suggest that careful assessment of reasons for fostering might help agencies identify parents with potential to be high level caregivers. In particular, foster parents interested in helping children with special problems provided more placements and were more likely to have a child placed at the time of the survey. Those wanting to provide family-based care had longer tenure as foster parents and were licensed to care for more children. Parents who wanted to continue to care for children after their children were grown provided more placements and were more likely to plan to continue as foster parents. Parents fostering because they wanted a larger family provided for children with a variety of
These reasons for fostering might be indicative of the core group of active, committed foster parents who provide over half of foster care placements (Gibbs, 2004; Martin, Altemeier, Hickson, Davis, & Glascoe, 1992).

Other reasons correlated negatively with utilization. Foster parents motivated by wanting companionship, wanting to be loved by a child, or because they are single and want a child were likely to provide fewer placements than parents fostering for other reasons. Those fostering as a way to adopt were less likely to have a placement at any given time. Parents fostering to provide a home for a specific child might only accept one placement. On an individual basis, placements with families fostering for these reasons might have positive outcomes for the child in care. However, agencies with large numbers of such families might have a less experienced pool of foster parents resulting from shorter lengths of service and higher turnover rates. Systematically collected information about reasons for fostering might give agencies a clearer picture of its family foster homes. Agencies can use this information to assess and to plan strategies for recruitment, training, and retention.

Utilization depends on foster care workers' decisions and on children's needs as well as on foster parent interests and motivations. The relationship between reasons for fostering and utilization is not a simple one. Reasons for fostering do not indicate if a family has the skills, abilities, and resources to care for a child. Families who care for children with special needs might take fewer children because of the time and resources involved in caring for one child. Foster families who experience high numbers of placement disruptions may report caring for more children. In that case, the number of children fostered is not an adequate measure of foster home utilization. Regarding the special needs children fostered, only data on the number of different types of special need children fostered were collected in this study. Future studies of utilization that measure family resources, placement disruptions, and the total number of special needs children fostered will add to understanding the relationships between reasons for fostering and foster parent activities.

The present study is based on a large, national probabil-
ity sample of licensed foster families, and it provides the best estimates to date of reasons for fostering and foster home utilization. However, this sample has limitations that should be considered when drawing implications and in planning future research in this area. In particular, it did not include kinship foster families. Consequently, the findings are not necessarily applicable to the increasing number of kinship foster families. The sample was limited to current licensed foster families who were relatively experienced in terms of length of service and number of children fostered. If this is the case, the present study might overestimate endorsement for a specific reason for fostering. It also might underestimate the strength of the relationship between reasons to foster and foster family utilization.

Finally, the sample in the present study was collected in 1991. It might be that over the last decade reasons for fostering and patterns of utilization might have changed. In particular, families might be fostering in response to increased awareness of the need for families for children of their cultural and racial heritage and the need for permanency planning for children in care. The average licensed capacity of foster homes has decreased over time due to smaller dwellings and stricter agency requirements (DHHS, 1993). The Adoption and Safe Families Act emphasizes concurrent planning for reunification and an alternative permanent situation that encourages foster families to adopt (GAO, 1997). In an effort to achieve permanency goals, many States recruit and train foster and adoptive families jointly (GAO, 2002). Therefore, it is reasonable to expect that new foster parents will have different patterns of utilization. Consequently, the relationship between reasons for fostering and foster family utilization might also have changed.

Future research should collect reasons for fostering from foster family applicants, and follow these families prospectively. Such a design would make it possible to examine the stability of reasons for fostering over time and explore the relationship between reasons for fostering and various fostering measures such as foster parent willingness to foster children with special needs and teenagers, foster parent satisfaction, number of placement disruptions, reasons for placement disruptions, retention, reasons for discontinuing fostering (when applicable), and foster child well-being and safety.
This survey relied primarily on reports of foster mothers. Although foster mothers form the foundation of functioning for many foster families, mothers and fathers in two-parent families may differ in their reasons for fostering. Such differences might influence the length of service and the types of services provided.

Conclusion

The present study extends previous research by providing a more detailed picture of how reasons for being a foster parent relate to foster home utilization. Results of the present study do suggest that better utilization is linked to reasons for fostering, but clearly a methodologically rigorous program of research is needed to better understand and ameliorate this problem.

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References


Economic Mobility of Single Mothers: The Role of Assets and Human Capital Development

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University of Illinois at Urbana-Champaign

This study examines the economic mobility of single mothers. It highlights the relationships between single mothers' financial assets and human capital development (educational advancement, job training, and work hours) with their economic mobility. Analysis of data from the National Longitudinal Survey of Youth (NLSY79) indicates that assets may help improve upward economic mobility. Assets, however, have differential impact on single mothers with different income levels. In addition, human capital development mediates the positive link between assets and the economic mobility for mothers living between the 100% and 200% federal poverty. These results support asset building as an investment strategy to enhance the long-term economic well-being of single mothers. The findings also underscore the importance of examining within-group variations among single mothers in designing effective asset-building policies and programs.

Key words: economic mobility, human capital, single mothers

The rapid increase of single-mother families in the past decades and the higher poverty rates among these families have been widely recognized (Fields & Casper, 2001; McLanahan & Booth, 1989; McLanahan & Kelly, 1999; McLanahan & Sandefur, 1994; Nichols-Casebolt & Krysik, 1997). Studies also found that compared with other groups, female-headed households
have experienced lower upward economic mobility (Caputo, 1999; Weinstein, 2000). These studies indicate that contributing factors to the economic hardship of single mothers include their low earning capacity, low job opportunities in economically depressed areas, and meager public benefits.

This research, however, has not paid adequate attention to the impact of assets on the economic mobility of single mothers. Interest in asset accumulation for low-income families has increased in recent years in both policy and academic discussions. Studies show that increasing asset inequality has become much more prominent than that of income (Oliver & Shapiro, 1995; Wolff, 2001). Single mothers accumulate fewer assets compared to the general population (Bernheim & Scholz, 1993; Carney & Gale, 1999; Schmidt, 2004; Yamokoski & Keister, 2004). Lack of asset accumulation may not only contribute to the lower economic status of single mothers, but, perhaps more important, restrict their economic mobility (Sherraden, 1991).

Furthermore, while theory suggests different potential pathways through which assets may enhance economic status (Sherraden, 1991; Shobe & Page-Adams, 2001), empirical research has not examined possible mechanisms by which asset holding may impact the economic success (Scanlon & Page-Adams, 2001). Studies also indicate that the impact of assets on the economic well-being of single mothers may vary by their specific life circumstances (Edin, 2001). Existing research has sparsely examined these possible differences yet.

To address these issues, this study explores the associations between financial assets and human capital development with economic mobility between 1994 and 2000. Specifically, this study seeks to answer the following research questions. First, what is the relationship between single mothers' assets and their upward economic mobility? Second, do assets impact the economic mobility of single mothers through its influence on their human capital development? Third, does the impact of assets on the economic mobility vary by the income levels of single mothers?

Understanding the dynamic relationships between assets, human capital development, and the economic status of single mothers is particularly important in the context of welfare policy. The implementation of the Personal Responsibility and
Work Opportunity Reconciliation Act (PRWORA) in 1996 has focused on individual responsibility for long-term economic well-being. While welfare caseload has largely decreased since the welfare reform, many welfare leavers face precarious financial circumstances (Anderson & Gryzlak, 2002; Cancian, 2001; Loprest, 2001). These have led to increasing interest in investment approaches for assisting welfare recipients, and the low-income single parents in general, to enhance their economic well-being. Thus, it is necessary to understand how asset building, a promising investment strategy, impacts the economic mobility of single mothers.

Background: Theory and Past Research

Theoretical Framework

Within economic perspectives, some scholars make a distinction between income and assets as economic resources (Oliver & Shapiro, 1995; Sherraden, 1991; Wolff, 1995). These scholars indicate that the importance of assets is more than a flow of income for current or deferred consumption. Assets, as the stock of wealth in a household, can provide economic security for many families. Supporting this argument, a number of studies have found positive associations of assets with economic well-being (Page-Adams & Sherraden, 1997; Scanlon & Page-Adams, 2001).

Furthermore, assets may indirectly affect people's economic status by helping them invest in themselves and enhance their human capital development. Assets can provide security and resources for investments to improve long-term development. Assets also may enhance self-sufficiency and future orientation (Sherraden, 1991; Yadama & Sherraden, 1996; Zhan & Sherraden, 2003). For example, Yadama and Sherraden (1996) found that savings and house values had links with positive attitudes and behaviors. Some positive attitudes such as personal efficacy and future orientation may be important determinants of performance in a wide range of life events, including active engagement in long-term planning and productive activities (Bandura, 1997; Shobe & Page-Adams, 2001). A person with these qualities may want to further invest in education or skill training and pose positive work attitudes or efforts (Cho, 2001).
Finally, in order to protect their existing assets, people may be more motivated to work and to improve their skills. Due to all these reasons, assets may stimulate people to engage investment and productive activities.

Based on these arguments, this study explores the direct impact of assets on the economic mobility of single mothers as well as assets' possible indirect impact through its influence on human capital development.

*Assets and Economic Well-Being*

In the last decade, as more attention has been given to assets as an indicator of household economic status, some studies have explored how assets are associated with the economic well-being of single-mother families. Cho (1999) found that financial assets had positive effects on the economic well-being of women after their marital disruption; financial assets were associated with increased income and reduced welfare dependency of divorced women. Rocha (1997) found that single mothers with assets (home ownership and savings) were more likely to live above the 100 percent poverty level compared with their counterparts without such assets. Raheim and Alter (1995) noted that assets appeared to increase the economic security of families on public assistance. Cheng (1995) further indicated that assets could help reduce the intergenerational transmission of poverty in female-headed households.

*Assets and Human Capital Development*

A few studies also have examined the impact of assets on labor force participation and educational improvement. Yadama and Sherraden (1996) found that among general population, both house values and savings were positively related to future planning activities, such as finding a new job. However, they found that assets were not related to productive money saving or human capital accumulation activities. Cho (2001) found that asset holding (both financial assets and having a vehicle) before and one-year after marital disruption was related to increased work hours of divorced women, especially for non-remarried women. Self-report surveys of the participants of structured savings programs for the poor
(McBride, Lombe, & Beverly, 2003) further indicated that participants were more likely to plan for their and their children's education after joining the programs.

Human Capital Development and Economic Well-Being

Human capital theory argues that investment in human capital can raise future returns in the labor market even though one may forgo short-term earnings for long-term gains (Becker, 1993; Mincer, 1979, 1989; Schultz, 1993). Human capital usually refers to education, work experience, and job-related training.

Empirical studies indicate that educational attainment, especially post-secondary education, positively affects the economic standing of single mothers (e.g., Cho, 1999; Mauldin, 1990; McKeever & Wolfinger, 2001; Rocha, 1997; Smock, 1993). Most of these studies have examined the economic status of divorced women after a couple of years of their marital disruption. The longitudinal study of Sandfort and Hill (1996) further showed that young single mothers' education predicted their self-sufficiency and increased the possibility to get married in later years. Studies that examine the economic status of welfare leavers also indicate that a majority of former welfare recipients with postsecondary education worked at jobs with better pay and benefits, and were less likely to return to welfare (Cancian, 2001; Harris, 1996; Loprest, 2002; Meyer & Cancian, 1998; Smith, Deprez, & Butler, 2002; Strawn, 2004).

In terms of the impact of employment and job training, studies found that employed single mothers and those with more work hours had higher incomes (Dixon & Rettig, 1994; Mauldin, 1990; Smock, 1993, 1994). The findings on the impact of single mothers' prior work history are mixed (Bianchi, Subaiya, & Kahn, 1999; Smock, 1993, 1994). Findings on the effects of job training are also mixed (Cho, 1999; Hamilton, 2002; Mauldin, 1990; Mauldin & Koonce, 1990).

This Study

As seen from the above discussion, this previous research has several limitations. First, the potential association between assets and the long-term economic well-being of single mothers has not been adequately studied. Second, the possible mediat-
ing effect of human capital development in the link between assets and economic mobility, which is highlighted by theoretical arguments, has not been examined. Third, it is also important to investigate whether the impact of assets varies by the income levels of single mothers. Through the analysis of a nationally longitudinal representative sample, this study examines how the asset accumulation of single mothers (measured in 1994) and their human capital development (measured between 1995 and 1999) are related to their economic mobility (changes of income-to-needs ratio in 2000 compared to that in 1994). This study investigates how these relationships differ by single mothers’ income levels.

Methods

Data and Sample

This study uses data from the National Longitudinal Survey of Youth (1979 cohort, NLSY79), a household survey of a representative sample of 12,868 young men and women who were 14 to 22 years when first interviewed in 1979 (Center for Human Resource Research, 2001). Respondents were interviewed annually between 1979 and 1994, and then biannually between 1994 and 2002. The NLSY79 is well-suited for the purpose of this study because it oversamples the economically disadvantaged population, and it includes a variety of asset measures.

The sample for this study includes the respondents who were single mothers in 1994, remained in the sample, and have relevant information during the study period (1994-2000). Single mothers were defined as female respondents who were not married and had at least one child under 18 living in households in 1994. After listwise deletion of cases with missing data for all variables used in the analysis, the final sample include 704 single mothers (N = 856 before deletion). Further analysis indicates that there is no systematic difference in the demographic and socioeconomic characteristics between the missing data sample and the study sample. Thus bias as a result of missing data is likely to be minimal.

In order to examine how assets and other factors influence
the economic mobility of single mothers with different economic status, the sample is divided into three groups for analyses according to their income-to-needs ratio in 1994: mothers who lived below the 100% federal poverty ("poor single mothers"), mothers who lived between the 100% and 200% federal poverty ("middle-income single mothers"), and those who lived above the 200% federal poverty ("high-income single mothers").

Measures

Assets. The assets of a mother includes her net worth and three types of ownership in 1994. Net worth in 1994 was calculated by subtracting the total value of debts (debts of home, business, credit card and others) from the total value of assets (assets of home, business, bank accounts, real estate, stocks, and all other assets). Because the distribution of this variable was quite skewed, the natural log of this measure was used in regression models.

Dichotomous measures of assets ownership include home ownership (yes = 1, no = 0), savings or checking account ownership (yes = 1, no = 0), and automobile ownership (yes = 1, no = 0). Dichotomous measures instead of actual amounts of these assets are included because the values of these types of assets are correlated with net worth. Other types of assets ownership (e.g., IRAs, CDs, stocks, business) were not included in the analyses because a small percentage of single mothers had these assets.

Human Capital Development. The human capital development of a mother includes her educational advancement, work experience, and job-related training between 1995 and 1999. Educational advancement is measured as whether women had any increased educational years during this period (yes = 1, no = 0). Work experience is measured as the average annual work hours, and job training indicates whether women had received any forms of job-related training (yes = 1, no = 0).

Economic Mobility. The dependent variable in this study, the economic mobility of a mother, is measured as the change of her income-to-needs ratio in 2000 compared to that in 1994. A family's income-to-needs ratio is defined as family income divided by the family-size-adjusted poverty guideline. Family income in NLSY79 is measured as the sum of income of all
Control Variables. Because of their potential influence on the economic mobility indicated by previous studies (see a review by Caputo, 2003), the following demographic, social and economic variables are included in the analysis as control variables. The inclusion of these variables will help eliminate omitted variable bias and possible alternative explanations of variance in the dependent variables.

Variables that were measured in 1994 include women's age, race/ethnicity, marital status, educational status, number of children in households, health status, and income-to-needs ratio. Race/ethnicity was dummy coded (White, African American, and others), and White is the reference group in regression analyses. Marital status also was dummy coded: those who were never married are the reference group and coded as 0, and those who were previously married (divorced, separated, or widowed) were coded as 1. Mother's education in 1994 was coded as a nominal variable with three categories: less than high school degree (<12 years of education), high school degree (12 years of education), some college education or above education (>12 years of education). This variable was dummy-coded in multiple regressions, with less than a high school degree being the reference group. Health status is measured as whether mothers had any health problems that limited types or amount of work that they could do (yes=1, no=0). The age of a mother at the birth of her first child is also controlled.

In order to control for environmental factors, whether women lived in rural areas and the unemployment rates of their residence in 1994 are included. In addition, due to their potential influence on the economic mobility, three cumulative variables between 1995 to 1999 are also included: whether women got married (yes=1, no=0), whether they had new child(ren) (yes=1, no=0), and years they had received AFDC/TANF.

Analysis

Descriptive information was first presented on the characteristics of poor, middle-income, and high-income single mothers. In order to examine the independent impact of assets and human capital development on the economic mobility
after controlling for other demographic and socioeconomic factors, and to examine possible mediating effects of human capital development, hierarchical regression models were used in which economic mobility was first regressed on control variables, and then assets and human capital development were added sequentially to the models. Results of regression analyses are presented separately for poor, middle-income and high-income mothers.

Results

The characteristics of the sample are presented in Table 1. Of the 704 single mothers in 1994, 36% (n=257) lived below the 100% federal poverty, 33% (n=229) lived between the 100% and 200% federal poverty, and 31% (n=218) lived above the 200% federal poverty. Lower-income single mothers were more likely to be African Americans, to be never married, and to have health problems, and they were less educated and had more children living in households. Lower-income mothers also were less likely to get married and more likely to have additional children between 1995 and 1999. Some characteristics of the middle-income mothers, such as race/ethnicity, marital status, whether having health problems, and percentages of having new-born children, were similar to those of high-income mothers.

Single mothers were also diverse in their assets accumulation and human capital development. While three groups of mothers all made progress in their asset accumulation between 1994 and 2000, especially in home ownership and bank account ownership, middle-income mothers had lower, and poor mothers had much lower asset ownership and net worth in both 1994 and 2000 than high-income mothers. Poor single mothers were much less likely to receive job training and to continue their education compared to other two groups. Middle-income single mothers on average had the most increase in their upward economic mobility (0.81), followed by poor single mothers (0.64) and high-income single mothers (0.55).

As mentioned, in order to examine how assets and human capital development in the model.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Women below 100% poverty (N=257)</th>
<th>Women between 100% and 200% poverty (N=229)</th>
<th>Women above 200% poverty (N=218)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean or Percentage</td>
<td>Mean or Percentage</td>
<td>Mean or Percentage</td>
</tr>
<tr>
<td>Control Variables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>33</td>
<td>33</td>
<td>33</td>
</tr>
<tr>
<td>Race / ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td></td>
<td>48%</td>
<td>51%</td>
</tr>
<tr>
<td>African American</td>
<td></td>
<td>45%</td>
<td>43%</td>
</tr>
<tr>
<td>Others</td>
<td></td>
<td>7%</td>
<td>6%</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Never married</td>
<td>47%</td>
<td>33%</td>
<td>30%</td>
</tr>
<tr>
<td>Previously married</td>
<td>53%</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>Educational Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than high school</td>
<td>33%</td>
<td>15%</td>
<td>6%</td>
</tr>
<tr>
<td>HS graduate</td>
<td>50%</td>
<td>48%</td>
<td>44%</td>
</tr>
<tr>
<td>Some college</td>
<td>15%</td>
<td>32%</td>
<td>33%</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
<td>2%</td>
<td>5%</td>
<td>16%</td>
</tr>
<tr>
<td>Number of children</td>
<td>2.5</td>
<td>2.0</td>
<td>1.6</td>
</tr>
<tr>
<td>Age at birth of first child</td>
<td>19</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Having health limitations</td>
<td>23%</td>
<td>8%</td>
<td>6%</td>
</tr>
<tr>
<td>Living in rural areas</td>
<td>20%</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>Unemployment rate of residence</td>
<td>2.9</td>
<td>2.9</td>
<td>2.8</td>
</tr>
<tr>
<td>Having newborn child(ren) (1995-1999)</td>
<td>19%</td>
<td>13%</td>
<td>11%</td>
</tr>
<tr>
<td>Having been married (1995-1999)</td>
<td>19%</td>
<td>28%</td>
<td>38%</td>
</tr>
<tr>
<td>Years of receiving welfare (1995-1999)</td>
<td>2.4</td>
<td>0.8</td>
<td>0.2</td>
</tr>
<tr>
<td>Assets in 1994</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership</td>
<td>11%</td>
<td>23%</td>
<td>39%</td>
</tr>
<tr>
<td>Bank account ownership</td>
<td>18%</td>
<td>49%</td>
<td>70%</td>
</tr>
<tr>
<td>Automobile ownership</td>
<td>49%</td>
<td>77%</td>
<td>85%</td>
</tr>
<tr>
<td>Net worth ($)</td>
<td>4,276</td>
<td>10,524</td>
<td>18,864</td>
</tr>
<tr>
<td>Assets in 2000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership</td>
<td>21%</td>
<td>43%</td>
<td>58%</td>
</tr>
<tr>
<td>Bank account ownership</td>
<td>28%</td>
<td>57%</td>
<td>72%</td>
</tr>
<tr>
<td>Automobile ownership</td>
<td>56%</td>
<td>79%</td>
<td>87%</td>
</tr>
<tr>
<td>Net worth ($)</td>
<td>4,498</td>
<td>10,873</td>
<td>20,475</td>
</tr>
<tr>
<td>Human Capital Development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having educational advancement</td>
<td>10%</td>
<td>14%</td>
<td>15%</td>
</tr>
<tr>
<td>Having received job training</td>
<td>28%</td>
<td>40%</td>
<td>44%</td>
</tr>
<tr>
<td>Average annual work hours</td>
<td>1,091</td>
<td>1,771</td>
<td>2,035</td>
</tr>
<tr>
<td>Dependent Variable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in income-to-needs ratio</td>
<td>0.64</td>
<td>0.81</td>
<td>0.55</td>
</tr>
</tbody>
</table>

capital development are related to the economic mobility of
Economic Mobility of Single Mothers

single mothers, three regression analyses were conducted for the poor, middle-income, and high-income single mothers, with economic mobility regressed on control variables and then on assets and human capital development variables. Results are presented in Tables 2, 3, and 4. To further examine whether the

Table 2: Regression Analysis of Women’s Economic Mobility: Women below 100% Poverty

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficients</th>
<th>Coefficient</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age in 1994 (White)</td>
<td>0.07</td>
<td>0.08</td>
<td>0.09</td>
</tr>
<tr>
<td>Age in 1994 (African American)</td>
<td>-0.04</td>
<td>0.08</td>
<td>0.11</td>
</tr>
<tr>
<td>Age in 1994 (Others)</td>
<td>-0.49</td>
<td>-0.40</td>
<td>-0.50</td>
</tr>
<tr>
<td>(Never married)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously married</td>
<td>0.34*</td>
<td>0.19</td>
<td>0.12</td>
</tr>
<tr>
<td>(Less than high school)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>0.30</td>
<td>0.14</td>
<td>0.18</td>
</tr>
<tr>
<td>Some college or above education</td>
<td>0.38</td>
<td>0.14</td>
<td>0.03</td>
</tr>
<tr>
<td>Number of children in households</td>
<td>-0.11</td>
<td>-0.11</td>
<td>-0.13</td>
</tr>
<tr>
<td>Age at the birth of first child</td>
<td>-0.01</td>
<td>-0.02</td>
<td>-0.02</td>
</tr>
<tr>
<td>Health limitations</td>
<td>-0.25</td>
<td>-0.34</td>
<td>-0.13</td>
</tr>
<tr>
<td>Income-to-needs ratio in 1994</td>
<td>-0.83**</td>
<td>-0.69*</td>
<td>-0.68*</td>
</tr>
<tr>
<td>Rural residents</td>
<td>-0.12</td>
<td>-0.09</td>
<td>-0.08</td>
</tr>
<tr>
<td>Unemployment rate of residence</td>
<td>-0.03</td>
<td>-0.03</td>
<td>-0.02</td>
</tr>
<tr>
<td>Having additional children</td>
<td>-0.23</td>
<td>0.16</td>
<td>-0.07</td>
</tr>
<tr>
<td>Having been married</td>
<td>0.68**</td>
<td>0.62**</td>
<td>0.47*</td>
</tr>
<tr>
<td>Years of receiving welfare</td>
<td>-0.09*</td>
<td>-0.07</td>
<td>-0.04</td>
</tr>
<tr>
<td><strong>Assets Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership</td>
<td>-0.43</td>
<td>-0.43</td>
<td></td>
</tr>
<tr>
<td>Bank account ownership</td>
<td>0.69**</td>
<td>0.59*</td>
<td></td>
</tr>
<tr>
<td>Automobile ownership</td>
<td>0.45*</td>
<td>0.45*</td>
<td></td>
</tr>
<tr>
<td>Log net worth</td>
<td>0.81</td>
<td>0.21</td>
<td></td>
</tr>
<tr>
<td><strong>Human Capital Development 1995-2000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational advancement</td>
<td></td>
<td></td>
<td>0.73*</td>
</tr>
<tr>
<td>Receiving training</td>
<td></td>
<td></td>
<td>-0.19</td>
</tr>
<tr>
<td>Work hours</td>
<td></td>
<td></td>
<td>0.0002</td>
</tr>
<tr>
<td><strong>R^2</strong></td>
<td>0.21</td>
<td>0.26</td>
<td>0.30</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>257</td>
<td>257</td>
<td>257</td>
</tr>
</tbody>
</table>

Note —Categories in parentheses are reference groups.

* p<.05. ** p<.01. *** p<.001.
impact of assets on the economic mobility differ by mothers’ income levels, a regression analysis on the economic mobility was conducted for the full sample which included interactions of asset variables with mothers’ economic levels (middle-income mothers was the reference group) (Table 5).

**Poor Single Mothers.** Table 2 shows that the regression model was statistically significant and the control variables together explained about 21% of the variance in economic mobility.

### Table 3: Regression Analysis of Women’s Economic Mobility: Women above 100% and below 200% Poverty

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficients</th>
<th>Coefficient</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at 1994 (White)</td>
<td>-0.01</td>
<td>0.002</td>
<td>0.003</td>
</tr>
<tr>
<td>African American</td>
<td>-0.08</td>
<td>0.14</td>
<td>-0.002</td>
</tr>
<tr>
<td>Others</td>
<td>0.06</td>
<td>0.17</td>
<td>0.12</td>
</tr>
<tr>
<td>(Never married)</td>
<td>-0.02</td>
<td>0.05</td>
<td>-0.09</td>
</tr>
<tr>
<td>(Less than high school)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>0.32</td>
<td>0.20</td>
<td>0.23</td>
</tr>
<tr>
<td>Some college or above education</td>
<td>0.37</td>
<td>0.21</td>
<td>0.31</td>
</tr>
<tr>
<td>Number of children in households</td>
<td>-0.22*</td>
<td>-0.20*</td>
<td>-0.19*</td>
</tr>
<tr>
<td>Age at the birth of first child</td>
<td>-0.05</td>
<td>-0.05</td>
<td>-0.06</td>
</tr>
<tr>
<td>Health limitations</td>
<td>0.35</td>
<td>0.41</td>
<td>0.80*</td>
</tr>
<tr>
<td>Income-to-needs ratio in 1994</td>
<td>-0.31</td>
<td>-0.35</td>
<td>-0.36</td>
</tr>
<tr>
<td>Rural residents</td>
<td>0.46</td>
<td>0.61*</td>
<td>0.55*</td>
</tr>
<tr>
<td>Unemployment rate of residence</td>
<td>0.04</td>
<td>0.04</td>
<td>0.08</td>
</tr>
<tr>
<td>Having additional children</td>
<td>-0.85*</td>
<td>-0.75*</td>
<td>-0.81*</td>
</tr>
<tr>
<td>Having been married</td>
<td>1.42***</td>
<td>1.54***</td>
<td>1.64***</td>
</tr>
<tr>
<td>Years of receiving welfare</td>
<td>-0.11</td>
<td>-0.05</td>
<td>-0.07</td>
</tr>
<tr>
<td><strong>Assets Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership</td>
<td>0.14</td>
<td>0.14</td>
<td></td>
</tr>
<tr>
<td>Bank account ownership</td>
<td>0.78*</td>
<td>0.27</td>
<td></td>
</tr>
<tr>
<td>Automobile ownership</td>
<td>0.26</td>
<td>0.04</td>
<td></td>
</tr>
<tr>
<td>Log net worth</td>
<td>0.61</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td><strong>Human Capital Development 1995-2000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational advancement</td>
<td>0.67*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receiving training</td>
<td>0.03</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work hours</td>
<td>0.0002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R²</td>
<td>0.26</td>
<td>0.34</td>
<td>0.41</td>
</tr>
<tr>
<td>N</td>
<td>229</td>
<td>229</td>
<td>229</td>
</tr>
</tbody>
</table>

Note — Categories in parentheses are reference groups.

* *p < .05. **p < .01. ***p < .001.
Among the control variables, women who were previously married in 1994 and those who got married between 1995 and 2000 had more increase in their income-to-needs ratio. Single mothers who received more years of welfare had less upward economic mobility. Income status in 1994 was negatively related to the upward economic mobility, i.e., the poorest poor had lower economic mobility.

After assets variables entered, the $R^2$ increased by about 24% (from 21% to 26%). Results show that bank account ownership and automobile ownership of poor single mothers were positively related to their economic mobility; home ownership and net worth, however, were not related their economic mobility (the correlation coefficient for home ownership was negative). Furthermore, after assets variables were entered, the relationships between marital status in 1994 and years of receiving welfare with economic mobility disappeared, indicating that assets may account for the links between these variables and economic mobility.

Table 2 also shows the full model with human capital variables added. Poor single mothers who continued their education experienced higher level of economic mobility. Work hours and receiving training, however, were not related to economic mobility. In addition, after these three variables were entered, bank account ownership and automobile ownership were still related to economic mobility; the coefficients for bank account ownership, however, dropped by about 15% (from 0.69 to 0.59).

**Middle-Income Single Mothers.** Table 3 shows that the regression model for single mothers who lived above poverty but below 200% poverty line. The model was statistically significant and the control variables together explained about 26% of the variance in economic mobility. Among the control variables, women who had more children and those had new child between 1995 and 1999 had less economic mobility. Those who got married during this period had more increase in income-to-needs ratio.

After assets variables were entered, the $R^2$ increased by about 31% (from 26% to 34%). Bank account ownership of single mothers was positively related to their economic mobility; home ownership, automobile ownership, and net
worth, however, were not related to their economic mobility. Results also show that women who had educational improvement after 1994 also had higher increase in income-to-needs ratio. Furthermore, after human capital variables were entered, the relationship between bank account and economic mobility

Table 4: Regression Analysis of Women's Economic Mobility:
Women above 200% Poverty

<table>
<thead>
<tr>
<th>Variables</th>
<th>Coefficients</th>
<th>Coefficient</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Control Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age in 1994 (White)</td>
<td>0.09</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>African American</td>
<td>0.28</td>
<td>0.28</td>
<td>0.21</td>
</tr>
<tr>
<td>Others</td>
<td>0.72</td>
<td>0.65</td>
<td>0.55</td>
</tr>
<tr>
<td>(Never married)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previously married</td>
<td>0.25</td>
<td>0.21</td>
<td>0.23</td>
</tr>
<tr>
<td>(Less than high school)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school graduate</td>
<td>0.41</td>
<td>0.38</td>
<td>0.26</td>
</tr>
<tr>
<td>Some college or above education</td>
<td>0.49</td>
<td>0.36</td>
<td>0.41</td>
</tr>
<tr>
<td>Number of children in households</td>
<td>0.03</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Age at the birth of first child</td>
<td>0.02</td>
<td>0.02</td>
<td>0.03</td>
</tr>
<tr>
<td>Health limitations</td>
<td>-1.31*</td>
<td>-1.19</td>
<td>-1.07</td>
</tr>
<tr>
<td>Income-to-needs ratio in 1994</td>
<td>-0.21</td>
<td>-0.17</td>
<td>-0.20</td>
</tr>
<tr>
<td>Rural residents</td>
<td>0.14</td>
<td>0.32</td>
<td>0.25</td>
</tr>
<tr>
<td>Unemployment rate of residence</td>
<td>0.17</td>
<td>0.21</td>
<td>0.13</td>
</tr>
<tr>
<td>Having additional children</td>
<td>-0.16</td>
<td>-0.16</td>
<td>-0.07</td>
</tr>
<tr>
<td>Having been married</td>
<td>0.31</td>
<td>0.29</td>
<td>0.29</td>
</tr>
<tr>
<td>Years of receiving welfare</td>
<td>-0.39</td>
<td>-0.38</td>
<td>-0.38</td>
</tr>
<tr>
<td><strong>Assets Variables</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership</td>
<td>0.11</td>
<td>0.11</td>
<td></td>
</tr>
<tr>
<td>Bank account ownership</td>
<td>0.15*</td>
<td>0.09*</td>
<td></td>
</tr>
<tr>
<td>Automobile ownership</td>
<td>0.11</td>
<td>0.10</td>
<td></td>
</tr>
<tr>
<td>Log net worth</td>
<td>0.25*</td>
<td>0.19*</td>
<td></td>
</tr>
<tr>
<td><strong>Human Capital Development 1995-2000</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational advancement</td>
<td></td>
<td></td>
<td>0.41*</td>
</tr>
<tr>
<td>Receiving training</td>
<td></td>
<td></td>
<td>0.56*</td>
</tr>
<tr>
<td>Work hours</td>
<td></td>
<td></td>
<td>0.008**</td>
</tr>
<tr>
<td>R²</td>
<td>0.11</td>
<td>0.13</td>
<td>0.20</td>
</tr>
<tr>
<td>N</td>
<td>218</td>
<td>218</td>
<td>218</td>
</tr>
</tbody>
</table>

Note --- Categories in parentheses are reference groups.  
*, **, *** p<.05, .01, .001.

Table 5: Regression Analysis of Women's Economic Mobility:
### Variables

#### Control Variables

- **Age in 1994**: 0.06
- **(White)**
  - African American: 0.29
  - Others: 0.16
- **(Never married)**
  - Previously married: 0.15
- **(Less than high school)**
  - High school graduate: 0.23
  - Some college or above education: 0.48 *
- **Number of children in households**: -0.11 *
- **Age at the birth of first child**: 0.05
- **Health limitations**: -0.15
- **Rural residents**: -0.01
- **Unemployment rate of residence**: -0.09
- **Having additional children**: -0.23 *
- **Having been married**: 0.65 **
- **Years of receiving welfare**: -0.07
- **(Middle-income mothers)**
  - Poor mothers: -1.49 *
  - High-income mothers: -0.69

#### Assets Variables

- **Home ownership**: 0.07
- **Bank account ownership**: 0.38 *
- **Automobile ownership**: 0.08
- **Log net worth**: 0.17 *

### Human Capital Development 1995-2000

- **Educational advancement**: 0.19 *
- **Receiving training**: 0.08
- **Work hours**: 0.0003 *

#### Interactions of assets with mothers' income status

- **Home ownership * poor mothers**: -0.16
- **Bank account ownership * poor mothers**: -0.27 *
- **Automobile ownership * poor mothers**: 0.21
- **Log net worth * poor mothers**: -0.22
- **Home ownership * high-income mothers**: 0.29
- **Bank account ownership * high-income mothers**: 0.06
- **Automobile ownership * high-income mothers**: -0.28
- **Log net worth * high-income mothers**: 0.41 *

#### Other Statistics

- $R^2$: 0.13
- $N$: 704

---

Note — Categories in parentheses are reference groups.

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

disappeared, indicating educational advancement may mediate the links between bank account ownership and economic mobility for these mothers.

### High-Income Single Mothers

Table 4 shows that the re-
gression model for high-income mothers was statistically significant, and the control variables together explained about 11% of the variance in economic mobility. Among control variables, only health status was negatively related to the economic mobility, i.e., women who had health problems were less likely to improve their economic status.

After assets variables were entered, the $R^2$ increased by about 18% (from 11% to 13%). Bank account ownership and net worth were positively related to their economic mobility. After human capital development variables were further added, results show that women who had educational improvement, receiving training, and those who worked more hours had higher increase in income-to-needs ratio. Furthermore, after human capital variables were entered, bank account and net worth were still positively related to with economic mobility, but their coefficients moderately dropped (about 40% drop for bank account ownership, and 25% drop for net worth).

What factors might explain why the middle-income mothers made the most progress in their upward economic mobility? First, the high-income mothers were probably not changing much in their economic status because they were already in good shape in 1994. Second, the above results indicate that marital status, educational advancement, and asset accumulation might help explain the differences in the economic mobility between poor mothers and middle-income mothers. Getting married between 1994 and 2000 was positively related to the economic mobility for both poor and middle-income mothers. However, a much higher proportion of middle-income mothers (28%) got married than poor mothers (19%). Similarly, educational advancement was related to the economic mobility of both groups of mothers, and middle-income mothers were much more likely to continue their education (40%) than poor mothers (28%).

The results presented in Tables 2-4 also suggest that asset accumulation might have stronger association with the economic mobility for middle-income single mothers. For example, after assets variables were added to the model for middle-income mothers, the variance explained in the economic mobility increased by 31%, compared to 24% increase in the model for poor mothers and 18% increase in the model for high-income
Economic Mobility of Single Mothers

mothers. Furthermore, for middle-income mothers, the impact of bank account ownership on the economic mobility operated mainly through its influence on educational advancement (Table 3). This indicates that bank account ownership may have stronger impact on the educational improvement of these mothers. In order to further determine whether the impact of assets on the economic mobility varies by the three income levels of single mothers, interaction terms between mothers' income levels and asset variables were constructed and added into the regression model on the economic mobility for the full sample (Table 5). Results show that compared to poor mothers, bank account ownership had stronger impact on the economic mobility for middle-income mothers. Net worth had stronger impact on the economic mobility for high-income mothers.

Discussion and Implications

Consistent with previous studies, this study found positive associations between assets and the economic mobility of single mothers, after controlling for household income and a variety of other respondent characteristics. The links between assets and economic mobility, however, were different for poor, middle-income, and high-income mothers. Net worth was only linked to the economic mobility for high-income mothers. It is possibly because net worth was much lower for mothers living below the 200% federal poverty. Automobile ownership was only related to the economic mobility of poor mothers, perhaps because the automobile was the only important asset for most of these mothers. Furthermore, bank account ownership had stronger influence on the economic mobility of middle-income mothers than its impact on poor mothers, which helps explain the higher levels in the economic mobility of middle-income mothers.

Home ownership was not related to the economic mobility of single mothers in this study (for poor single mothers, the coefficient was negative). This is not consistent with findings from some previous research (Scanlon & Page-Adams, 2001). The possible poor quality of housing owned by single mothers, especially by poor mothers, may contribute to this inconsistency. Previous studies have suggested that the lo-
cation of a home and neighborhood conditions may be as important as ownership (Coulton, 2003; Denton, 2001; Finn, Zorita, & Coulton, 1994). This issue is very important for the consideration of asset-based policies, and more studies are needed.

Furthermore, the results show that after human capital variables were added into the model, the relationships between mothers' bank account ownership and upward economic mobility disappeared for middle-income mothers. This result provides somewhat tentative evidence that mothers' human capital development may mediate the relationship between bank account ownership with the economic mobility of these mothers. In other words, owning bank accounts may provide some economic security for middle-income single mothers to pursue further education or job-related training. These findings may be able to provide some insight into possible mechanisms that transmit the economic effects of assets. Again, these mechanisms could be different for single mothers with different economic status and need to be further elaborated.

Mother's education advancement increased their upward economic mobility, irrespective of their income levels. Work hours, however, were related to the economic mobility of higher-income mothers only. It is possibly because low-income single mothers are more likely to have low-wage jobs that offer little opportunities for advancement. Similarly, job-related training was only positively linked to the economic mobility of high-income mothers, perhaps due to the fact that this group of single mothers is more likely to receive high quality job training with potentials for career advancement. These findings may indicate that the quality of employment or job-related training of single mothers is important for their economic upward mobility. Somewhat surprisingly, educational status in 1994 of mothers was not related to their economic mobility. Further analysis indicates that for the full sample, education was positively linked with economic mobility. Limited variations in educational status within each group of mothers may contribute to the insignificant findings.

It is worth mentioning that different demographic factors were related to the economic mobility of poor, middle-income and high-income mothers. For example, marriage helped
Economic Mobility of Single Mothers

improve the economic status of poor and middle-income single mothers, but not for the mothers living above the 200% federal poverty. This is possibly because high-income mothers were better educated and were more likely be employed, thus depending less on marriage to improve their economic status. Also, number of children and having additional children were negatively related to the economic mobility of middle-income mothers only. This may be due to the fact that these mothers were more likely to be employed than poor mothers; on the other hand, they had less financial ability to pay quality childcare compared to high-income mothers (Hofferth, 1995). Thus, reliable child care maybe a more important factor that prevents these single mothers from participating in the labor force or skill-building activities, thus reducing their earnings potential.

When interpreting the above results, it should be noted that while causal ordering was established between assets (measured in 1994), human capital development (measured between 1995 and 1999), and economic mobility (measured in 2000), possible alternative explanations exist. A wide range of personal, family, and community characteristics could affect assets accumulation, human capital development, and economic mobility of single mothers. In other words, single mothers who own assets may have unobserved characteristics that also lead to human capital development and economic mobility. It could be that these characteristics are causing both assets and development. Although important factors that were indicated by previous studies have been controlled in this study, it is not possible to control for all relevant variables.

The results from this study suggest that promoting asset accumulation of single mothers could be a useful strategy to improve their economic status. Asset building strategy could be particularly potential to help the middle-income single mothers (i.e., mothers living between the 100% and 200% of federal poverty) improve their educational status and economic well-being. While bank account and automobile ownership were positively related to the economic mobility of poor mothers, these mothers benefited less from their assets compared to higher-income mothers. Thus, asset-building programs may need to be adjusted to accommodate specific
needs of poor single mothers.

Home ownership of single mothers was not related to economic mobility, indicating that poor neighborhood conditions may be an obstacle to asset accumulation and compromise the positive impact of assets. Asset-building programs that incorporate community services and that are tailored to specific life circumstances of single mothers may have better potential to promote their economic well-being.

Among human capital variables, this study shows that education advancement helped single mothers improve their economic status, irrespective their poverty status. Obtaining continued education, however, is often difficult for single mothers, especially for low-income single mothers with small children who are trying to juggle through multiple responsibilities. For example, this study found only a small percentage of women had advanced their education. Thus, special designed policies or programs are perhaps needed to promote their education. The results of this study also underscore the importance of high-quality employment or job-related training for low-income mothers.

In sum, the findings from this study support strategies of assets building and human capital development to help enhance single mothers' economic status. It is equally important to note that single mothers are a diverse group and assets may have different impact on the economic mobility of its subgroups. Asset-building policies and programs may need to take into particular consideration of the specific life context of poor single mothers.

References


Economic Mobility of Single Mothers

policy and Economy, 7, 73-110.


Fairness Issues in Law and Mental Health: Directions for Future Social Work Research

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Concepts from the procedural justice literature in social psychology are examined that offer useful guidance for social work researchers with interests in investigating informal adjudications, speciality treatment courts, and other areas of the administrative process previously neglected in mental health services research. These theoretical concepts are offered as an alternative to the therapeutic jurisprudence framework being adopted by some social workers in the field of law and mental health. The issues outlined in this paper also draw on the health services and psychotherapy literature to highlight issues involving process and procedure as social justice and their significance for advancing a new role for social work researchers in the field of law and mental health research.

Keywords: procedural justice, law and mental health, therapeutic jurisprudence, treatment courts

This paper examines issues of fairness and justice in the field of law and mental health. Justice is one of the many moral standards employed by philosophers and ethicists to evaluate
the social institutions of any society (Folger & Cropanzano, 1998; Cohen, 1989). Justice has become a major area of study in the social and the behavioral sciences (Bierhoff, Cohen & Greenberg, 1986; Deutsch, 1985; Folger, 1984; Lerner & Lerner, 1981; Mikula, 1980; Wakefield, 1988a; Wakefield, 1988b). In addition, there is a burgeoning body of research derived from classic works in social psychology on procedural (Deutsch, 1975; Lind & Tyler, 1988; Thibault & Walker, 1975) and distributive (Greenberg & Cohen, 1982; Walster, Walster, & Berscheid, 1978) issues of justice.

Although social work as a profession has had a longstanding commitment to values of social and economic justice (CSWE, 1994; NASW, 1999), social work researchers have contributed minimally to our understanding of the role of justice in the field of law and mental health. Psychologists, psychiatrists, and lawyers have dominated most advances in this field of scientific inquiry. Yet these professionals do not possess the same avowed commitments to social justice as the profession of social work.

In the field of law and mental health, therapeutic jurisprudence has gained prominence as a useful framework for examining issues of law and policy (Tomkins & Carson, 1999). Therapeutic jurisprudence (TJ) directs researchers to concentrate on the law as a therapeutic agent by examining the therapeutic consequences of the law (Madden & Wayne, 2003). This approach to social legal inquiry focuses on whether the legal rule or practice contributes to the psychological and physical well-being of a person who is subject to legal proceedings (Rottman & Casey, 1999). For this reason, some social workers are also looking to this framework as an important guide to research and practice in the field of law and mental health (Madden & Wayne, 2003).

While this framework is consistent with values that are important to social workers, it does not take into account issues of fairness involving procedures and interpersonal processes that influence how consumers evaluate the fairness of their mental health services. Indeed TJ helps us focus on effective outcomes, but does not specify or give explicit theoretical guidance as to how the law should promote the achievement of therapeutic effects in any area of mental health law (Carson,
2003; Kress, 1999; LaFond, 1999; Sales & Shulman, 1996). This lack of theoretical guidance is one of the important reasons why social workers should be open to integrating other useful conceptual frameworks into their research of issues involving the interface of law and mental health.

The purpose of this paper is to examine how evolving theoretical conceptions of fairness in social psychology can assist social workers in advancing research in the field of law and mental health. Wakefield (1988a; 1988b) established the utility of employing distributive justice as a framework for guiding social work practice and the conceptual links between psychotherapy and justice. In this paper, we argue that social workers also need to adopt procedural justice as a framework for investigating social justice concerns in the field of law and mental health not covered by concepts in the distributive justice framework.

The paper begins with a brief overview of traditional legal assumptions about the exclusion of extra-legal factors, such as science and justice, in law and in law-like decision-making processes. To set the background, we also examine how the architects of therapeutic jurisprudence have offered useful insights about the role of science in law that can be exploited by social work researchers to realize some of their own social justice aims. Following this, we review the literature in social psychology on procedural justice to clarify how decision-making procedures and interpersonal processes are linked with social justice concerns involving issues of fairness. In examining this social science literature, we also identity concepts that can guide the research and the evaluation of services in the field of law and mental health. We conclude with a review of developments in law and mental health procedures and in interpersonal processes that can benefit from research by social workers with interest in procedural and interpersonal justice matters.

Background of the Problem

Scholars and advocates in mental health have a long history of appealing to justice in evaluating and in defending their standards of care. However, these appeals are rarely uniform
since they do not involve a claim to a distinctive principle of justice. Throughout the course of human history, a diverse array of meanings, values, and interpretations has been applied to the concept of justice. Aristotle, for instance, assumed that equality and lawfulness were two key characteristics of justice. At other points in history, different dimensions of the concept of justice have gained prominence such as fairness (Rawls, 1971), liberty (Nozick, 1974), fundamental human rights (Dworkin, 1977), impartiality (Barry, 1996), caring (Gilligan, 1977; 1982), needs (Deutsch, 1985), and social utility (Pound, 1951). Policy makers, administrators, and jurists confront the perennial task of having to strike a balance between these competing moral principles. Yet, the role of social science in this selection and ranking process has not been clarified.

Traditional scholarship in justice studies has relied primarily on normative and legal methods of inquiry. As a consequence, justice issues were considered a fundamental province of the disciplines of moral philosophy and law (Faden & Beauchamp, 1986). In moral philosophy, the objective is to provide a defense or justification for theories and principles that serve as “action-guides” in social relationships (Faden & Beauchamp, 1986). For example, the prominent theories of Rawls (1971) and Nozick (1974) on social justice have stimulated substantial debate in academic and in policy circles about appropriate principles for allocating social benefits. The aims of each of these treatises on justice are different from the pragmatic aims found in traditional legal scholarship that has been challenged by the developer of TJ (Wexler, 1993). In traditional methods of legal inquiry, issues of justice arise from the specific relief sought in legal disputes (Redlich, 1981). That is, justice problems do not arise from a study of philosophical theory or from trying to resolve a general problem of justice (Cahn, 1944). In the world of Anglo-American law, justice is considered a prescriptive guide to action that is extracted from established legal precedents deemed relevant for remedying a specific legal dispute (Wexler, 1993). This doctrinal approach to justice relies on the law for guidance and not on morality, science, or principles of justice.

Although these fundamental differences between philosophy and law exist, justice is a principle that can play an
important role in law. Indeed, there are a number of prominent works in jurisprudence (Cahn, 1955; Petrazycki, 1955; Dworkin, 1977) that confront the relationship between law and morality. This relationship is often denied, however, by positivists such as Austin (1885) and Hart (1961) who assert "the absence of any connection between law and morals" (Loh, 1984, p. 640). Under a positivist theory of law, laws do not have to be morally justified to be considered valid. To some extent, this perspective has influenced the development of what Fox (1993) has termed "ambivalence" toward the legitimacy of principles of equity or justice in legal decision making. In fact, common law traditions have a long history of limiting the role of principles of equity or justice in law (Fox, 1993). Although this subordinate role is widely recognized in many traditions of law, it is astonishing that there has been such limited systematic study of the law as an agent of justice in many areas of law, including the field of mental health policy and law.

In mental health law, studies have focused on the impact of law on reforms designed to improve quality of care (Bagby, 1987; Bagby & Atkinson, 1988; Miller, & Fiddleman, 1983). However, principles of justice are rarely the focal areas of concern or the primary unit of analysis. Most inquiry in this area of study has focused on the implementation of civil commitment criteria, or on whether and how court decisions have been implemented by clinical personnel or legal authorities (Peters, Miller, Schmidt, & Meeter, 1987; Reed & Lewis, 1990). Some attention (Rubin, 1996) has been devoted to evaluating the economic efficiency of the changes mandated by the courts. But, the principles of justice underlying these mandated legal changes are either implied or taken for granted. The process involved in selecting valid principles for allocating scarce resources is rarely subjected to social science methods of inquiry. This oversight is due in part to many unchallenged assumptions in traditional legal scholarship about the role of social science in assessing issues of fairness and justice. However, these unchallenged assumptions about science in law are not limited to issues of distributive justice. They also involve important procedural issues of justice.

For instance, fairness emerged as a pivotal area of concern in the field of administrative law following the landmark
decision of *Goldberg v. Kelly*, (1970). This case ushered in a veritable revolution in procedural due process in the United States in the field of social welfare (Verkuil, 1976). Verkuil (1976) pointed out that the reasoning in the Goldberg decision relied on three fundamental principles in its evaluation of the procedures due in terminating Goldberg's welfare benefits: fairness, efficiency and satisfaction. In a footnote to his article in the *University of Chicago Law Review*, he said "Two of these criteria, satisfaction and efficiency, are the province of the social sciences (sociology, psychology and economics), while the third, fairness, is primarily the province of the law" (Verkuil, 1976; p. 739). This assumption about issues of fairness, although consistent with the institutional culture of the law, severely restricts the potential role of scientific methods in evaluating issues of fairness. It also ignores the important role social science can play in designing procedures that comport with principles of fairness (Ashford, 1996).

Fairness claims are likely to increase in mental health given recent developments in the organization and in the administration of mental health services in the United States (Mechanic, 1999). Managed care is one of these developments that includes a number of decision situations involving the termination and the reduction of treatment benefits. For instance, many consumers are incensed when health care providers terminate their access to high cost medications from which they have already derived some perceived benefit. These situations confront challenging procedural issues of fairness. What level of procedural safeguards are these individuals due? How do these procedures strike an appropriate balance between the competing principles of fairness, efficiency, and satisfaction?

As Verkuil observed, "Few would disagree with the proposition that all government decision making should employ procedures that produce fair and accurate results, that are seen as doing this by those subjected to the process, and that do so at the lowest cost to the system" (1976 p., 741). Although administrative entities in mental health services have developed procedures to maximize each of these goals, researchers have devoted minimal attention to studying the relationship between these established procedures and recognized principles of justice. For instance, what impact will the level
of due process in proceedings involving termination and reduction of benefits have on principles of perceived fairness by mental health consumers?

Clearly, the consequences of most procedural mechanisms employed in informal adjudications of mental health care have not been subjected to appropriate forms of empirical scrutiny. Yet procedural and distributive issues of justice are confronted at each and every phase of the mental health service system. However, as Schopp (1993) points out, the majority of the developments in legal doctrine and in traditional legal scholarship in mental health law are directed toward establishing rules and procedures to protect issues of individual liberty. In his view, this emphasis “sometimes constrains the manner in which the mental health system can pursue its therapeutic mission...” In our view, it also constrains the system’s capacity to serve the ends of justice in distributing desirable treatment benefits. For this reason, we are proposing that there is a need to establish a special research agenda for social workers in mental health law and services research that targets procedural and distributive issues of justice. However, this paper is focusing only on examining the contributions of procedural issues of justice to illustrate the utility of a specific body of theory in the social science literature that can help social work researchers structure investigations of justice in the field of law and mental health.

**Process and Procedure As Social Justice**

A very basic characteristic of human existence is that we live our lives in relationships with other human beings. From its earliest beginnings, the profession of social work recognized the importance of these human relationships and “attempted to employ the concept of relationship in a conscious and deliberate way for the benefit of the people served” (Macht & Ashford, 1991, p. 47). Indeed, concepts of process and relationship were focal concerns in many of the early writings of social work (Compton and Galloway, 1975 Hamilton, 1951; Perlman, 1964). Yet, in recent years, process and relationship issues have taken a back seat to consideration of outcomes following shifts in administrative priorities from issues of quality of care to
issues of costs.

Although relationships have been established between the therapeutic alliance and improved outcomes in psychotherapy research (Hovarth & Greenberg, 1994), there is a paucity of studies examining the role of relationships in case management services for persons with serious mental disorders and their role in improving outcomes. (Draine & Solomon, 1996; Howgego, Yellowlees, Owen, Meldrum, & Dark, 2003; Solomon, Draine & Delaney, 1995). Some services researchers (Howgego et al. 2003) have argued that relationships have been neglected in the case management literature because of a lack of appropriate concepts for studying relationships or alliances between the case managers and their consumers. We believe that the social psychology literature on procedural justice offers excellent concepts for guiding investigations of dimensions of relationships in case management and other areas of mental health services delivery that are neglected by the concept of a working alliance and other conceptualizations of therapeutic relationships.

In the psychology of justice literature, process and relationships emerged as central units of analysis in the second wave of justice research (Ashford & Faith, 2004). The first wave of research concentrated on understanding how people reacted to the outcomes of resource allocation decisions (Adams, 1965; Deutsch, 1985). Researchers wanted to know the conditions under which equity, equality, and need served as appropriate standards for evaluating issues of fairness (Brockner & Siegel, 1996; Folger & Cropanzano, 1998). They examined how people judged the fairness of the outcomes associated with resource allocation decisions (Brockner & Siegel, 1996; p. 390). This approach to the study of justice focused on describing and understanding the perceptions of people. Unlike in philosophy, this scientific approach to the study of justice assumes that "justice is defined phenomenologically. That is, an act is 'just' because someone thinks it is just and responds accordingly" (Folger & Cropanzano, 1998, pp.xiv).

The second wave of research in the justice literature concentrated on examining the contributions of procedures to perceptions of fairness. This line of research was initiated by the seminal work of Thibaut and Walker (1975). These scholars
investigated how adversarial and inquisitorial approaches to legal disputes influenced judgments of fairness. Their research specifically looked at the relative contributions of control over the decision and control over the process in explaining judgments of fairness. The findings of their initial investigations indicated that disputants were willing to forgo decision control if they were given appropriate control over the process. These findings about the independent contributions of process control to perceptions of fairness launched an area of inquiry in psychology and the social sciences that continues to this day (Folger & Cropanzano, 1998).

Thibaut and Walker’s (1975) conceptual formulation of procedural justice adopts a social exchange approach to the procedural effects observed in their research on dispute processes (Tyler & Blader, 2000). In their conceptualization of procedural justice, it is assumed that people seek to maximize their outcomes in situations where they lack control over the decisions by substituting their direct control over the outcomes with a form of indirect control over how evidence is presented in dispute processes. Their focus on the structural aspects of procedures is consistent with conceptions of fairness in formal legal theory that equate fairness with notions of due process of law. Lind and Tyler (1988) have proposed, however, an alternative model of procedural justice that explains many observed procedural effects in legal and other organizational settings that are not accounted for by Thibaut and Walker’s (1975; 1978) control theory. Their group-value model takes a relational or social approach to investigating how procedures influence judgments of fairness (Tyler & Blader, 2000; Tyler, 1989) that we believe holds significant promise for social work researchers.

Humans depend on other people for meeting many needs. In the social psychology literature, Folger and Crapanzano (1998) have identified two of these broad sets of needs: economic or quasi-economic needs, and socioemotional needs. Economic needs refer to all of the concrete material things that people require in order to exist in society that cannot be fulfilled without social cooperation (e.g., food, shelter, clothing, and money). Many forms of self-interest theory, including social exchange theory, assume that people are “motivated to
maximize their personal outcomes, particularly outcomes that are concrete, tangible and material” (Brockner & Segal, 1996, p. 399). Moreover, self-interest theory is one of the predominate explanations that have been examined widely in the psychology of justice literature for understanding procedural effects observed in studies of perceptions of fairness (Tyler & Blader, 2000).

Socioemotional needs, on the other hand, refer to a class of needs that many social psychologists assume are more closely aligned with a person’s social nature (Folger & Crapanzano, 1998). As Lind and Tyler (1988) point out, people engage and cooperate in groups for psychological and social reasons that are not related simply to material needs. Their theory takes into account many of the assumptions derived from social-identity theory (Tajfel, 1982; Tajfel & Turner, 1979) which contends that humans also are motivated by their need for being valued and esteemed by others. In their theory, it is assumed that issues of identity and social inclusion provide insights into why people value group membership. In addition, Tyler and Blader (2000) posit that group identification provides alternative explanations for what people mean when they say that an organization or a social institution’s procedures are fair. Indeed, Lind and Tyler’s (1988) relational approach has demonstrated in studies across settings and contexts that people evaluate procedures using the relational information that these procedures convey in addition to the outcomes that they experience from the procedures (Lind & Tyler, 1988; Tyler, Boeckmann, Smith & Huo, 1997; Tyler & Smith, 1997).

Tyler and Lind (1992) have extended their group-value thesis to examining the deference of people to the decisions of authorities. In this expanded version of group-value theory, they have continued to focus on the important role that procedures play in conveying relational information. The distinct relational variables examined in their expanded model are: standing or status recognition, trust in the intentions or the motives of authorities; and neutrality (Tyler, 1998; Tyler & Degoey, 1996). Some scholars (Beis, 1987) consider the quality of treatment that people receive from authorities as representing a third type of justice---interactional justice. “Interactional justice was introduced as an independent, third type of
fairness contrasted with both procedural and distributive justice” (Folger & Cropanzano, 1998 p. xxiv). However, other scholars consider interactional justice as representing a variant of procedural justice. That is, this approach to procedural justice focuses less on the structure of procedures and more on the interpersonal treatment received by people in decision making processes, including interpersonal sensitivity (treating people respectfully and with dignity) and appropriate explanations (clearly and adequately explaining decisions to participants in dispute processes) (Brockner & Siegel, 1996, p. 391). Appropriate explanations are considered a component of interactional justice primarily because the kinds of explanations provided by decision makers convey information to the recipients about the motivations of the decision maker and about the participant’s social standing (Ashford & Faith, 2004; Beis, 1987; Blader & Tyler, 2003).

This brief review of the procedural justice literature indicates that procedural and interactional justice are related topics that hold significant promise for treating aspects of legal and administrative processes (including interpersonal interactions) as a form of social justice. Although progress in services research is unlikely without a focus on outcomes, services research also cannot ignore the pivotal role played by relationships in the implementation of mental health interventions (Howgego et al., 2003). Early psychotherapy research devoted substantial attention to examining relational considerations in therapeutic contexts (Carkhuff & Truax, 1965; Truax & Carkhuff, 1964). More recently, research on relational considerations has adopted the concept of the working alliance to examine bonds in psychotherapeutic contexts (Hovarth & Greenberg, 1994), and in a few isolated instances, some social work researchers have extended this concept to examining relationships in the provision of case management services (Draine & Solomon, 1996; Solomon, Draine, & Delaney, 1995).

The President’s New Freedom Commission Report, Achieving the Promise: Transforming Mental Care in America (2003) identified hope, trust, and other relational concerns as keys to achieving individual recovery for persons with serious mental disorders. The Institute of Medicine’s Crossing the Quality Chasm: A New Health System for the 21st Century also
emphasized the importance of health care that is built upon continuously healing relationships. Despite such advocacy for the principle of respectful care in health-care relationships, there is a paucity of research that extends concepts from the social and behavioral sciences to the study of the role of therapeutic relationships in the respectful treatment of persons under various forms of legal coercion. For instance, while the efficacy of using court-ordered, community-based treatment for the seriously mentally-ill in civil commitment legal procedures is unproved (Lidz, 1998; Monahan, Swartz, & Bonnie, 2003; Parrish, 1993), the use of coercion in the treatment of substance-abusing offenders has demonstrated that clients referred by the criminal justice system for treatment are retained longer than persons not subject to the same coercive sanctions (Collins & Allison, 1983; Delong, 1988; Leukefeld & Tims, 1988; Simpson & Friend, 1988). Nonetheless, we do not know how these coercive legal strategies influence perceptions of fairness and whether these perceptions play an influential role in treatment retention and completion issues.

In addition, health services research has explicated and examined the role of social interactions in help-seeking, service utilization, and compliance with treatment regimes. This work has focused on the role of social processes (specifically, social network interactions and the social dynamics within networks) to understand how decisions about seeking services or complying with treatment are based on or influenced by these rather than by people thinking in an entirely rational, and individual, manner to choose their options and course of action. The point is that the social context of networks is the arena in which influence occurs and these decisions are made (Pescosolido, 1991, 1992, 1996). Nevertheless, there is a dearth of research in the current mental health and social work literature on how relationships and procedures influence consumer perceptions of fairness, especially in recent developments in mental health policy and law involving treatment courts and new administrative processes. However, this requires changes in conceptions of law that allow for social science to play a more important role in our legal institution. It also requires researchers in social work to adopt procedural conceptions of justice in examining various types of
therapeutic relationships.

Procedural Developments and the Promise of Investigating Issues of Procedural Justice

Since the 1980s, there has been unprecedented experimentation in state and in local courts with the integration of substance abuse and mental health treatment in the adjudication process—popularly referred to as specialty treatment courts, problem-solving courts, drug courts, mental health courts, and so forth (Casey & Rottman, 2000; Cooper & Trotter, Jr., 1994; Goldkamp, 2000; Nolan, Jr., 2001; Rottman & Casey, 1999). The growing numbers of persons with substance abuse and mental health problems entering the justice system are challenging the courts to explore alternative ways of supervising and providing mandated treatment services (Ashford, in press; Berman & Feinblatt, 2005). Some of the early research on drug courts found that having a judge in the role of case manager contributed to noted differences in treatment engagement and retention rates from that achieved by social workers, probation officers, and other more traditional case managers (Ashford, 2004; Belenko, 2001). However, none of these studies has identified the procedural mechanisms or aspects of the relationships between judges and offenders that contribute to these and other desired outcomes.

In most drug courts, judges attempt to “reinforce progress, sanctioning ‘slippage’ in a nonpunitive manner designed to enhance the defendant’s assumption of responsibility for his or her rehabilitation, and to augment treatment services” (Copper & Trotter, 1994, p. 93). A key component of many drug courts, the use of graduated sanctions is based on the untested assumption that defendants are motivated to maximize their gains and minimize their losses by shaping their actions to be consistent with program contingencies (Ashford, Wong, & Sternbach, 2005). However, it is unclear whether the sanctioning structure is what contributes to desired outcomes or whether it is something about the nature and quality of the interpersonal treatment between judge and defendant that leads to increased levels of compliance with and engagement in treatment. Issues of this nature are fruitful areas for social
workers to apply theories of procedural justice to test competing hypotheses about treatment engagement and retention.

In civil commitment proceedings, persons with mental illness can be court-ordered to outpatient as well as inpatient treatment. Persons receiving outpatient treatment on court-ordered status often do not receive their prescribed treatments. In some cases, this problem is due to the system’s failure to fulfill its legal duties as the designated mental health authority. Because of these and other forms of administrative noncompliance, some jurisdictions have begun to experiment with having increased judicial involvement in the administrative process. In these jurisdictions, judges hold report-and-review hearings to monitor whether mental health authorities are fulfilling their legal duties. Judges perform similar roles in other areas of law, including child welfare law. Yet, the literature in mental health has been virtually silent on these procedural changes, as well as general report and review processes in other areas of therapeutic law. Because social workers are actively involved in many of these legal processes, they are uniquely positioned to raise relevant empirical questions for further study about procedural innovations, including the testing of alternative procedural mechanisms deemed appropriate for such administrative processes.

Procedural justice issues are not limited to the study of mental health services only in courtroom-based contexts. Issues of identity and fairness addressed in relational theories of justice (Blader & Tyler, 2003; Tyler & Blader, 2000) also can contribute to improving our understanding of the success, or lack thereof, of other mental health interventions, including interventions designed for persons with serious and persistent mental disorders. Although services research has documented the significance of identity issues (Corrigan, 1998; Jackson, 2001; Dickerson, Sommerville, Origoni, Ringel, & Parente, 2002; Markowitz, 2001; Wright, Gronfein, & Owens, 2000), this work has not examined the independent contributions of relational issues of justice to treatment engagement and compliance issues. Program structure and interpersonal treatment by staff can contribute to feelings of stigma and/or other identity relevant attributions (Corrigan, River, Lundin, Penn, Uphoff-Wasowski, Campion, et al., 2001) that could supersede
the therapeutic benefits of treatments in motivating compliance with treatment regimens. For this reason, social workers can make a distinct contribution to services research by specifying obstacles and barriers to treatment engagement and compliance that result from procedural factors—either structural or interpersonal in nature. To this end, we recommend that members of the professional social work community give due diligence to the investigation of procedural justice effects in various areas of mental health services research. Moreover, we contend that social work is positioned uniquely among the mental health professions to play a pivotal role in examining how cultural values about cooperating with treatment authorities in legal proceedings can vary across ethnic groups and how these variations contribute to treatment engagement and compliance. In summary, theoretical developments in the social psychology of procedural and interpersonal justice offer social work researchers useful concepts for testing many service relevant hypotheses that are consistent with our profession’s sanctioned commitment to issues of social justice.

Conclusions

Social work educators (Pelton, 2001; Longres & Scanlon, 2001) have again acknowledged the significance of social justice in our profession’s mission. But, as Longres and Scanlon (2001) point out, the profession has not clarified how it defines social justice and how its definition can inform research and teaching activities. These educators surveyed instructors of research courses to identify topics specific to justice-oriented research and to identify theoretical frameworks or perspectives that might be in keeping with a social justice orientation. Their findings indicated that most of the instructors they surveyed could not identify appropriate theoretical frameworks or perspectives for guiding justice-oriented research. For this reason, the concept of procedural justice reviewed in this paper not only can contribute to establishing a specific research agenda in the field of law and mental health for social workers, but also holds significant promise for informing other areas of social work research involving decision-making procedures and interpersonal processes.
In the organizational psychology literature, conceptualizing process and procedure as social justice topics has contributed already to many reforms in methods of employee compensation and other areas of organizational management. These theoretical frameworks also can contribute to reforms in informal adjudication processes, specialty treatment courts, and other components of court ordered treatment. But, before social workers can integrate these concepts into their research on mental health services, they must devote increased attention to exploring the knowledge base on procedural justice in the social psychology and the social science literature. By targeting topics of fairness that are relevant to theories of justice, members of the social work profession will be better positioned to avoid the concerns raised by Longres and Scanlon (2001). Indeed, the social sciences do have an important contribution to make in dealing with issues of fairness in mental health policy and law previously neglected by traditional scholarship in law and in social work.

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Fairness Issues in Law and Mental Health


The Use of Critical Ethnography in Managed Mental Health Care Settings

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How social workers in managed mental health care settings exercise their professional authority may have profound consequences for the provision of ethical and value-based services to vulnerable populations. Building upon Gidden’s theory of structuration, this article describes the use of critical ethnography as a specific research methodology that may support social workers in the exercise of their authority. This article examines the historical roots of critical ethnography and provides a detailed examination of its underlying assumptions and research procedures. The article concludes with a case example of a critical ethnography conducted within a managed mental health care setting.

Keywords: critical ethnography, managed care, mental health, social work, professional authority

Front-line social workers in managed mental health care contexts often experience cultural incongruence between management values and their own professional values. Among the most profound are those conflicts that exist between managerial and professional values (Furman, 2003; Scheid, 2003; Shapiro, 1995). Nonetheless, social workers may have opportunities to shape the procedures and practices of their managed mental health care organizations. This article will describe the utility
of critical ethnography as a set of methods that may be used to assist social workers in becoming more consciously aware of how they take up their professional authority in managed mental health care contexts.

The revised code of ethics of the National Association of Social Workers (1999) stresses the professional obligation of social workers to incorporate the core values (i.e., service, social justice, dignity and worth of the person, importance of human relationships, integrity and competence) of social work at all levels of practice, including their practice in organizations. The importance of upholding the core principles and values of social work practice is particularly crucial in today's managed mental health care settings. Indeed, the proliferation of for-profit managed care plans and the funneling of vulnerable individuals and groups into these plans has resulted in decreased quality care for persons with severe mental illness, including persons with fewer economic resources and those from marginalized racial and ethnic groups (Himelstein, Woolhandler, Hellander, & Wolfe, 1999; LaRoche & Turner, 2002; Mechanic, 2002, Mechanic, 1999, Mechanic & McAlpine, 1999; Sullivan, 1999).

Arguably, since its inception, social work has grappled with conflicts surrounding its professional identity. Indeed, as Cloward (1972) commented: “Among the various dilemmas confronting social workers, the most profound, although the least acknowledged or examined, is the conflict between our presumed role as helping agents and our bureaucratic role as agents of social control” [as cited by Racine (1984, p. 42)]. Perhaps nowhere is this conflict more evident than in managed mental health care settings, where social workers are increasingly replacing medical personnel as the more economical and hence preferred providers of mental health treatment (Cohen, 2003).

Despite these challenges, the current privatization of managed mental health care may provide social workers and other mental health professionals with opportunities to more proactively develop and create ethically-based programs and services geared to vulnerable populations. For example, effective case management and decision-making processes, roles that social workers typically assume in managed care
settings, may be pivotal in ensuring quality services to consumers (Dobmeyer, McKee, Miler, & Wescott, 1990; Manning, Wells, and Benjamin, 1987; Rogers, Wells, Meredith, Sturm, & Burnham, 1993; Brady and Krizay, 1985). Therefore, the ways that social workers take up their organizational and professional authority in managed mental health care settings may have important consequences to consumers.

Authority has been defined in institutional contexts as "the given right to perform roles" (Kahn & Kram, 1994, p. 17). Historically, there have been at least two very different traditions or approaches to studying roles. The first is a structural view, espoused by traditional sociologists, most notably Talcott Parsons. A structural understanding of roles highlights its normative function, or the expectations that people come to expect from persons occupying particular statuses in the social structure.

Another approach to understanding roles emanates from a social-psychological perspective. This perspective focuses on the active processes involved in "making, taking and playing at roles" (Goffman, 1967). Within this tradition, roles are examined for their dynamic aspects, rather than their place in the social structure. Individuals are viewed as active in the process of taking up their roles.

Critical ethnography may well be suited for a study of how social workers take up their roles, both normatively and proactively, in managed mental health care settings. Specifically, critical ethnography may be used to examine how social work practices in managed mental health care contexts may serve to reproduce or maintain prevailing organizational structures and policies. Also, it may be used to discover how social work practice may change or recreate an organization's structures and policies.

**Structuration and Social Practices**

The exercise of authority by social workers in managed care settings may be conceptualized as occurring within a dynamic, historical, cultural, and interpersonal process of structuration (Giddens, 1993). Structuration theory posits that practice and structure form a transformational loop, with each
influencing the other. According to structuration theory, social practices are influenced by the structures within which they occur, and, at the same time, contribute to the maintenance of those structures. However, feminists and other critics have charged that structuration theory emphasizes the deterministic nature of structure, rather than the transformational potential of human agency.

Giddens described structuration as "tie(ing) the structural integration or transformation of collectivities or organizations as systems to the social integration or transformation of interaction on the level of the life-world" (p. 131). The concept of structuration attempts to eliminate the distinction between action and structure and instead insists on the "interdependence of action and structure" (Campbell, 1996, p. 20).

According to Craig (1992), the concept of structuration gives "priority to social practices as opposed to actors and structures. The 'duality of structure' refers to the fact that structures are both produced by human action and are what Giddens called the medium of human action" (Craig, 1992, p. 43-44). In his theory of social practices, Giddens sought to retain the notion of praxis, defined as "the involvement of actors with the practical realization of interests, including the material transformation of nature through human activity" (Giddens, 1993, p. 53). Giddens [as quoted by Campbell (1996, p. 20)] defined action as "the causal interventions of corporeal beings in the on-going process of events-in-the world" (Giddens, 1993, p. 75; italics in original). The concept of structuration provides a theoretical basis upon which to conceptualize how critical ethnography may be used to assist social workers to better take up their professional authority in managed mental health care contexts.

The Utility of Critical Ethnography in Managed Care Contexts

Critical ethnography may be used to examine the ways that social workers in managed mental health care contexts may be constrained by organizational structures and policies (e.g., premature termination of services, pressures to follow specific treatment protocols, intrusions into professional and technical autonomy, lack of coordinated services, etc.) but, more
importantly, it may also be used in the service of supporting social workers in the development of innovative and creative approaches that better meet the needs of clients. Thus, critical ethnography may be used in the service of achieving organizational 'praxis,' defined by Freire (1996) as "social action upon the world in order to transform it" (p. 36).

Critical ethnography has been described by Thomas (1993) as "the study of the process of domestication and social entrapment by which we are made content with our life conditions" (p. 7). Domestication refers to the ways that individuals' perceptions and behaviors are "tamed" by ideologies that "construct advance meanings and justifications for our actions and the actions of others" (p. 9). More importantly, critical ethnography seeks to resist reflexively processes of domestication and "unleash critiques" that expose "broader social processes of control, taming, power imbalance, and the symbolic mechanisms that impose one set of preferred meanings or behaviors over others" (p. 9). For example, critical ethnography can be useful to social workers in managed mental health care settings who may feel pressured to operate within a medical model approach and thus find themselves expected to provide mental health solutions to social welfare problems (Goldman & Morrisey, 1884).

**Critical Ethnography versus Conventional Ethnography**

Critical ethnography is described as a "style of analysis and discourse embedded within conventional ethnography" (Thomas, 1993, p. 3), and thus shares several common fundamental strategies with it. These strategies include a "reliance on qualitative interpretation of data and core rules of ethnographic methods and analysis, an adherence to a symbolic interactionist paradigm, and a preference for developing 'grounded theory' (Glaser & Strauss, 1967)" (Thomas, 1993, p. 3).

However, critical ethnography differs from conventional ethnography in that it seeks to do more than just describe and interpret culture and cultural phenomenon. Critical ethnography seeks to change it. Specifically, critical ethnography seeks to make visible those covert structures of power and oppression that subtly and yet forcefully "construct and limit choices, confer legitimacy, and guide our daily routine" (Thomas, 1993,
Critical ethnography has a political purpose. It asks 'what could be?'.... (It) refers to: ...the reflective process of choosing between conceptual alternatives and making value-laden judgments of meaning and method to challenge research, policy, and other forms of human activity (1993, p. 4).

Locating Critical Ethnography within Paradigms of Research

Guba and Lincoln (1995) offered a definition of a paradigm: "A paradigm may be viewed as a set of basic beliefs that deals with ultimate or first principles. It represents a worldview that defines, for its holder, the nature of the world and its parts" (p. 107). Critical ethnography may be distinguished from other research paradigms, such as positivist and post-positivist paradigms, on the basis of differences in ontology, epistemology, and methodology. Ontology refers to the nature of reality and how it is understood to exist, epistemology refers to the nature of knowledge or the "relationship between the knower or would-be-knower and what can be known" (p. 108), and methodology refers to how the inquirer goes about "finding out whatever he or she believes can be known" (p. 108). Illustrations of the differences among the three aforementioned paradigms of research along the dimensions of ontology, epistemology, and methodology will follow.

Positivism

In the positivist paradigm, the ontological view of reality is that it is out there waiting to be apprehended and discovered. Within this paradigm, the epistemological assumption is that the researcher is capable of being neutral and objective. The belief is that research can be value-free and methodological procedures may be employed to reduce or eliminate bias in order to ensure the validity of data. The methodological assumption is that cause and effect relationships between
variables are verified through experimental procedures and empirical tests.

**Post-positivism**

Within the post-positivist paradigm, the ontological assumption is that reality is believed to exist in an absolute form but cannot be understood positively or perfectly due to the fallibilities and imperfections of human processes of apprehension. Thus, the epistemological assumption is that the researcher's ability to be neutral and value-free is not seen as an absolute. Objectivity is considered an ideal to strive toward, even though it can never be attained. Findings may be falsified, rather than verified. Research is typically conducted in naturalistic settings.

**Critical Theory**

In critical theory, reality is thought to be apprehendable, but what is taken as real is actually a "virtual or historical reality" (Guba & Lincoln, p. 110) shaped by "social, political, cultural, economic, ethnic, and gender factors, and then crystallized into a series of structures that are now taken as 'real'" (p. 110). There is no discrete distinction between researcher and researched, both are viewed as mutually influencing the other. The researcher cannot disavow or separate him or herself from underlying values or biases. The paradigm stresses dialogue and dialectical relationships between the researcher and research participants. The goal is to generate ways to transform consciousness and become more aware of the covert structures that influence consciousness.

**Underlying Assumptions of Critical Ethnography**

According to Thomas (1993), critical ethnography proceeds from the premise that "the structure and content of culture make life unnecessarily more nasty, brutish, and short for some people" (p. 33). Critical ethnography contends that "social constraints exist and research should be emancipatory and directed at those constraints..." (p. 21). Emancipation refers to "the process of separation from constraining modes of thinking or acting that limit perception of and action
toward realizing alternative possibilities" (p. 4). Critical ethnography seeks to identify those alternative possibilities and suggests ways that "we are able to change both our subjective interpretations and objective conditions" (p.18). The central premise of critical ethnography is that "one can be both scientific and critical, and that ethnographic description offers a powerful means of critiquing culture and the role of research within it" (p.vii).

Historical Roots of Critical Ethnography

Critical ethnography may be traced to both interpretive movements in anthropology and sociology and also to neo-Marxist and feminist social theory (Anderson, 1989). Interpretivists were concerned with redressing the over-determinism of positivist epistemologies by acknowledging the role of human agency and focusing on the native's point of view (Malinowski, 1922) and the importance of local knowledge (Geertz, 1973). Social life was viewed as consisting of meanings negotiated by individual actors engaged in social practices.

Neo-Marxist and critical feminists were concerned with the dialectical interplay between social constraints and human agency (Anderson, 1989). Critical feminists, in particular, underscored the importance of praxis or human agency and explicitly sought to "probe the lived realities of human actors and the conditions informing both the construction and possible transformation of these realities" (Dilorio, 1982, p. 22-23; as quoted by Anderson, 1989).

Critical ethnography was viewed as differing from both interpretivist and critical feminist ethnography in its assertion that "the perspectives of informants are necessarily permeated with meanings that sustain powerlessness and that people's conscious models exist to perpetuate, as much as to explain, social phenomena" (Anderson, 1989, p. 253). Anderson quoted Thompson (1981), who cautioned that research participants should not be "naively enthroned, but systematically and critically unveiled" (p. 143) thus stressing the importance of assisting participants in resisting and overcoming processes of "domestication."
The onset of critical ethnography in education is dated to the emergence of the “new sociology” in Britain (Anderson, 1989). During that time, in the 1970's, both Britain and the United States “saw the cross-fertilization of sociological phenomenology (particularly the works of Berger & Luckmann, 1967; Garfinkel, 1967; and Schutz, 1964) and Marxian social analysis” (Anderson, 1989, p. 255).

Among early critical ethnographers, Anderson (1989) noted a tension between an emphasis on the structural versus the phenomenological, with some favoring an emphasis on the structural (Sharp & Green, 1975), and others favoring an emphasis on agency (Willis, 1977). According to Anderson, (1989), early British critical ethnographers sought to maintain a balance between both Marxian conceptions of social structure and phenomenological concerns with human agency.

He further explained that American critical ethnographers “viewed ethnographic methods as a way out of what many saw as structural overdeterminism,” (p. 256) which occurs when researchers are more concerned with issues of social reproduction, rather than resistance. Anderson stated: “American critical ethnographers...turned to theories of social production that view the process of social and cultural reproduction as one filled with complex forms of resistance and accommodation” (p. 256).

Anderson offered what he characterized as a “persistent criticism” of educational critical theory, in its tendency toward social critique, rather than the development of “a theory of action that educational practitioners can draw upon to develop a “counter-hegemonic” practice in which dominant structures of classroom and organizational meaning are challenged” (p. 257). More recent efforts to empower research respondents through a process of “consientizacao” (Freire, 1996), which, as Anderson explains, “makes humans subjects rather than object of history,” comprise efforts to assist critical researcher in the development of counter-hegemonic research practices. These practices include the use of oral history methods (Wexler, 1987), informant accounts and narratives (Gilbert & Abell, 1983; Meichler, 1986), and collaborative research endeavors (Freire, 1996; Mies, 1983; Aronowitz & Girouz, 1985; Wexler, 1987).

Thus, within the historical evolution of critical
ethnography, the reciprocal relationship between structure and practice has been stressed, with researchers and theorists differing on whether to focus on the restraining and delimiting forces of structure, or the potential liberating effects of human agency. Thomas' (1993) conceptualization of critical ethnography and the research procedures that underpin it seeks to both acknowledge the "domesticating" effects of structure while seeking also to identify and support the potential transformational nature of human agency or praxis. In order to accomplish this dual task, the researcher must be open to scrutinizing the ways that he or she is indoctrinated into normative ways of thinking and acting, utilize research methods that seek to identify how research respondents may be similarly indoctrinated, while, at the same time, identifying areas in which human agency or praxis is actually taking place. Most importantly, the research procedures of critical ethnography are themselves designed to be praxial, or capable of creating transformative action and change.

Research Procedures of Critical Ethnography

Thomas (1993) proposed several data collection and analytic procedures that adhere to the underlying premises of his conceptualization of critical ethnography. First, to ensure accuracy and avoid processes of 'domestication,' the researcher must always scrutinize interview and observational data for imposition of the researcher's values. That is, the researcher must search for any instances of asking leading questions or prompts that do not emanate from the actual collected data. "It is as important to analyze interviewer's style of questioning and interjected responses as it is to interpret the responses themselves, because the interviewer's prompts can predetermine informants' discourses" (p. 39). Moreover, the researcher's questions must be examined for the extent to which they may be reproducing inadvertently prevailing organizational structures and attitudes.

Second, when interviewing participants, it is important to look for anomalies – contradictory answers, defying observed reality, cover-ups or gaps – in the data elicited. This is a way of getting underneath conventional responses to questions that
may serve the purpose of impression-management and accessing a deeper level of meaning. By getting below the surface, the researcher may be able to identify areas of resistance and agency. Thomas suggested that interviewers need to be flexible and ready to ad-lib or reframe questions in order to get below the surface.

Third, Thomas proposed using a process of 'defamiliarization' to "look for non-literal meanings of our data texts" (p. 43). Defamiliarization is a way of distancing ourselves from the taken-for-granted aspect of what we see and allowing us to view what we have seen more critically. We take the collection of observations, anecdotes, impressions, documents, and other symbolic representations of the culture we studied that seem depressingly mundane and common, and we reframe them into something new...The researcher decodes the ways that the symbols of culture create asymmetrical power relations, constraining ideology, beliefs, norms, and other forces that unequally distribute social rewards, keep some people disadvantaged to the advantage of others, and block fuller participation or understanding of our social environs (p. 43).

Moreover, Thomas contended that researchers must constantly and rigorously examine how their values and beliefs affect "data gathering, analysis, and subsequent display of data to an audience" (p. 46). Thomas explained that "through reflection, an act of repeated thinking about our project, we become self-aware of the process and consequences of knowledge production" (Thomas, 1993, p. 46). Also, the language we use to communicate our data to our audience must always be examined to identify "traditions, norms, institutions, artifacts and other characteristics of culture that provide access into the netherworld of mundane life to unblock alternative metaphors and meanings" (p. 45-46). According to Thomas, two main questions guide critical reflexivity. First, how does one's ideology influence the work? Second, how does the research challenge injustice and what are the implications for action?

Critical Reflexivity

Anderson (1989) contended that a consideration of reflexivity is not new to critical ethnography and has been a central topic in any discussion of ethnographic methods and
procedures. Historically, reflexivity has included a consideration of the relationship between theory and data (Glaser & Strauss, 1967), as well as a reflection on the effects of the researcher's presence on the data collected (Hammersley & Atkinson 1983; Lincoln & Guba, 1985).

However, in critical ethnography, the role of reflexivity may also be expanded to include a consideration of the dialectical relationship between structural/historical forces and human agency (Anderson, 1989). Anderson summarized reflexivity in critical ethnography as including a consideration of the dialectical process among "(a) the researcher's constructs, (b) the informants' commonsense constructs, (c) the research data, (d) the researcher's ideological biases, and (e) the structural and historical forces that informed the social construction under study" (p. 254-255).

Critical Ethnography: A Case Example

Between the spring of 2002 and the summer of 2004, this author conducted a critical ethnography within a large health maintenance organization (Bransford, 2006). The purpose of this critical ethnography was to examine the practice of authority -- personal, professional, and organizational -- by individual social workers in a managed mental health care organization. The study focused on 17 individual social workers in two outpatient mental health centers of a large, northeastern health maintenance organization (HMO), and identified and critically examined the historical and cultural precedents, contexts and conditions (e.g., organizational, interpersonal, and intrapersonal) that facilitated or inhibited their exercise of authority. A theoretically-based, underlying assumption of the study was that the practice of authority by social workers in managed mental health care settings may provide a legitimate basis upon which they may strive to create organizations that more effectively support the ethical principles and values of professional social work practice.

Methods of Data Collection and Analysis

Methods of data analysis included a combination of participant observation, document analysis, in-depth interviews,
and focus groups. A focus group was convened at each of the two study sites to review preliminary findings and to solicit the input of participants in a process of refining and clarifying conceptual propositions derived from data analysis. Additionally, the focus groups provided an opportunity for social work participants to "use critical knowledge for social change" (Thomas, 1993, p. 4).

The interviews with staff members were both informal and formal. The informal interviews were designed to provide anecdotal material and "off the cuff" observations of the uses of authority in the exercise of group and organizational tasks in the two study sites. The formal interviews included open-ended, semi-structured questions that asked individual respondents to provide examples of their subjective experiences of exercising their authority in work contexts. Interpersonal processes between interviewer and interviewee were examined to provide further illumination about how authorization was conferred or not conferred by both participants to the interview. When respondents allowed, the interviews were audio-taped, transcribed and examined for historic and cultural precedents, contexts and conditions surrounding processes of authorization and de-authorization.

Organizational texts (meeting minutes, memos, and other presentations and representations of organizational life) were examined to identify "how people are constrained by the constructions they build and inherit from the past" (Denzin 1992, p. 23), and to understand how people may liberate themselves from these constraints (Freire, 1996) and perform "social action upon the world in order to transform it" (p. 36). Analysis of organizational texts assisted in the generation of interview questions and in providing contextual data (e.g., historical, organizational, structural) relevant to processes of authorization and de-authorization.

Focus groups were convened to provide respondents who participated in the individual interviews with an opportunity to discuss and develop critiques of propositions that emerged from the analysis of data. This kind of "member checking" was used to corroborate and/or disconfirm the interpretation of observational and interview data and to encourage respondents to take up their authority in the service of data analysis.
Study participants were asked to reflect on how the experience of participating in the study affected their experience and use of authority in organizational contexts. Moreover, the use of focus groups provided additional opportunities to observe authorization and de-authorization processes occurring among participants, and to note discrepancies between focus group data and data from participant observation and individual interviews (Morgan, 1997).

Methods of data analysis were consistent with those proposed by Thomas (1993) and included de-familiarization, searching for anomalies, and the use of critical reflexive practices. The analysis was thickened through the use of field notes, memos, and through constant referral to both grounded and extant theory. The ongoing processes of data collection, analysis, and reflexivity were used to inform and enrich each part of the process, such as interviewing organization members and critically analyzing the relationship of the researcher to the setting. Moreover, the joint processes of observation and participation are the hallmarks of praxis—critical reflection and purposeful action.

Results

Several salient authorization processes were identified that could be used to assist social workers with better taking up their professional authority in managed mental health care settings.

These authorization processes included identification with clients’ struggles and needs; staying within the boundaries of one’s work role; degrees of freedom from organizational acculturation; internalized role models; age and experience; turning point and last straw experiences; and having time and space to think through and process ideas. Virtually all of the respondents across all systems of analysis identified supportive and collaborative relationships with others as conducive to a successful exercise of professional authority

De-authorizing processes included repercussions for speaking up, fear of conflict, concern about losing organizational privileges, overt and covert collusive practices occurring between management and workers, and subtle degrees of
power among psychiatrists, psychologists and social workers. Gender, class, age and race were mitigating factors in the ability of social workers to exercise their authority. Subversive practices, such as extending sessions beyond their prescribed limits or reclassifying psychotherapeutic groups as psycho-educational groups to avoid the institution of co-pays or session limits, were identified as comprising covert efforts to exercise professional authority in a managed mental health care organization.

Moreover, a number of respondents reported, both within individual interviews and in the focus groups, that they felt better able to engage in organizational change strategies as a result of their participation in the research process. For example, within individual interviews, respondents were asked to identify and analyze episodes of authorization and de-authorization in organizational contexts and thus were enabled to discover strategies for organizational change.

Conclusion

This article has defined and described critical ethnography as a research methodology that may be used by social work researchers in managed mental health care settings to make those settings more amenable to the underlying values of social work practice. The analytic procedures of critical ethnography seek to make visible those organizational structures and policies that may constrain workers from exercising their professional authority in managed care contexts, such as organizational imperatives that classify individuals into diagnostic categories rather than develop programs and services that promote social justice or change. The goal of these procedures is to identify ways that workers may more consciously take action to change those organizational structures and policies that impede the provision of quality services to consumers. Researchers could use these findings to help shape social work policy, practice, and education.

In addition to social work researchers conducting critical ethnographies that adhere to the rigors of formal research, line social workers in these settings could utilize some of the analytic procedures of critical ethnography as heuristic
tools in their organizational practices. For example, workers could carefully examine their ways of both interviewing and conceptualizing their clients’ difficulties in living for imposition of personal and cultural assumptions and biases. They could also examine their own reflective processes for anomalies or contradictory answers in order to avoid ubiquitous human tendencies toward self-deception and to penetrate to a deeper level of understanding. This could be done through reflexive processes occurring before, during and after therapeutic sessions, and also in reaction to meetings, memos, documents, and other organizational texts and artifacts.

Workers could adapt procedures of de-familiarization into their clinical work. Thus, they could critique their work with clients for the extent to which they are actually meeting their clients’ needs, rather than simply conforming to a strictly medical model approach. Also, by critically examining their organizational practices, social workers could assess whether they are exercising methods of social control or advocacy in their work with consumers.

The fact that managed mental health care delivery systems are increasingly used to treat vulnerable populations previously served by human service organizations makes crucial the need for social work researchers to utilize critical methodologies that don’t seek simply to understand managed care policies and social work practices, but also seek to change them. Critical ethnography offers a set of methods that aim to fulfill that purpose.

References

Critical Ethnography in Managed Care


Set in a mix of primary and secondary research reports, this anthology consists of 78 pieces published between 2000-2002 in various professional sources. Seeking to introduce the reader to a representation of the current state of the art, the editor chose this eclectic collection from a sample of about 2500 listed in *Social Work Abstracts*. Unlike the DSM with its classifications and codes for psychiatric pathology, the editor views social diagnosis as “a conscious and concise statement of the spectrum of judgments we make on first meeting a client and expand and modify throughout our contact with him or her. These judgments serve as the basis on which we decide to engage or not engage in particular activities for which we are prepared to accept professional responsibility (p. viii).”

Compared to other references tackling psychosocial diagnosis—evidence-based research to impressionistic practice wisdom—this collection is rather broad in scope. The editor assumes a maverick stand! How does he do this? By avoiding predetermining the treatment fate of those who fall within our purview via dogmatic preconceptions regarding the range of classifications of human behavior. Rather, the reader is invited to synthesize and to translate the material as it applies to one’s practice.

The volume is divided into four parts containing from 18 to 26 chapters. In the editor’s energetic writing style, each part is introduced by a brief introduction and succinct overview. Part I is entitled *Who Is the Client from a Developmental Perspective*. It has 22 chapters covering the range from low birth weight children, parenting stress, envisioning fatherhood, adoption issues, foster care, homoerotic behavior,
grandparenting, widowhood, and end-of-life decisions. The bulk of the chapters are based upon primary research.

For the 20 chapters of Part II, The Problem as a Component of Diagnosis, there are three divisions: (a) problems with a mental illness basis, (b) problems of a psychosocial nature, and (c) problems with a physical basis. Specific subjects can range from borderline personality disorder, survivals of sexual abuse, domestic violence in later life, staking, and senile dementia. The chapters are generally based on secondary research with interpretations and applications.

The third part, Elements of Diversity to be Addressed in Our Diagnosis, consists of 18 chapters principally in the vein of conceptual and/or essentially literature review articles. This part is also divided into three parts: (a) specific components of diversity, (b) generic diversity factors, and (c) intra cultural factors in diversity. Specific chapters address such issues as treatment of Arab Americans, depressive symptoms in farm women, social work with immigrants and refugees, biracial sensitive practice, racism as a clinical syndrome, and the financial vulnerability of people with disabilities.

Part IV, Interventions: What Does Our Diagnosis Lead Us To?, contains 18 chapters constituting primarily case study and/or conceptual selections. Chapter topics extend to the use of crisis teams, therapeutic dream work, harm-reduction approach, long-distance psychoanalysis, value of pets in geriatric practice, parent training via CD-ROM, and being a strength coach.

This reference of 782 narrative pages extends over a breadth of diverse topics relevant to social work diagnosis and hence practice. In the various writing styles one journeys through sometimes complex issues affecting the here-and-now of social work diagnosis. One implicit underlying plea is for acceptance and affirmation of a range of human differences and outlooks. In other words, the reader needs to deflect any subtle conceptual ethnocentrism at the professional level, including setting aside anchoring on one’s period of training and coming into the present. Yet the knowledge base is still uneven, developing, and diversified, but hopefully progressing—perhaps while even traversing into an occasional blind alley, or by having an unsubstantiated idea ricochet from yesteryear.
In references of this kind, some key topics may not be given relevant space. For instance, apart from a scattering of brief discussions in a few chapters, the subjects of substance abusers and substance abusing mentally ill (MISA) clients are not dealt with directly in the form of at least one unified chapter. The chapter on the harm-reduction approach does use the treatment of substance abuse as an illustration for that model. Yet in most inner city mental health agencies of which I am aware, MISA clients can constitute up to 70 to 90 percent of the caseload. Perhaps this is due to the paucity of literature on the topic in traditional social work journals. Yet in the timeframe there are many articles related to this topic in clinical psychology, psychiatry, and specialty substance abuse journals.

Considering the volume and diversity of material, shifts in writing styles, and the rather small print, this might not be considered as casual professional reading. The subject index is thorough. The sources for the chapters are identified in a “Credits” section at the end of the volume. One possible drawback is the lack of information on the authors themselves such place, position, and background. The discerning reader might view this as useful. Apart from these concerns, the reference would be a significant additional to any social worker’s professional library.

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A number of the plays in August Wilson’s cycle on African American life in the 20th century carry memorable images of urban decay, geographic isolation of the African American community, and the impending negative impacts of gentrification. These images appear normal—congruent with what we
know about race, culture, ethnicity and neighborhood life. The neighborhood case studies of Uptown Chicago, Jackson Heights New York, and San Antonio-Fruitvale Oakland in Michael Maly’s well written book *Beyond Segregation: Multiracial and Multiethnic Neighborhoods in the United States* counter these desolate scenes with surprising examples of successful unplanned neighborhood integration.

Maly suggests that instances of successful unplanned neighborhood integration go almost unnoticed in the research literature. The resulting central message of the book is that exploring these atypical cases offers valuable insight into a variety of grassroots methods that can help to generate stable neighborhood integration. In this light, Uptown, Jackson Heights, and Fruitvale should give pause to those who believe that people of different cultures, socioeconomic backgrounds, and countries of origin cannot successfully live together via naturally occurring integration. As one of the key informants says about the development of stable integration in Uptown: "I think there is less us versus them. Some people are trying really hard to maintain the us versus them ... but I think less and less, in reality people are permitting themselves to be pitted against the other." (p. 94).

The book consists of five chapters. The first two chapters give a concise history of racial and ethnic segregation and integration in urban United States and examine how changing demographics can impact neighborhoods in various ways. The chapters contrast the powerful external mechanisms that created segregation with the internal grassroots actions of individuals and citizen groups that prevented it and provide a sufficient theoretical underpinning for the three cases studies that constitute the last three chapters. Separate from the five main chapters are a conclusion, which revisits many of Maly’s main points, footnotes, and references.

The case study chapters begin with a story told by one resident who in some ways symbolizes the neighborhood experience of integration, which Maly details by using secondary data and interviews with key informants. He does an adept job of leaving the reader to interpret the meaning and interplay of the individual interviews with the larger trend data. Each of the neighborhood cases demonstrates how the organic process
of integration varies in terms of what factors are essential and to what extent those factors interact with the contexts of time and place. An eloquent example is how active conflict between groups in the Chicago neighborhood of Uptown played an important role in creating and maintaining stable integration where as in Fruitvale and Jackson Heights, the conflict between neighborhood groups was on a much smaller scale, had different dynamics and was significantly less important.

Several salient themes emerge from the five chapters. These include firstly that racial and ethnic diversity need to be understood in more complex ways; and secondly, that racial and ethnic integration should be combined with socio-economic integration and that one does not readily exist without the other. Another theme is that immigration is often the life blood of integrated neighborhoods. The final and principal theme is best expressed by another of Maly’s key informants: “I mean, it [neighborhood integration] happened because nobody obstructed it, not necessarily because somebody nurtured it.” (p. 66).

The one complaint is that the key informant interviews are from 1995-1996, a decade ago, before the current boom in urban housing ownership. The changes in housing prices may have considerably altered the level of integration in all three neighborhoods and therefore current perceptions of residents may be dissimilar to those held in 1995. For example, Maly notes that the median price of a one or two family house increased from $183,000 to $240,000 between 1995 and 1999 in Jackson Heights. The December 9, 2005 Weekly Thikana, a Jackson Heights neighborhood newspaper, states that the average cost of a two bedroom apartment is $380,000 and a New York Times online profile of the neighborhood pegs the beginning prices of single family homes at $400,000 and two family homes at $600,000. Even a cursory nod to the possible impact of these sizeable increases in housing prices would have sufficed. A separate prologue would have been even better.

Michael Maly articulates a number of important insights into neighborhood functioning, stable unplanned integration, and the roles of grassroots movements that should interest a wide variety of scholars. Beyond the book’s value as a piece
of research, it is a joy to read and it is highly recommended.

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This is an unusual book, in part a series of biographical sketches of Sigmund Freud and a host of other pioneers in the development of psychoanalysis in Europe, and in part the story of the invention of free mental health treatment centers by psychoanalysts in Berlin, Vienna, and other European capitals. The story is set in the tumultuous, and at the end, horrific times between the end of World I and the ascendancy of Hitler's Third Reich.

Elizabeth Danto bases her work on extensive examination of over twenty archival sources in the United States and Europe, ranging from the Archives of the New York Psychoanalytic Society to the Otto Rank papers at Columbia University to the Archives of the Sigmund Freud Foundation in Vienna. She also interviewed fifteen individuals who had some connection with the development of psychoanalysis and the free clinic movement, although she only identifies the background of three of these interviewees, making their information less useful.

This far-ranging history discusses the development and operation of free out-patient mental health clinics for working class people in European cities from 1920 until the rise of the Third Reich. In 1918, at an international conference of psychoanalysts, Sigmund Freud encouraged his peers to set up these free institutions because, he believed, "The poor man should have just as much right to assistance for his mind as he now has to the life-saving help offered by surgery (pp, 1-2)." Freud reached a receptive audience, and at least twelve of these clinics were established in European cities in the years between the two world wars. The first clinic, the Poliklinik, was established in Berlin, quickly followed by the Ambulatorium in Vienna. These pioneer clinics, and those that followed, were staffed by psychoanalysts and their students. They treated the troubles of
young people, delinquents, and those suffering from psychosomatic illnesses through time-limited psychoanalysis.

The roster of those who devoted at least some of their time to clinic practice includes many familiar names: Sigmund and Anna Freud, Erik Erikson, Carl Jung, Bruno Bettelheim, Melanie Klein, Wilhelm Reich, Karen Horney, Erich Fromm, and Alfred Adler. Those donating time to the clinics were interested in social as well as psychological issues and believed that psychoanalysis could "share in the transformation of civil society." Many were Socialists and some were Communists. They hoped for the transformation of society after World War I and believed in Erikson's concept of the importance that the social environment plays in human development.

Danto traces the history of the free clinics through their heady early days up until their dissolution under the Nazi and Fascist regimes in Europe. She describes their leadership, the backgrounds of the psychoanalysts who joined the clinic movement, the psychoanalytic societies which helped support them, the professional groups that hindered the movement, the services and psychoanalytic training offered, and the types of clients seeking help. She details the socio-economic and educational backgrounds of the psychoanalysts who joined the clinic movement, their leftist political attachments, and their commitment to social change. She also attends to the larger context of "Red Vienna" and the other social democracies created in Europe between the wars. The book ends with the tragic details of the "Aryanization" of the clinics' staff, the flight from Germany and Austria to America and other safe havens by almost all of the psychoanalysts, and the transformation of the clinics into instruments of the Nazi regime.

This is an extremely important story, but unfortunately it is marred by extensive length, an overwhelming emphasis on detail, dense writing with page-length paragraphs, typographical errors, an inadequate index which also includes page number errors, and generally, poor proof reading. For example: "Deutsch was one of the few first women admitted to the University of Vienna" (p. 62); a reference to a woman who was "originally a Berlin relative of the Freuds" (one wonders if she divorced them), and the author's note to the editor on picture placement: "Figure 3 belongs somewhere within or after the next paragraph" (. 22), which remains in the book.
If the reader has the time to labor through the details, and can ignore the lack of proofreading, this is a worthwhile and gripping story. It may well change the image of the detached and apolitical psychoanalyst that many of us inherited.

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According to the latest United States census, roughly one-quarter of the nation’s population is below 17 years of age. This substantial number of persons, one might expect, would have “rights”. Thus, Guggenheim’ book title, *What’s Wrong with Children’s Rights*, is intriguing. From all sorts of bully pulpits, preachers, politicians, and pundits discuss the nature and extent of children’s rights in cases of abortion, adoption, education, nutrition, health care, use of car safety seats, exposure to military recruitment presentations, bullying, zero tolerance for weapons in school, family and dating violence...the list is almost endless. Guggenheim, in his highly thought-provoking book, takes issue with the notion that a child’s “rights” necessarily coincide with the child’s “interests”.

As Guggenheim suggests, for instance, if society focused on a child’s interests, society would eliminate cigarettes, pollution, and war—all of which are dangerous to children. Children are not the only members of society, however, and social life involves give-and-take between different groups. Guggenheim points out that, though the sanctity of “parents” and “children” is pronounced in American society, neither word is mentioned in the U.S. Constitution. Nonetheless, policies regarding how adults parent children draw heavily on constitutional precepts, and the Supreme Court has acknowledged that “the interests of parents in the care, custody, and control of the children” is one of the most highly valued liberty interests of the Court. The book, which is well-written but challenging, is a revealing overview of legal decisions affecting parent-child-state
relationships, and it is illustrated by his many examples (taken straight from the newspaper) of knotty family problems.

Guggenheim discusses major Supreme Court decisions which have shaped current ideas of children's rights: *Meyer v. Nebraska* of 1923 which buttressed parents' liberty interests as protected by the Due Process Clauses of the 14th and 15th Amendments, and *Pierce v. Society of Sisters* of 1925, which dictated that the State cannot "standardize" its children through mandatory curriculum; *Buck v. Bell* of 1927 (which dealt with compulsory sterilization to prevent transmitting "imbecility"); *Skinner v. Oklahoma* (1942), which dealt with sterilization of felons; *Griswold v. Connecticut* (1965), concerning distribution of contraceptives; and *Stanley v. Illinois* of 1972, relating to custody rights of an unmarried father. These and other cases set an outer limit of acceptable parental behavior. Guggenheim maintains that creating these parental rights and duties allows children to reciprocally share the rights of their parents, and may more properly be termed issues of "family autonomy" rather than of "rights".

After reviewing the history and nature of children's and parents' rights in the United States, Guggenheim applies his thinking to such issues as custody, visitation, foster care, termination of parental rights, and the adolescent's rights to abortion. Throughout, Guggenheim voices concerns that some children's activists have led society astray by championing the cause of children's rights apart from the rights of parents. He urges those who deal with children to examine how they make decisions on behalf of children. He dismisses the widely-accepted idea that a court-appointed adult charged with speaking for the child actually represents the child's best interests. Rather, the court-appointed adult can only voice his/her assessment of the situation from an adult perspective; no one can really speak for the child. Consequently, Guggenheim's argument goes, society should assume the adult responsibility to make decisions that take into account all parties.

His treatment of the Michigan case of Baby Jessica is an example. Baby Jessica, placed for adoption at birth in 1991, was the subject of a protracted custody dispute between adoptive and biological parents. The biological parents ultimately prevailed, with news magazines carrying the heart-rending
picture of a wailing 3-year-old being removed from the only parents she had known to live with her biological parents, strangers to her. Guggenheim’s contention in his examination of this case is that child advocates should look at this kind of case, not for the ultimate outcome, but for the ways we reach consensus on what the correct answer should be. One way to minimize the pain of cases such as Baby Jessica’s, Guggenheim asserts, is to minimize the time it takes to resolve the case through the legal system. The body of law on the matter of unmarried fathers leads us to believe, if the unmarried father financially supports his progeny and strives to create a relationship with his children, the state’s response is more positive than to the father who does not support or relate to the child. The Supreme Court has established that fathers should not lose their rights without due process of law. Guggenheim contends that Jessica’s birth father’s case met the rule of law, and that had the legal system allowed him true due process, the case could have been resolved long before Jessica celebrated her third birthday.

Throughout this book, Guggenheim returns to his theme: adults should advance children’s rights by treating children like children, and by accepting adult obligations to care for and mold children. Ultimately, Guggenheim seems to say that there is no such creature as children’s rights apart from parents’ rights; children have no obligations apart from parental obligations. Parents sometimes voice the adage that “If my kids are OK, I’m OK”. Guggenheim might give that phrase a twist by having children say, “If my parents are OK, I’m OK”. In the final analysis, both statements are accurate.

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This insightful book covers in depth the historical development of Health Maintenance Organizations (HMOs) while
interjecting the experience of the Wisconsin Marshfield Clinic as an HMO case study. The author carefully documents the broader context of national health care policy making as it relates to HMO development and actual health practices within the Marshfield Clinic. The book covers many topics including, but not limited to, a brief history of health insurance prior to the 1970's, the enactment of the HMO Act, health care in rural America, Antitrust Legislation, private and public sector HMO development, accountability, and health promotion strategies.

What is evident from the very first chapter is the careful research conducted by the author in documenting findings from multiple sources including individual researchers, governmental sources as in Health and Human Services, the Rand Study, and the Robert Wood Johnson Foundation. Of particular interest to the reader is the coverage on rural populations and the lack of a coordinated health care plan to address rural health care needs in the United States.

Coombs correctly points out that the development of the HMO movement was ignited due to a perceived health care crisis in the 1970's. The movement had utopian beliefs that a coordinated health care delivery system which focused on preventive care would address the escalating costs in health care as well as provide for easier health care access and a healthier American population. The increased HMO enrollments of the 1980's and 1990's have now been replaced by a decreased overall number of enrollments specifically within the private insurance sector. This decrease in enrollment numbers within the private insurance sector was primarily due to the public dissatisfaction with utilization restrictions placed on the health care consumer. Employers on the other hand desired cost effective and affordable health care for their employees and looked to the insurance industry to create health plans which were both affordable and desirable. The author concludes that the original HMO movement is dead due to a multiplicity of stakeholders and stake challengers, privatization, lobbying, technology, paperwork, the political marketplace, and chronic disease and illness. What is left of the HMO movement is a myriad of managed health care arrangements that have been designed to attract customers and resembles and includes features of other non HMO insurance plans. Coombs supports
through her research and demographic data that the current health care crisis is more critical today than in the 1970's.

However, the author does suggest several strategies that could be used to address the problem, such as resolving the financing inequities of insurance within the private and public sectors and modeling our health delivery against other industrialized nations who spend far less for the health care and receive a far greater return.

I would take exception with the book's assertion that the HMO movement not only contributed but created our current health care crisis. Several caveats concerning our current health care crisis need to be addressed within this context. Policy experts for many decades have pointed to the Constitution and our policy making process in the United States as the focal point for health and welfare concerns in this country. Constitutional arguments regarding states rights vs. federal oversight for health care has resulted in a log jam of incremental legislation to address national health care needs. Coupled with these two opposite approaches in addressing the health and welfare needs of the population are our free market economy and the volatile political marketplace. As a pluralistic country we attempt to mediate between many differing viewpoints whenever we legislate. Within the larger context of health and welfare, we have been unable to construct a unified and consistent approach in addressing the overall health and welfare of our population. Other contributing factors such as the revolution of new medical discoveries, the breakdown of the American family (who traditionally provided most health care to its members), corporate health care industry mergers, and the penetration of health care into the community setting have all led to further complications. Until we address the underlying Constitutional interpretation of who provides health care and under what form, we will be ill prepared to develop a sustainable continuum of health care for the United States.

Most recently, several initiatives, such as the newly created Medicaid Advisory Commission, and the Integrated Care Program funded by the Robert Wood Johnson Foundation have taken on publicly funded health care issues. The Medicaid Advisory Commission has been set up to advise the federal government on future Medicaid funding and services while
the Integrated Care Program has funded five state demonstration projects with the purpose to integrate the financing, delivery and administration of care under dual eligible patients who are covered under both Medicare and Medicaid. Since Medicaid HMO enrollment is the only sector that is growing at the present time, these initiatives will hopefully enlighten policy makers.

The corporate health care industry, academic professionals and doctoral level students who are in medical and allied health related professions will find this book extremely helpful. Coomb’s book serves a valuable function in the thorough examination of a very complex subject. Since health care policy and practice continues to evolve at a fast pace it is hoped that the author of this book and others will continue to research its best practices.

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Peter Baldwin suggests that responses to public health challenges today are largely shaped by past experiences. He illustrates this theory by examining current public health responses to the AIDS pandemic. He poses three major arguments: First, that responses to the AIDS pandemic have been remarkably diverse; second, that industrialized liberal democracies were markedly more interventionist than others favoring communal rather than individual rights; and third, that the intervention approaches chosen broadly correspond to the prevention tactics used during the nineteenth century when dealing with earlier contagious epidemics. The public health spectrum of interventions ranges from those that are considerably restrictive of individual rights in favor of communal protections (such as quarantines, institutionalization, screening, mandatory reporting, contact tracing, and forced treatments) to those that are more laissez-faire and concerned with civil rights and
confidentiality (such as found in public health campaigns to change knowledge, attitudes, and behaviors). At one end of the spectrum, impositions of governmental and administrative strictures limit the choices for individuals in the name of protection of the community. At the other end, personal liberty, sexual freedom, and voluntarism characterize interventions.

Control of epidemics may reflect the overall political climate that characterizes the industrial democracies. Also, they are tailored to prior experiences in control of epidemics that may not fit the overall political climate as much as the patterned responses to epidemics. Baldwin argues that the United States and Sweden use more restrictive communitarian approaches while Germany and France use more hands-off approaches. An historical analysis shows the patterns of responding to prior epidemics provides a clearer emphasis than traditional political approaches in the countries analyzed. Historical experiences become better predictors than current political climates. AIDS thus interacts with communal versus individual rights contagion control rather than transcends the metaphors for sexual expression, substance use, race, gender and class. Responding to contagious outbreaks becomes an "epidemiological Rorschach" for complex and intertwined political, social, legal, and moral imperatives.

The "golden age of public health" evinces conflict between ideologies supporting notions of improved health and well-being resulting from improved community development (such as clean air; clean water; sanitation and nutritional adequacy) and those believing improved lifespan is accounted for by advances in medical technology and medical services. Ideology shapes the change focus: from promotion of health and well-being to treatment of pathologies. The political and social climate moderates restrictiveness. For example, public sentiments against quarantines limit the restrictiveness, though the ideological impulses support it.

Professional health care providers may support communal approaches that run counter to their quarantinist, disease prevention or social reformist, health promotion ideology counter-currents. Are epidemics the result of social inequality and noxious environments or contagious pathogens? Context and experience shape responses. Responses waiver between
concerns with discrimination, marginalization and stigmatization or control of malevolent organisms. The eradication of contagion becomes the metaphor for community development and social equality or that of plagues and containment. Ideology is accused of willingness to sacrifice the common good for civil rights and non-discrimination in a Western individualism prism, or a willingness to sacrifice freedom for curing ills. Permissiveness and indulgence clashes with zealotry and rigid dogmatism: and epidemic control is the symbol rather than the outcome.

Baldwin provides an engaging portrayal of diverse policy responses in the context of social and political vectors. He presents a wide scope of ideas shaping the policy options but is not indifferent to the restrictive choices favored. While rich in description of policy options and the social and political issues influencing the debates, the argument lacks empirical grounding. Is there scientific support for restrictive versus behavioral change models? There is a detailed story of policy choice outlined in this readable and fascinating text, but not an empirical guide to the impact of these policy choices on pandemic control. The ideological conflict grows in intensity. Some are accused of endangering the public; some are willing to impose draconian restrictions on behaviors in the name of obsequious morality. The question of whether either has a measurable impact on contagion control is illusive, even when the conflict over policy approaches are well documented. Promoting public health is not a fusty theoretical debate, but a drama played out in prisons, in hospitals, in morgues, as well as in legislative halls and in houses of worship. Community development battles pathogenesis for ideological predominance. Contagion is the wager.

Ronald J. Mancoske
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Book Notes


The ability to check “all that apply” when presented with a list of race and ethnicity options was a milestone for the recognition of people with a multiracial or multietnic heritage. Since the 1997 revisions to the Federal policy on race and ethnic definitions, all government forms must provide this opportunity. The 2000 Census was the first to do so, and as a result we learned that approximately 3% of the U.S. population identifies as multiracial and that 6% of married couple households are interracial. Interest in this area of study is growing, yet it remains difficult to locate materials on interracial issues.

This book is an invaluable reference that addresses this problem by providing an annotated bibliography and critical discussion of major themes that arise in both scholarly and popular literature, film and on the internet. The guide is written for a wide audience of potential researchers, students, multiracial individuals and the general public. The authors begin with strategies for accessing the literature and highlighting the barriers that occur in this field, including inconsistent vocabulary for search terms, changes over time in acceptable language for describing multiracial individuals, and the overwhelming negative bias found especially in the early, pre-civil rights literature. Other practical features are lists of search terms by specific indices, a glossary of terms used in interracial literature and a chapter devoted to teaching a higher education course about race in which a teacher shares his experiences with the development and structure of a course.

The value of this book derives from the annotated materials, which are organized into thematic chapters: “hot button issues” (such as perception of physical appearance), historical literature, politics, dating and marriage, families, transracial adoption, books for children and youth, identity development,
sexuality and cinema. The authors, and additional contributors, describe the main ideas of each item and for some works, background information about the author or context for when the item was written or produced is also provided. A further strength of this resource guide is the breadth of material that is included and reviewed, with items spanning the last one hundred years and presenting a diversity of viewpoints. By reading through the bibliographic annotations, the reader can emerge with an introductory understanding of the evolution of the field of interracial studies.

The authors acknowledge that the items included in the bibliography are not all-inclusive, and therefore it is important to understand their selection criteria. The materials were included based upon quality of the argument, quality of the content, supportable evidence, substantive content, and balance of perspectives and media types. It is clear that these criteria were successfully maintained, though there is some uncertainty regarding the exclusion of seemingly valuable materials from the annotated bibliography that had been referenced within the introductory essay to a chapter. In addition, there are inconsistencies in style, format and depth of review between the chapters, likely due to the varying authorship of each chapter. There is some overlap in the entries, with each review of a given item differing according to theme. However, as a whole, the annotations are engaging and represent significantly improved access to information on interracial issues.

"Rose M. Barreto, University of California, Berkeley"


A great deal has now been written about the impact of globalization on economic and social conditions. For example, the literature on globalization has dealt in depth with the way currency speculation and the flow of finance capital has created economic difficulties for a governments around the world. A good deal has also been written about the effects of globalization on employment and incomes. Although some scholars
have speculated on the way globalization has contributed to environmental problems, the subject has been neglected and there is a need for a comprehensive analysis of the relationship between globalization and environmental sustainability.

In this book, Clapp and Dauvergne rise to the challenge and provide one of the first detailed assessments of the relationship between globalization and the environment. The book examines different aspects of this complex relationship and specifically address issues such as trade, investment, financing, wealth and poverty. The authors discuss each of these issues in great depth and provide a helpful account of different perspectives on the way the environment has been affected by economic globalization. Their analysis is facilitated by identifying four major normative perspectives or what the authors call “world views” on environmental issues. These are market liberalism, institutionalism, bioenvironmentalism and “social green” thinking. The book begins by defining these perspectives and then traces the history of each perspective. The perspectives are then applied to provide a succinct analysis of the policies and prescriptions each offers for improving environmental conditions. For example, the diverse positions of market liberals, institutionalists, bioenvironmentalists and social greens on world trade, investment and financing are examined and contrasted. The book also provides a comprehensive discussion on the nature of globalization. Another helpful chapter describes the evolution of environmental thinking with reference to globalization and development, and provides a chronological overview on the major international meetings that have been held to discuss the environment.

This is an extremely readable book which is packed with detailed information. It will be a major resource for anyone wanting to have information about efforts to deal with environmental issues at the global level. One of the book’s great strengths is its balance. Different points of view are represented and arguments for and against different perspectives are elaborated. Although some scholars may view the division of environmental thought into four categories as somewhat limiting, it summarizes complex and sometimes heated controversies into a manageable commentary. The authors are to be commended on a major accomplishment and their book
should be widely consulted.


A significant number of social work histories have now been published. Although these histories tend to cover the same chronological ground, each has a different slant offering varying interpretations of the factors that gave rise to the emergence of the profession or otherwise covering different aspects of the profession's development. However, most of these histories have focused on developments within particular countries and relatively few have paid attention to the evolution of social work on an international scale. Payne's new book is an important exception, and while it is primarily concerned with the development of social work in the United Kingdom, it reaches out internationally to cover the emergence of social work in other parts of the world. It also addresses a number of key issues that will be of concern to social workers in many different countries.

As the author points out, the book is primarily intended for students who sometimes struggle with historical questions and whose knowledge of international events may be limited. Accordingly, the book is written in a straightforward style that students will find helpful. However, this does not mean that the author avoids complex issues. In fact, much of the book is concerned with the differences of opinion that have characterized social work since its beginning. The author does an excellent job of explaining these controversies and in finding a healthy balance between articulating his own views and those of others who take a different position on key issues of relevance to social workers around the world.

The first three chapters of the book are primarily concerned with tracing social work's origins in the 19th century and its subsequent development up to the end of the 20th century. Payne draws on a wide range of literature to support this account including information from countries as diverse as Japan, Zimbabwe, India and the United States. The remaining chapters of the book deal with the key issues facing social work. These include perceptions of the social workers role, the values and philosophies that characterize professional
endeavor and the contribution of knowledge and research. It also includes an interesting chapter on professional social work education and the debates between universalists who believe that Western educational models are relevant to all countries and relativists who believe in the indigenization of the educational experience.

The author has produced an extremely valuable account of the history of social work and the many challenging issues the profession has dealt with over the years. His ability to summarize a huge amount of information in a relatively short book is astounding. In addition, the book is well written and the author's sensitivity to the complexities of the issues facing the profession is commendable. Although the book is primarily intended for social work students, it will be a useful resource for practitioners and academics alike. It deserves to be widely read.


The social work profession emerged in the 19th century in the context of rapid industrialization and urbanization. It was in the overcrowded and unsanitary slums of the rapidly expanding cities in of Europe and North America that the first social workers sought to meliorate the problems of poverty and deprivation either through direct casework intervention or the neighborhood-focused activities of the Settlement Houses. Since those early days, social work has been largely associated with urban needs and problems, and the majority of social workers today are employed in urban areas. This is to be expected since the majority of people in the industrial countries live in urban areas. The proportion engaged in agricultural pursuits has declined steadily over the last century.

It is not surprising, therefore, that the needs of rural people have historically been neglected by the social work profession. There is a serious shortage of social workers in the rural areas, and often highly skilled and demanding social work roles are filled by unqualified personnel. It was because of these
challenges that social workers began in the mid-1970s to promote the idea of rural social work as a specialized field of practice. They have drawn attention to the unique needs of rural communities and the importance of formulating practice interventions that specifically address these needs. Over the years, the literature on rural social work has also expanded and some schools of social work now place much more emphasis on curricula content concerned with rural issues.

This edited collection of chapters dealing with diverse aspects of rural social work makes a useful contribution to the literature on the subject. Compiled by Nancy and Roger Lohmann of the University of West Virginia, the book addresses a number of important issues affecting rural social work practice. It is divided into four parts that deal respectively with the context of rural social work practice; specific interventions that address rural social needs; key client populations and fields of practice; and finally, social work education for rural practice. Although the chapters are somewhat uneven, the book addresses many interesting issues such as welfare reform in rural communities; the role of telecommunications technologies in rural social work; the role of nonprofit organizations; community building and the unique ethical challenges posed by rural life. In addition to covering familiar fields of practice such as mental health, aging and health care, the needs of gay and lesbian people and rural minorities are also discussed.

The book makes an important contribution to the literature and should be widely consulted by anyone interested in rural social welfare. Indeed, since more urban people now live in rural areas and commute to work in the towns and cities, the need to understand the interface between the urban and rural will become more important. There is much in this book that will inform social workers everywhere and contribute to the challenge of understanding the rapidly changing social environments in which they practice.


Political advocacy has been a recognized social work
activity for many decades. Indeed, the profession's founders were actively engaged in the political process, advocating on a number of key social issues. However, this does not mean that advocacy has been central to the profession's mission. Although social workers are exhorted to engage in advocacy, it cannot be claimed that advocacy is given high priority. Similarly, while the rhetoric of advocacy and social justice feature prominently in social work discourse, social workers and their professional associations have not always taken a strong stand on major political issues. For example, the profession has been largely silent on the currently topical issues of torture and the invasion of Iraq.

The publication of a new book on the topic of advocacy for social justice by Richard Hoefer is, therefore, to be welcomed. Written in a highly accessible style, the book is specifically designed to meet the needs of undergraduate and master's level social work students. But its call to the social work profession to live up to its ethical commitment to engage in advocacy—as mandated by the NASW Code of Ethics—is an important one which should be heeded by social work practitioners and educators as well.

The book is comprised of ten chapters. The first chapter situates advocacy within the context of a generalist approach arguing that advocacy is not a specialized, separate social work activity but an integral part of daily practice. The second chapter tackles the difficult topic of social justice and links the concept to two major schools of thought as articulated by John Rawls and Robert Nozick. Chapter three addresses the question of whether social workers are politically active and discusses the reasons for their involvement in political advocacy. Chapters four to nine are concerned with practical issues, outlining the steps in the advocacy process. These steps involve an analysis of the issue, planning for advocacy, the use of negotiation and persuasion, presenting information effectively, evaluation, and finally ongoing monitoring. The final chapter offers an historical account of progressive social welfare developments in the United States showing how these have provided the basis for advocacy in social work.

Students will enjoy the straightforward exposition of the steps in the advocacy process and the author's effective use
of case study material. Hoefer effectively links advocacy to
generalist social work practice and shows how of social work
practitioners can engage in a variety of advocacy roles as a
part of their daily practice. He has also successfully condensed
a great deal of material into a slim and intelligible book. The
book should be widely prescribed in social work courses and
should also serve as an important resource for practitioners. It
is a readable and helpful addition to the limited literature on
the subject.

Katherine van Wormer, *Introduction to Social Welfare and Social
Work: The U.S. in Global Perspective*. Belmont, CA: Thomson
Brooks/Cole, 2005. $76.95 paperback.

Social work is, increasingly, an international profession.
The pressures of globalization exacerbate social problems ev-
everywhere as well as connect those working to alleviate human
suffering in the global community. As such, international social
work has in recent years become a new subfield within the dis-
cipline. However, it is too often treated as an additional field of
study, outside of traditional social work, instead of providing
a contemporary perspective touching each one of social work’s
populations, policy concerns, and values. Social work’s rele-
vance to today’s most pressing issues requires a broadening of
the scope of the field.

This book is, in part, an update of the author’s earlier book,
*Social Welfare: A World View* and a response to recent dramatic
international events impinging upon the welfare of vulnerable
populations. It is a welcome continuation of her international
refashioning of the basic social work textbook. Part One, Social
Welfare: Structure and Functions, includes excellent concep-
tual definitions, an examination of American values that shape
policy choices contrasted with mainly Scandinavian alterna-
tives, and broad discussions of world inequality through the
lens of globalization. Van Wormer’s international analysis of
social problems reveals the global connections of oppression.
In the human rights chapter, van Wormer blends domestic and
international social issues together through a discussion of
social work’s role in working for justice. Part Two, Social Work
across the Life Cycle, deftly incorporates environmentalism, social psychology, and spirituality into a human behavior and the social environment framework. The last few chapters on child welfare, health and mental health, and the elderly read more like a standard textbook, despite including a range of international children's issues like children soldiers and comparative health care policies including Cuban rural health care.

Timely as it is comprehensive, van Wormer's book addresses questions such as what is social work's relevance to the causes of and responses to 9/11. The core strength of this book is its attention to international issues and how they relate to social work. Although the history and policy areas are necessarily short on technical details, the author provides a wonderful synthesis of domestic issues and global concerns linked within the rubric of familiar social work topics.

Invoking the social work imagination, van Wormer successfully places American social work within a global perspective. This text poses a challenge to the American isolationism that too often restricts social work from its true potential. Suitable for undergraduate and graduate courses alike, this book should be required reading for instructors concerned with meeting CSWE's mandate to prepare students for global social work practice. Breaking with the usual parochialism found in most introductory texts, van Wormer has made a valuable contribution to the task of training social workers to meet the growing challenges of a shrinking world.

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