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Editor's Note:

Two articles authored by David Stoesz have appeared in our recent September and December issues: "The Consolidation of the Secondary Financial Services Market" in September (41.3), and "Are Payday Loans Really Evil? Controversy, Regulation, and Innovation in the Secondary Financial Services Market" in December (41.4).

These articles focused on various aspects of the secondary financial services market. The author has been employed as a consultant by a representative of the Alternative Financial Services industry in recent years. While the *Journal* has no reason to believe that this relationship had a substantial influence on the content of the articles, some may consider it to be a conflict of interest. In the interest of full disclosure, Dr. Stoesz asked that these facts be known to readers.

Special Issue Call for Papers: Mind-Body Interventions in Social Work

Guest Editors: Yvonne A. Unrau, Ph.D. and
Melinda McCormick, M.S.W.

Western Michigan University
School of Social Work

The Journal of the Sociology and Social Welfare (JSSW) announces a special issue dedicated to studies of mind-body interventions as applied to social problems to prevent adversity and promote wholeness and well-being among individuals, groups, organizations, or communities served by the social work profession.

Mind-body interventions include a diverse group of practices such as controlled breathing practices, meditation, yoga and practices associated with spirituality;¹ and are considered one domain of practice of Complementary and Alternative Medicine (CAM).² In this special issue, we explore usefulness and effectiveness of mind-body interventions as applied to groups of marginalized individuals in society including but not limited to individuals living with conditions of homelessness, mental illness, domestic violence, child abuse and neglect, poverty, incarceration and discrimination based on race or gender-identity orientation.

While all high-quality manuscripts focused on mind-body intervention research will be considered, we are particularly interested in papers that describe methods and key findings of mind-body intervention studies and discuss applications to social service practice and/or public policy. In addition, we are seeking papers that will contribute to scholarly contemplation regarding the use of mind-body approaches in the social welfare field to address issues of transformative healing and change among populations and communities marginalized by oppressive social conditions such as poverty, discrimination and violence.

Topics of interest include, but are not limited to, the following:

- Completed efficacy studies that determine the specific effects of a mind-body intervention using experimental methods;
- Completed outcomes, effectiveness and case studies that investigate the feasibility and usefulness in general populations or settings;
- Systematic methods to develop/adapt existing mind-body interventions to new populations or settings;
- Studies of implementation of mind-body interventions in community settings;
- Methodological research on mind-body interventions, including advances in methods for measuring and analyzing fidelity and dosage data in community settings.

Authors are invited to contact the guest editors to discuss ideas for submissions.

Yvonne A. Unrau (yvonne.unrau@wmich.edu)

Melinda McCormick (melinda.m.mccormick@wmich.edu)

Submission Process

We invite authors to submit manuscripts not to exceed thirty double-spaced (12-pitch font) pages (including references and tables) on any of the topics above as well as related topics. Manuscripts received by August 8, 2015 will be considered by a special issue of JSSW with an anticipated publication date in 2016. Please send MS Word manuscripts that adhere to the APA Manual, 6th edition style, electronically, as email attachments to: Melinda.m.mccormick@wmich.edu.

Manuscript Submission Deadline: August 8, 2015

Endnotes:

1. National Center for Complementary and Alternative Medicine (NCCAM). Expanding horizons of healthcare: strategic plan, 2005-2009. Available at: <http://nccam.nih.gov/sites/nccam.nih.gov/files/about/plans/2005/strategicplan.pdf>
2. Other domains of CAM (i.e., biologically-based treatments, manipulative and body-based methods, and energy therapies) are out of the scope of this call for papers.

Special Issue Call for Papers: The Basic Income Guarantee (BIG)

Guest Editors: Michael A. Lewis, Ph.D.
The Silberman School of Social Work
Hunter College, and

Richard K. Caputo, Ph.D.
Wurzweiler School of Social Work
Yeshiva University

The financial crisis of 2007-2008 and its recessionary aftermath have, once again, raised the issue of whether a market economy can be relied upon to assure economic security. Although the market economy is dynamic and quite productive, the financial crisis has highlighted its instability and tendency to produce high unemployment, low wages, stagnant wages, greater income inequality or a combination. Many would argue that the social welfare system, with its myriad of safety net programs, is intended to address such conditions. Yet it has holes that have allowed many to still live in poverty, many more to live with a very realistic fear of falling into poverty, and an erosion of the middle class. This instability and tendency toward low wages, stagnant wages for middle class families, or no employment in a market economy, coupled with a social safety net system riddled with holes, suggests that it is time to think about new approaches to income and wealth distribution, not only for purposes of poverty prevention or even poverty reduction, but also for social justice. Are there fairer and more efficient ways to distribute the fruits of our individual and collective efforts to everyone's benefit?

One such program is the basic income guarantee (BIG), also called the guaranteed income. The idea is simple: replace most income support programs with a floor under everyone's income, structured so that no one is in poverty and everyone is better off financially if they earn more in the private market. We're issuing a call for papers for a special issue of the *Journal of Sociology and Social Welfare* (JSSW) to explore the merits of BIG and related proposals such as guaranteed jobs, stakeholder grants, asset accumulation policies, and living wage legislation. We're interested in proposals related to BIG

because some have argued that the goals of BIG could be better realized by other approaches, such as government guaranteeing a job instead of an income. The special issue is intended to consider the economic, social, political, and philosophical questions about BIG and related policies. The papers will be written by social workers and academics in related disciplines. The special issue is intended to explore some of the following Topics:

- BIG, other related programs, and social justice
- BIG, other programs, and gender relations
- Financing BIG and related programs
- BIG, other programs, and the labor Market
- BIG, related programs, and civic engagement
- BIG, related programs, and the bargaining power of workers
- BIG, related programs, and the family
- The political feasibility of BIG and related programs

We invite authors to submit manuscripts not to exceed thirty double-spaced (12-pitch font) pages (including references) on any of the topics above as well as related topics.

Manuscripts received by September 30, 2015 will be considered by a special issue of JSSW with an anticipated publication date in June or September 2016. Please send MS Word manuscripts that adhere to the APA Manual, 6th edition style, electronically, as email attachments to:

Michael A. Lewis, Professor
michael.a.lewis@hunter.cuny.edu

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Successful Approaches to Ending Female Genital Cutting

KAY YOUNG MCCHESENEY

Department of Social Work
University of Illinois Springfield

Female genital cutting (FGC) is practiced in 28 African countries; infibulation is practiced in nine African countries. Six unsuccessful approaches to ending FGC are reviewed: cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches. Two successful programs that have resulted in communities abandoning FGC, including Tostan in Senegal, are described. Successful programs are community-led, aim to change social norms in the whole community, and empower women. Governments and NGOs should use community-led programs based on participatory methods as recommended interventions in order to promote community-wide abandonment of FGC.

Key words: female genital cutting, cultural relativism, health education, feminism, human rights legislation

This paper will compare the characteristics of two successful programs to end female genital cutting (FGC) with six unsuccessful approaches to ending the practice. The purpose of the paper is to suggest that there are successful approaches to ending FGC, they are reproducible, and they should be employed as recommended interventions.

The World Health Organization defines three major types of FGC: clitoridectomy, excision, and infibulation. Clitoridectomy involves partial or total removal of the clitoris. Excision involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Infibulation involves excision of the labia minora and the labia majora, and stitching together the remaining tissue, leaving a seal over the vagina, with a posterior opening that

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may be as small as a matchstick or as large as 3 cm. in diameter, for the passage of urine and menstrual fluids (World Health Organization [WHO], 2008). FGC may be done as early as infancy or as late as adolescence, depending on the culture.

Some type of FGC is practiced in 28 countries in Africa, as well as in parts of the Middle East, and among some groups in Asia (Asekun-Olarinmoye & Amusan, 2008; WHO, 2008; Yoder, Wang, & Johansen, 2013). This paper will focus on FGC in Africa. Although the worldwide prevalence of FGC is not known, Yoder et al. (2013) estimated that about 87 million women age 15 and above have been cut in 27 African countries and Yemen alone (p. 189). In some African countries, FGC is almost universal. For example, Yoder et al. (2013) reported the prevalence of FGC among women aged 15 and older as 98% in Somalia, 96% in Guinea, 93% in Djibouti, 91% in Egypt and Sierra Leone, 89% in Eritrea and Sudan, and 85% in Mali (p. 197). Infibulation is the major type of FGC practiced in Somalia, Djibouti, Eritrea, northern Ethiopia, and northern Sudan. It is also practiced in parts of Egypt, Gambia, Kenya, and Mali.

The practice of FGC in the Nile Valley and around the Red Sea is apparently of ancient origin. Female mummies from ancient Egypt show evidence of excision and infibulation, and in the fifth century B.C., the practice of FGC was reported by Herodotus (Caldwell, Orubuloy, & Caldwell, 2000). Thus, the practice of FGC in Africa predates both Christianity (which spread in North Africa after about 33 A. D.), and Islam, (which spread in North Africa after 632 A. D.) (Khaja, Barkdull, Augustine, & Cunningham, 2009). Although a significant percentage of participants believe that the practice of FGC is religiously based, religious scholars from both Christian and Islamic traditions report that there is no basis in either the Bible or the Qur'an for the practice.

Unsuccessful Approaches to Ending Female Genital Cutting

Outsiders from the global North have tried many approaches to end FGC, including "legislation, medicalisation (training health professionals to perform the procedure under sanitary conditions), religious condemnation, information, 'just-say-no' campaigns, educational efforts, and attempts

to institute alternative rituals”—all with little effect (Easton, Monkman, & Miles, 2003, p. 246). Six unsuccessful approaches will be discussed in this paper: cultural absolutism, cultural relativism, health education, feminism, human rights legislation, and psychosocial approaches. They will be contrasted with two programs that have successfully ended the practice of FGC in their communities.

Cultural Absolutism

Cultural absolutism describes an inability to be aware of a culture other than one's own, and a desire to impose one's culture on others. The essence of cultural absolutism is ethnocentrism—the attitude that the “natives” are “backwards”—all we need to do is tell them how much better our Northern culture is and they will recognize FGC as a “barbaric” practice and abandon it. One of the best known examples of this was the attempt to end FGC among the Kikuyu in Kenya (Caldwell et al., 2000). During the 1920s and 1930s, Protestant missionaries from Scotland mounted a major campaign against FGC. They declared that parents who “circumcised” their daughters would be banned from attending church and girls who underwent the procedure would be banned from attending school. This effort backfired so badly that historians believe it was one of the antecedents of the Mau Mau rebellions. Jomo Kenyatta, the founding father of Kenya, explicitly linked FGC to anti-colonial nationalism; the group circumcision ceremonies for girls became a symbol of the nationalist movement (Boyle, McMorris, & Gomez, 2002).

Cultural absolutism underlies many of the other unsuccessful approaches to ending FGC. Gruenbaum (2005) concluded that “Change strategies should be based not on the assumption that traditional beliefs are irrational and just need a good dose of public health education” (p. 435). Caldwell, Orubuloy and Caldwell (2000) concluded that one of the barriers to ending FGC is the sense in Africa that Northern demands for abandonment of FGC were “based on little more than foreign cultural aggression” (p. 238).

Cultural Relativism

The lack of success of religious condemnation led to a relatively quiescent period during the mid-20th century, when the

anthropological view of cultural relativism held sway. During the 1950s, the official view of the World Health Organization was that these “operations” on girls were “based on social and cultural backgrounds,” and therefore WHO did not take a stand against them (cf. Boyle & Carbone-Lopez, 2006, p. 441; Caldwell et al., 2000, p. 240). Ethnographic work conducted in a number of societies showed that beliefs about FGC differed from culture to culture, and began to reveal the complexity and embeddedness of FGC. Ethnography continues to contribute to the discourse on FGC to the present day.

For example, among the Kikuyu in Kenya, FGC, usually clitoridectomy, is part of a group coming-of-age ceremony. Among the Kikuyu, membership in an age set is determined by communal circumcision ceremonies where a group of young women are initiated into womanhood. An uncircumcised girl would remain “a child forever” in the eyes of the tribe and could not marry (Caldwell et al., 2000, p. 245).

In Nigeria, the Yoruba believe that if an infant’s head touches the tip of the mother’s clitoris during birth, the child will die. Therefore, clitoridectomy must be performed in order for a daughter to be marriageable. If parents were to neglect circumcising their daughters, the daughters would be regarded as “abnormal or even monstrous,” and the parents and their daughters would be social outcasts (Caldwell et al., 2000, p. 236, pp. 246-247).

A number of cultures in Northern and Eastern Africa have the belief that women are naturally promiscuous, and if left to their own devices will, like Eve, seduce men. Therefore, their sexuality must be controlled (Hassanin, Saleh, Bedaiwy, Peterson, & Bedaiwy, 2008; Manderson, 2004). For example, in Mali, people believe that

a young woman’s sexuality has to be controlled to ensure that she does not become over-sexed and lose her virginity, thereby disgracing her family and losing her chance for marriage. In fact, it is believed that because an “uncut” clitoris will become big, activities like riding a bike or a horse, or even wearing tight clothing will arouse an unexcised woman, who may then rape men. (WHO, 1999, p. 5)

Thus, FGC protects a young woman's virginity, family honor and the social order.

Ellen Gruenbaum has been doing ethnography on FGC in northern Sudan since the 1970s, when she first accompanied a midwife on her rounds. In Arab Sudan, "virgins are made, not born," through infibulation, which is called "purification" in the everyday language of villagers (Gruenbaum, 2006, p. 122). It is the responsibility of mothers to see that their daughters are infibulated. It is considered essential to remove the clitoris so that girls will be less "tempted" to behave promiscuously, and to create a physical barrier that makes sexual intercourse impossible. In addition, in this culture, an open vagina is considered to be loathsome and disgusting—dirty, hairy, smelly and unclean—the opposite of "pure." An open vagina is seen as physically repulsive; in contrast, the infibulated cover over the vagina, which is seen as "smooth," "clean," "neat," and "hygienic," makes a woman physically beautiful to her husband (Gruenbaum, 2005, p. 436).

Quotes from informants give a sense of the multiple meanings of infibulation. For example, an elderly woman said, "we do not want a girl who is easily used by every man, a girl with a big hole or opening" (Igras, Muteshi, Woldemariam, & Ali, 2004, p. 259). Another woman thought that the uninfibulated vagina would be "a large, gaping hole, capable of accommodating both penis and testicles" (Gruenbaum, 2006, p. 125). Another said, "We don't want the girl to be dirty, open, with smelly underwear" (Gruenbaum, 2006, pp. 131-132).

Finally, in Arab Sudan, husbands are said to prefer the small, tight opening of a virgin (Gruenbaum, 2005, p. 437). At marriage, a girl who has been infibulated must be "defibulated," or cut open, before first intercourse. Or, if the opening is large enough, sexual intercourse can take place after gradual dilatation, which may take months. It is assumed that sexual intercourse will be painful for the wife (Gruenbaum, 2006, p. 127). Traditionally, the midwife re-infibulates the woman after giving birth, so that she will be pleasing to her husband (Gruenbaum, 2006, p. 121).

Although a great deal has been learned about the cultural meanings of FGC from field work conducted by anthropologists, the perspective of cultural relativism informs, but does

not end, FGC. For example, in 1980, Dr. Mahnaz Afkhami, Executive Director of the Sisterhood is Global Institute, said,

I have seen a lot more sensitivity from Northern feminists in the last few years, but ... sometimes their attempts at cultural awareness and sensitivity can go too far, as we see among those Northern women who say that female circumcision is just another cultural practice. (Spadacini & Nichols, 1998, p. 45)

Health Education

Sometime during the late 1970s, the health education approach to ending FGC began. By 1982, the World Health Organization (WHO) had changed its position and adopted FGC as a major health concern (Easton et al., 2003, p. 446). In essence, the health education approach was overlaid on top of cultural relativism. The health education approach did not tell people that their culture was bad per se, or condemn FGC outright. It just informed them of the medical consequences of FGC. The assumption was that once people knew the facts, they would stop practicing FGC (Shell-Duncan, 2008).

Health education stressed the fact that because practitioners used unsterilized instruments such as "sharp stones, broken glass, scissors, or unsterilized razor blades, without anesthesia," to cut girls, the girls experienced pain, bleeding, and infection, and occasionally died (WHO, 1999, p. 37). For example, Spadacini and Nichols (1998) described an education program for secondary school students conducted in Ethiopia during the early 1990s, in which FGC was approached "from a reproductive health perspective, as this is the only way people in the field are likely to listen," according to Dr. Dahab Belay, a health consultant on the project (p. 47).

Educational programs on the negative medical consequences of FGC were tried in several African countries, including Egypt, Ethiopia, Kenya, Nigeria, and Sudan. The results were consistent and unexpected. Researchers discovered that conducting an educational program "focusing on the short-term risks of genital cutting, such as bleeding, infection and pain, has apparently had the unintended result of promoting the 'medicalization' of FGC, rather than its abandonment" (Sedgh, Jackson, & Ibrahim, 2005, p. 426). For example, in Sudan,

trained midwives “were by the end of the 1980s performing 36% of all female circumcisions [infibulations]” (Caldwell et al., 2000, p. 246). In Nigeria, “female circumcision has become the province of the trained nurse, working outside her normal hours, and, for many, has become an important supplementary source of income” (Caldwell et al., 2000, p. 246). In Egypt, it is estimated that about 58% of all female circumcisions are conducted by physicians and trained nurse-midwives (Boyle & Carbone-López, 2006, p. 454). Askew (2005) argued that since medicalization “provides a financial incentive for health providers to take up the practice,” it is much more difficult to eliminate FGC where it has been medicalized (p. 469).

Obermeyer (1999) stated that while the problems of pain, bleeding and infection resulting from FGC have always been recognized, problems with labor and delivery were anecdotal and poorly documented. In a prospective study of more than 28,500 women giving birth in health care facilities in six African countries, the World Health Organization (2006) found that women who had undergone FGC had higher morbidity and mortality during childbirth than those who had not, and that the more extensive the FGC procedure, the higher the risk to both mother and infant. Women who had been infibulated had the highest risks. The study concluded that “deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death than deliveries to women who have not had FGM” (WHO, 2006, p. 1839). In addition, there is evidence that infibulations may affect primary fertility (Almroth et al., 2005).

Some argue that medicalization has resulted in “harm reduction”—surely FGC performed under sterile conditions with anesthesia is preferable to FGC performed with a shard of glass—and that medicalization has resulted in the substitution of “Sunna” circumcision (excision) for infibulation in some areas (Antonazzo, 2003, p. 475; Shell-Duncan, 2001). However, it is clear that health education alone does not result in the abandonment of FGC.

Feminism

Another approach to ending the practice of FGC was the feminist view that FGC was a “tool of patriarchy and a symbol of women’s oppression” (Boyle & Carbone-López, 2006, p. 441). Fran Hosken is often credited with turning FGC into an international feminist issue. She published the first Hosken Report on FGC in 1979, and made FGC a feminist issue by featuring it prominently in the Women’s International Network News (Gruenbaum, 2005; Johnsdotter, 2012; Manderson, 2004). Hosken is also credited with re-framing the term “female circumcision,” which implied that FGC was analogous to male circumcision (which does not impair sexuality and has no long-term medical consequences), as “female genital mutilation” (FGM) (Johnsdotter, 2012; Obermeyer, 1999, p. 80).

While the feminist rhetoric of Hosken and others captured the attention of the global community, it was highly controversial (Boyle & Carbone-López, 2006, p. 442). African women rejected the feminist view (Antonazzo, 2003, p. 472). They considered the term, “female genital mutilation,” to be offensive (Khaja et al., 2009; Manderson, 2004, p. 288). They pointed out that FGC is done by women (not men), for women, so that women can take their rightful place in society as wives and mothers. They flatly rejected the Northern view of women as sexual beings who were entitled to sexual choice and sexual pleasure. As Gruenbaum (2005) explained, women from cultures that practiced FGC valued “security, a husband’s love, a stable marriage, and socially approved child-bearing over sexual orgasm” (p. 437). In 1980, African women boycotted a session featuring Hosken at an international women’s conference, calling her perspective “racist,” “ethnocentric,” and “insensitive to African women” (Boyle & Carbone-López, 2006, p. 441).

Human Rights Legislation

Feminist advocacy against FGC, however, was not an isolated issue; it was part of a general feminist movement towards equal rights for women. During the 1970s, the argument that there was a relationship between gender equality and human rights gained ground (Boyle & Carbone-López, 2006, p. 442; Igras et al., 2004, p. 253). In 1979, the Convention for the Elimination of Discrimination Against Women (CEDAW),

which outlined a basic set of principles pertaining to gender and human rights, was adopted by the United Nations (Manderson, 2004, p. 285).

By the 1990s, the campaign against FGC was being framed as an issue of women's rights. A female child's right to be free of FGC, along with other kinds of violence against her person, was legally guaranteed in the United Nations Convention on the Rights of the Child (UN CRC), which came into force in 1990. In 1995, a Joint Statement of WHO, UNICEF, the United Nations Population Fund (UNFPA) and the United Nations Development Programme (UNDP) declared that framing FGC as a medical issue had been a 'mistake,' and asserted that women had a right to bodily integrity, which was interpreted as including the right to remain whole and un mutilated (Boyle & Carbone-López, 2006, p. 443). The Fourth World Conference on Women, held in Beijing in 1995, declared that women had the right to self-determination (to choose whether to have sex, marry, or have a child), and to be free from violence (including cultural practices such as female genital mutilation) (Manderson, 2004, p. 286). Thus, by 1995, female genital mutilation had been re-framed as a form of violence against women, like sexual assault and wife-beating. And in 1996, the U.S. passed legislation requiring countries to ban FGC in order to receive U.S. aid (Boyle et al., 2002). Ultimately, the women's human rights movement led to the adoption of the African Maputo Protocol on the Rights of Women in 2005 by the African Union.

The result of these international agreements was the passage of national legislation to ban FGC. Eventually, 27 of the 28 countries in Africa in which FGC is practiced ratified the UN Convention on the Rights of the Child (CRC) (Boyle et al., 2002, p. 6; Ngokwey, 2004, p. 186). Consequently, by the end of the 1990s, national legislation to ban FGC was put into place by all African countries except Somalia, which did not have a functional government. Ochaita and Espinoza (2001) point out that "the Convention [on the Rights of the Child] is not a mere declarative text, but rather a legally-binding instrument," that obligates all states that ratify the Convention to abide by its provisions (p. 330).

However, the approach of using legislation to end FGC has been largely unsuccessful. WHO (1999) concluded that,

despite bans on FGC at the national level, local practice of FGC remained largely unaffected. A large study in Egypt supported WHO's findings. Egypt already had a national law banning FGC, but in 2000, the law was strengthened so that health-care providers accused of performing FGC were penalized with three years of imprisonment, even if consent had been provided by parents (Hassanin et al., 2008). Hassanin et al. (2008) wanted to know if the new legislation had been effective in decreasing the incidence of FGC. Six years after the new law came into effect, they conducted a study of 3,730 girls attending middle schools in urban and rural Upper Egypt. They found that about 86% of girls aged 10-14 had been cut during the six years since the enforcement of the FGC ban began. They concluded that the new law had virtually no effect on the rates of FGC.

Devereux and Cook (2000) argued that anti-FGC legislation at the national level has not been very successful in eliminating FGC because such laws constitute another attempt to impose "fundamentally Northern concepts and programmes" on the global South (p. 64). They believe that anti-FGC legislation imposed at the national level will be unsuccessful as long as local institutions do not support it. Even in countries like Egypt, where national governments actually want to end the practice of FGC (as opposed to merely fulfilling the requirements for aid), North (1990) noted that "creating a system of effective enforcement ... is a long, slow process that requires time to develop if it is to evolve—a condition markedly absent in the rapid transformation of Africa from tribal societies to market economies" (p. 60).

In addition, as with the health education approach, there were unexpected consequences to imposing national anti-FGC legislation (Kelleher & Franklin, 2008). At the local level, Antonazzo (2003, p. 474) found that when Senegal imposed anti-FGC legislation in 1999 in order to comply with U.S. aid requirements, criminalization seriously hampered Tostan's successful grassroots program to end FGC. Antonazzo (2003) concluded that:

Making genital cutting illegal not only does not stop the practice, but it also turns everyday women and

girls into criminals. It bars women with genital injuries from seeking life-saving help. Even worse, outright criminalization creates a backlash where even more girls than before are having their genitals cut at younger ages, and successful local efforts to end the practice are undermined and rendered temporarily ineffective. (pp. 476-477)

Shell-Duncan (2008) further argued that criminalization due to legislation takes away women's rights to make their own choices. Therefore, she concluded that "efforts to end FGC through a human rights framework" by legislating against it can be seen as being in opposition to the goal of women's empowerment (Shell-Duncan, 2008, p. 231).

Psychosocial Approach

Keleher and Franklin (2008) call the sixth of the unsuccessful approaches to ending FGC the "psychosocial" approach. The purpose of the psychosocial approach is to change attitudes towards FGC. For example, in 2000, CARE decided to reorient their FGC abandonment programs to a "rights-based" approach in order to "play a larger and more direct role in facilitating social change" (Igras et al., 2004, pp. 251, 256). They decided to move from defining FGC "solely as a traditional practice with serious reproductive health consequences," to defining FGC as "an issue of human rights and gender violence" (Igras et al., 2004, p. 253). CARE's goals included empowering women by expanding education to include social and rights messages (Igras et al., 2004).

To implement this new strategy, CARE developed a series of education and advocacy messages about the negative social and health consequences of FGC (Igras et al., 2004, p. 263). Then, they conducted a well-designed intervention using a quasi-experimental design with a treatment and a control group. The attitudes of Somali refugees (who practiced infibulation) in two refugee camps at Dadaab, Kenya were assessed before and after the intervention. Over an 18 month period, using advertising and mass communication campaigns, they presented FGC as a violation of women's human rights in the intervention refugee camp. No educational campaign was conducted in the other refugee camp.

As with other unsuccessful approaches, the results were unexpected. The project evaluators found that “significant changes over the baseline measure have occurred in knowledge of the harmful health, social, and psycho-sexual consequences of FGC” in the intervention camp (Igras et al., 2004, p. 264). However, they were surprised to find that “there was no significant increase in the number of people wanting to end the practice” in the intervention camp (Igras et al., 2004, p. 264). Indeed, the few families in the intervention camp that decided not to circumcise their daughters were subjected to severe social pressure. Igras et al. (2004) reported that:

Other people in the project communities, the majority of whom wanted the practice to continue, started to exert social pressure and show their disapproval of families and individuals that wanted FGC to end. Several families moved from one refugee camp to another in an attempt to escape this social pressure. Families and girls who decided not to undergo female circumcision came to CARE and other agencies to ask for help and protection. (p. 264)

In other words, changing attitudes alone did not stop the practice of FGC. Those who tried to change their behavior as a result of their change in attitudes were subjected to severe social pressure.

The problem with the CARE approach is that while changing attitudes is necessary, it is not sufficient. Beliefs about FGC are socially constructed. They are culturally enacted by communities as a whole. Since they are culturally normative, they are enforced through social sanctions (cf. Imoh, 2012). Therefore, a focus on changing individual attitudes one person at a time will not achieve FGC abandonment. In order to stop the practice of FGC, the attitudes of the whole community need to change. What is needed is a successful model for sustainable change at the community level that can be reproduced.

Successful Programs to End FGC

Two programs have been successful in ending the practice of FGC: one from Ethiopia, and one from Senegal. I first encountered the Ethiopian program in 2008 in Muketuri, a rural

village in Amhara State, about 3 hours north of Addis Ababa. The story of this program is as follows.

In 1999, the German Foundation for World Population (DSW) funded the development of a course on Adolescent Sexual and Reproductive Health (ASRH) in Ethiopia. The program was written by an Ethiopian physician, and produced in Amharic and Oromo, the two most widely spoken languages in Ethiopia. The course included the usual components on sexual health, including prevention of HIV. It also included information on the consequences of three “harmful traditional practices” common in Ethiopia—FGC, bride abduction and early marriage. Then, the international NGO (DSW) turned the program over to an Ethiopian NGO, the Professional Alliance for Development in Ethiopia (PADET). PADET decided to start the program in Muketuri and hired a local young man to lead the program in 2000.

The program goal was to ‘Save a Generation from AIDS.’ The program design was to start an ASRH club in Muketuri, with a target audience of young adults from 13 to 29. In order to join the club, the young adults had to complete the ASRH course, be willing to lead community discussions and participate in other educational activities, and ultimately learn to teach the full course to others.

Initially, progress was slow. Condoms and other birth control methods were displayed during the course. Frank and open discussion of sexual matters was not customary in the community, especially for young women. Only a few young men attended the course. So, the program director met with community leaders, including village elders, the Muslim imam, the Ethiopian Orthodox priest, and parents, explaining the urgency of protecting the young from AIDS through education. Gradually, he made headway among community leaders and parents, who allowed their young people to attend.

Over time, the number of young people (including young women) in the community who completed the course increased. Graduates taught more sessions of the course and conducted educational activities, and an increasing percentage of community members were exposed to information on sexual and reproductive health issues. Club members built an ASRH community education center, which housed a health clinic with a full-time nurse, who is funded by the Ethiopian

health ministry, and participated in fund-raising projects for club activities. New ASRH clubs were started in several adjacent communities.

Although the primary goal of the program was reducing the incidence of HIV–AIDS, club members also participated in many discussions of FGC. Eventually a consensus was reached. In 2005, with support from many community members, including parents, religious leaders, and the women who had formerly been practitioners of FGC, the village elders decided to end FGC in Muketuri. (They also decided to ban bride abduction and the marriage of young women before age 18, other harmful traditional practices covered in the ASRH course.) Since then, several other villages in the area that have ASRH clubs have also decided to follow Muketuri's example and abandon FGC.

The second example of a successful program to end FGC is Tostan in Senegal. It is much larger than the program in Muketuri, and far better known, but in its beginnings it bears considerable similarity to the Ethiopian program. The word "tostan" is Wolof for 'breakthrough' or 'coming out of the egg.' The original program goal was to provide problem-solving skills to rural women in Malicounda-Bambara, an area where men worked as migratory labor in another country for most of the year. Initially, the Tostan program focused on literacy and teaching women the skills they needed to design their own projects as a means of addressing village needs. But then, Tostan added new modules on human rights and on women's health that included sessions on women's sexuality and FGC. Attendance at these sessions on women's health and women's human rights "broke all records, and lessons were disseminated by word of mouth around a much broader community" (Easton et al., 2003, p. 448). UNICEF provided funding for educational materials and most of the facilitator's salary, while the village provided food and housing for the facilitator and the remainder of the facilitator's salary (Easton et al., 2003, p. 446).

The outsiders who developed the original program thought that the women in the village would use their new collaboration and problem-solving skills to meet village needs by developing small livestock projects, well-baby clinics or improving village sanitation or the local water supply (Easton et al., 2003). However, when the women in Malicounda-Bambara

met to decide which village problem they wanted to address, the women chose something entirely unexpected.

They decided that their first priority was to end FGC once and for all. They discussed the issues with neighbors, local religious leaders and village elders. On 31 July 1997, the villagers of Malicounda-Bambara held a press conference in front of 20 Senegalese journalists and declared that they were renouncing the practice of FGC. The declaration was broadcast on national television and radio (Easton et al., 2003). Almost immediately, two nearby villages decided to join with Malicounda-Bambara and end FGC.

Soon thereafter, an imam from a neighboring community—who initially came to convince the women of Malicounda-Bambara that they were wrong, but eventually decided to support them after discussing FGC with the women in his own household—gave them some wise counsel. He advised the women to go to visit friends and relatives in nearby villages in the inter-marrying community, and said,

Do not tell the villagers what to do, but rather what Malicounda-Bambara and Nguerigne-Bambara have done, and why. Then let them tell their own stories and make their own decisions. Avoid using graphic terms or demonstrations for taboo activities. Refer to FGC simply as ‘the custom,’ as everyone knows what is meant ... Avoid condemning ... practitioners ... for practices they have been performing in good faith. (Easton et al., 2003, p. 449)

In less than a year, 13 inter-marrying villages around Malicounda-Bambara pledged not to cut their daughters. Since then, Tostan has offered the Community Empowerment Program to villages all over Senegal (Easton et al., 2003, p. 451). Not every village decides to end FGC. However, Tostan reports that since 1997, more than 5,500 villages in Senegal, and 1000 villages in neighboring Guinea, Burkina Faso, and other West African countries, have joined the women of Malicounda-Bambara in abandoning FGC (Tostan, n.d.). As in Muketuri, ending FGC was not one of Tostan’s original program goals. Nevertheless, a social movement has begun in Senegal.

Characteristics of Successful Programs

Comparing two successful programs to end FGC with the six largely unsuccessful approaches suggests that successful programs have several factors in common. Most programs, including the unsuccessful approaches, convey information about the harmful effects of female genital cutting. However, in addition, the successful programs share three other factors. First, they are community led, not externally driven. Second, they focus on changing social norms at the community level, rather than changing attitudes at the individual or family level. Third, they empower women (cf. Rahlenbeck & Mekonnen, 2010; Shell-Duncan, 2008).

Community-led. The first characteristic of successful approaches to FGC abandonment is that they are community-led (Antonazzo, 2003, p. 475). Community-led change requires full participation, results in the community defining their own needs (Devereux & Cook, 2000), and requires that outsiders hand over control to members of the community (Chambers, 1997). The idea of full participation comes from a set of methods, originally called Participatory Rural Appraisal (PRA), designed to empower the poor and marginalized people of a community to define their own needs, and decide on their own priorities for community development (Kumar, 2002). The goal is for outsiders to 'hand over the stick,' not to the local elite, but to a local facilitator whose aim is to let the villagers, including women, the disabled, and the socially marginalized, make decisions for themselves (Kumar, 2002).

In order to succeed, PRA methods require that outsiders turn over control to the community. Chambers (1997) stated that relinquishing control to the community requires that outsiders step aside and trust communities to make their own decisions. Chambers (1997) described this as difficult, but possible:

to put the last [the poor and marginalized] first is the easier half. Putting the first last is harder. For it means that those who are powerful have to step down, sit, listen, and learn from and empower those who are weak and last. (p. 2)

Trusting the community to make its own decisions is equally difficult for outside "experts," but it is the essence of

empowerment. Chambers stated that “much of the [participatory] rhetoric has been cosmetic and hypocritical as advocates and practitioners have failed to realize the need for personal and institutional change” (as cited in Kumar, 2002, p. 15). In both Muketuri and Malicounda-Bambara, facilitators who were members of the community presented educational information, including information on the harmful effects of FGC. At that point, they stepped back. Villagers could decide to discuss the new information with others, or let it drop. Whether the community decided to end FGC was truly left up to the community. In other words, outside NGOs turned over control to the community. These successful programs to end FGC were community-led, rather than imposed from the outside.

Community-level change. The second characteristic of successful approaches to FGC abandonment is that the goal is to change social norms at the community level, rather than to change attitudes at the individual level. The practice of FGC is driven by and enforced through social norms. As Keleher and Franklin (2008) stated, “FGM/C is a deeply entrenched social convention through which girls and their families acquire social status and respect. Failure to perform FGM/C may bring shame and exclusion” (p. 51). Therefore, change has to come one community at a time, not one individual at a time (cf. Antonazzo, 2003).

Mackie (1996) provided critical insight on this point. He showed that the practice of FGC serves the same social functions, and is enforced through the same social sanctions, as was foot binding in China. Like FGC, foot binding in China had been practiced for at least 1,000 years. Foot binding was said to enhance “womanliness,” promote good health and fertility, and confer higher status. The tiny, 4 inch, bowed feet produced by foot binding were considered aesthetically pleasing and sexually desirable to a husband. At the same time, since women with bound feet could only hobble, bound feet were said to ensure chastity and fidelity. Mothers were responsible for producing the tiny feet so their daughters could marry well; it was unthinkable that a man would marry a woman with unbound feet (Mackie, 1996, pp. 1001-1002). The parallels with FGC are unmistakable.

Yet foot binding was eliminated in one generation in China (Mackie, 1996, p. 999). The critical innovation was pledge societies. If only one family failed to bind their daughter’s feet, the

daughter would be unmarriageable, and the family would be social outcasts. So, the idea of pledge societies was introduced. When everyone in a marriage group pledged not to bind their daughter's feet, and not to marry their sons to girls with bound feet, the social sanctions were eliminated.

The problem that CARE experienced with their individually-based FGC abandonment program in Kenya was the issue of social sanctions. In the absence of change in the whole group, parents who decided not to have their daughter infibulated were violating such a strong social norm that they had to seek "protection" from CARE (Igras et al., 2005). Caldwell et al. (2000) observed the same issue in Nigeria.

The real resistance now in Ekiti [a Yoruba area of Nigeria] to the abandonment of FGM, and probably elsewhere, is cultural in only a very specific sense, that of not behaving in the way most of the society does. Mothers are justifiably worried about their daughters being different, especially in such important matters as their 'femaleness,' being treated as different, feeling different, and being unmarriageable. (p. 251)

Thus, successful programs to end FGC seek change of social norms at the community level, within a marriage group (Antonazzo, 2003, p. 476). Since most African cultures are communally based, a community-based approach has the added advantage of being more culturally appropriate; members of the community will find such an approach more comfortable than an individually-oriented attitudinal approach.

Empowering women. The third characteristic of successful approaches to FGC abandonment is that they include female empowerment. The emphasis is on teaching women the skills they need to "improve their economic and social status, as well as their ability to participate in a process of community consensus around norms upholding the protection of the rights of women and children" (Shell-Duncan, 2008, p. 229). Both the PADET program in Muketuri, and Tostan, in Senegal, trained women to identify and resolve community issues, including, but not limited to, issues involving harmful traditional practices like FGC.

In summary, six approaches to ending FGC have been unsuccessful largely because they have failed to recognize the strength and power of gendered social norms. Like all social norms, the practice of FGC is a “collective cultural pattern with benefits and sanctions anchored in a broad system of social behaviour” (Easton et al., 2003, p. 453). Since FGC is a “collective cultural pattern,” community-wide change must come from within, through literacy and empowerment of women influencing existing social institutions (Asekun-Olarinmoye & Amusan, 2008). However, despite the strength of social norms, culture is not static; it is dynamic. Beliefs about FGC are socially constructed and culturally enacted through daily life in communities. Therefore, Gruenbaum (2005) argued that change can and does occur, because “while cultural values are indeed powerful influences in structuring thought and action, human actors regularly critique their backgrounds, making choices that reinterpret their cultural and religious values” (p. 430).

Successful approaches to ending FGC will of necessity convey information about the harmful effects of FGC. However, in addition, in order to be effective, they must:

- Be community-led
- Change social norms at the community level
- Empower women

The two successful programs reviewed in this paper incorporate these characteristics. They respect local culture, employ participatory methods, and trust communities to determine for themselves whether and how they want to end FGC. As a result, both have been successful in ending FGC. These methods are reproducible and should be employed by international agencies and funders that are interested in ending FGC.

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The 47 Percent: U.S. Trends in Income Maintenance and Medicaid Spending, 1990-2011

ELGIN MANNION

GORDON C. CHANG

We analyze trends and variations in state-level expenditure growth for Medicaid, SSI, SNAP, and TANF. We explore three areas of interest: (1) How program structure impacts growth; (2) How programs responded to the 2008/2009 recession; and (3) How state preference for limited government, measured by Right-To-Work (RTW) status and political affiliation, impacts program expenditure growth. Findings show that program structure impacts expenditure growth: the state-matched programs like TANF and Medicaid grew slower from 1990-2011 than did open-ended federal programs like SNAP. OLS models found states with RTW policies and large Hispanic populations positively associated with higher income maintenance and Medicaid expenditure growth.

Key words: income maintenance, Medicaid, program expenditure growth, limited government, political affiliation, right-to-work status, Hispanic populations

All Western industrial governments re-distribute the national product through a variety of programs, for a variety of purposes (Alesina & Glaeser, 2004). While the United States is relatively more restrained than comparable nations in developing its welfare institutions, programs directed to serving the bottom quartile of the population have been the target of persistent criticism. Means-tested programs without an income stream have generally been the object of the most vocal calls for cutbacks and reforms. Opponents point to the continuously increasing enrollment numbers and expenditures, possibly resulting in a national pattern of dependency (Eberstadt, 2012). The 2012 Presidential election campaign exposed the deep political cleavages concerning government transfer payments targeted to the poor. Mitt Romney markedly said, at a private fundraiser on May 17, 2012, that 47% of Americans paid zero

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federal income tax and were thus “dependent upon government” and “will vote for the president no matter what” (see Mother Jones News Team, 2012).

Post election, attacks on transfer programs are represented in the recent legislation, The Nutrition Reform and Work Opportunity Act of 2013 (H.R. 3102, 2013). In an unprecedented move, the Bill decoupled the Food Stamp or SNAP programs from the Farm Bill, potentially increasing its political vulnerability (H.R. 3102, 2013; House Committee on Agriculture, 2013). The bill proposes to downsize the SNAP program over the 2014–2023 periods, reducing funding by \$40 billion and enrollment by 14 million. In addition, the bill contains sweeping changes to how the program operates. The Southerland Amendment to the bill proposes to reinstate the asset and income tests and work requirements, to eliminate state performance bonuses, actually providing incentives to states to cut program participation (Rogers, 2013). The bill further proposes lifetime bans for felons, drug testing of recipients by states, sanctioning of USDA and state staff for promoting the program, and, most importantly, shifting the burden of funding to state governments. Vocal advocates of block grants cite the advantages of greater state control and autonomy, and the potential for national and regional budget savings (Stenberg, 2008; see also Dilger & Boyd, 2013). Opponents to the proposed reform of SNAP (and Medicaid) into block grants argue that they may lead to deep cuts to the most needy populations, less oversight (Waller, 2005), and may increase the political vulnerability of the program (Pavetti & Schott, 2011).

In order to help inform the increasingly polarized debate about the future of means-tested programs, we analyze the general trends and variations in state-level expenditure growth for Medicaid, SSI, SNAP, and TANF, the programs targeted to poverty groups that do not have an income stream. We explore the following issues that may affect expenditure growth: (1) *Program structure*: Current legislation proposes to turn SNAP into flat-funded state block grants, and block grant reform for Medicaid is in debate. Does program structure (joint state/federal or federally funded) affect state spending levels? (2) *Program flexibility and utility*: Income maintenance programs are intended to provide a safety need for needy populations. How well did the four programs respond to the

2008/2009 recession? (3) *Political preference and economic policy*: Does the preference for small government inform state-level redistributive policies, and result in slower growth and lower expenditures for means-tested programs at the state level? Do business-friendly, state-level economic policies, namely Right-to-Work (RTW) legislation, influence the state-level program expenditure?

Income Maintenance: Important Safety Net, or Political “Gifts” and Efficiency Drain?

President Kennedy (1962) once remarked about fiscal policy: “the myths are legion and the truths hard to find.” The ideological divide over income maintenance programs cuts to the core of what type of society and size of government is considered desirable, and what fiscal strategy best fosters economic growth, with little or no common ground. From the progressive perspective, the income distribution is a “public good” (Thurow, 1971). Income maintenance programs provide an important safety net for the needy and result in a more equitable distribution (Cassiman, 2008; see also Calvo, 2011). While some short-term effects may be observed, they do not necessarily encourage long-term dependency (e.g., Vartanian, Houser, & Harkness, 2011). Governments redistribute resources to the poor for the political purposes of stability and equity (Okun, 1975; Thurow, 1971) or the objectives of stimulating aggregate demand in economic downturns (Romer & Bernstein, 2009; Weber, 2000; Zandi, 2008). From the Keynesian perspective (Keynes, 1964), transfer payments along with government purchases and tax cuts are important fiscal tools for government to deploy in times of economic contraction, creating a “floor” beneath which aggregate demand cannot fall. Tax cuts and transfer payments are best targeted to the middle and lower end of the distribution rather than the top, as they are more likely to immediately consume. Roosevelt’s New Deal and the Kennedy and Johnson administration’s “War on Poverty” programs subscribed to this theory of active government intervention in the economy, creating the very poverty programs now so hotly contested.

By contrast, the “classical” economic tradition prefers a minimalist model of state intervention. Resources need to

be shifted to those in the position to efficiently use them, the “savings class,” or in new parlance, the “job creators” (Bradley & Rector, 2010; Mankiw, 2013). Fiscal policy focused on deficit spending measurably impairs economic growth (Reinhart & Rogoff, 2010) by reducing labor market flexibility and diverting scarce sources from productive use (Gylfason, 1999). Personal government transfers “leak” economic efficiency and stifle innovation (Mankiw, 2013; Okun, 1975) in the misguided quest for equity. From the Public Choice Perspective (Buchanan & Tullock, 1962), income maintenance programs are examples of the “disease of democracy” (Rowley, 1993). They constitute, in Romney’s words, the political “gifts” (quoted in Berman, 2012) to voters that actively create the notorious 47%, or the “rent seeking” government-transfer-dependent populations (Becker, 1985). *A Nation of Takers* by Nicholas Eberstadt (2012) is a recent, widely publicized restatement of this argument, finding exponential growth in transfer payment from 1960 to 2010.

Such a preference for limited government, a quest for Federalist state autonomy, informs the debate on devolving programs such as SNAP and Medicaid into flat-funded block grants. The literature on the desirability of means-tested block grants as a model for income maintenance is divided. Block grants are fixed amounts (Dilger & Boyd, 2013), and are thus viewed as an aid in trimming costs on the local and federal level, as noted by Senator Paul Ryan. Block grants give the states, which are purportedly best qualified for local problem-solving, the needed flexibility to do so without the federal strings attached. They differ in legal status from open-ended entitlements structured like SNAP and Medicaid, which create individual “rights” to benefits that can be litigated (King, 2000; Melnick, 1994). Opponents point to incidences where states’ broad flexibility can divert funding from the needy (Posner & Wrightson, 1996) and lack the effective, mandatory program oversight built into entitlement programs (Waller, 2005).

Recent policy innovations by conservative governors at the state-level target entitlement reforms (Malanga, 2013). The combination of state budget shortfalls and vocal political aversion to redistributive programs creates a renewed need for comprehensive, comparative analysis of state-level funding and policy outcomes. The existing literature identifies major

factors explaining state-level variations in social spending. Economic factors identified include per capita incomes and a state's fiscal and revenue capacity (Holcombe & Stroup, 1996). Interestingly, states with less fiscal capacity spend less on social programs, despite federal grants, and use less of their own resources (Dilger, 1998; The Lewin Group, 2004). Most studies do not find a link between political culture, executive party control at the state-level, and state spending levels (Dilger, 1998; Holcombe & Stroup, 1996), with a few exceptions (Elazar, 1966; Hager & Talbert, 2000).

We explore an added political and economic proxy measure of interest to capture state-level preference of limited government and pro-business policies, the individual states' Right-to-Work status. Currently, 23 states have RTW laws, with Indiana becoming the most recent RTW state in February 2012. RTW legislations generally outlaw "union security" clauses, mandating workers in a collectively bargained contract to pay a share of the cost for union representation. RTW laws by themselves alone may have little effect on shaping economic performance, but they are a proxy of a vast array of "business friendly" measures that states have adopted to increase labor market flexibility, such as low tax rates, cash incentives for relocation, and lax environmental and safety regulations (Holmes, 2000; Lafer & Allegretto, 2011). Central to RTW policies is control of labor costs, and RTW states generally have lower per capita personal incomes (Gallagher, 2012).

Historical Background of U.S. Means-Tested Transfer Programs

In American public political discourse, the neutral term "transfers" has long been abandoned in the fight to curb government spending (Lind, 2012). Rather than transfers, more ideologically loaded terms like "welfare" or "entitlements" are generally used when discussing the future of redistributive programs. "Entitlements" generally refer to those programs that have been paid into by individuals through payroll taxes, such as Social Security, Medicare, Veteran's benefits and Workmen's compensation. "Welfare" refers to programs that are need-based and "means-tested" (Rector, 2012), and is defined by the Department of Commerce as "benefits received

for which no current service is performed" (Eberstadt, 2012). The cash program Earned Income Tax Credit, a subsidy for low-wage earners, is not part of this group due to work requirements, and therefore is not included in our analysis.

These means-tested programs make an easy target politically. Proposed cuts resonate well with a predictable base of voters. These programs are not represented by an effective lobby as are Social Security, Medicare, and Farm Subsidies. Proposing cuts thus generally does not incur political risks (Derthick & Teles, 2003). The four programs that fit this description are TANF (Temporary Aid for Needy Families) cash payments, the target of the 1996 Clinton PWRORA Welfare Reform; SSI (Supplemental Security Income) disability payments; SNAP, the Food Stamp Program; and Medicaid, medical care targeted to low income populations. Politically important, they have different funding streams: TANF and Medicaid are joint Federal/State programs, whereas SSI and SNAP are federally funded only.

The TANF/ADFC (Temporary Aid for Needy Families, formerly Aid to Dependent Families and Children) program consists mainly of cash assistance. It was created in 1935 as part of the Social Security Act, intended for "orphans" missing one or both parents. It was considered, in the context of the Great Depression, more advantageous to aid widows than have them take scarce jobs from male breadwinners (Trattner, 1999). This program was funded by states receiving unlimited Federal funds with matching state grants for eligible families. The program was generally disliked, often on moral grounds of encouraging out-of-wedlock birth. As individual states had the power to set the levels, 19 states passed legislation in the 1950s to exclude "undeserving" families such as single mothers and African Americans (Howard, 2007; Trattner, 1999). The continual program growth during the 1960s-1980s period generated further criticisms. Critics blamed the program for a variety of social ills such as the rise of single heads of households and family dissolution (Murray, 1984). The widespread criticism led to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) (P.L. 104-193, 1996). The 1996 Welfare reform for TANF under Clinton set time limits, added work requirements, and focused

on reducing unmarried births. Today, a large portion is given to children directly. Matched maintenance-of-effort requirement (MOE) fixed-amount block grants can be used in a variety of ways other than cash payments to clients. Only about 41% is spent on cash payments; the remainder is spent on childcare, job training, and transportation (Falk, 2013). Currently, TANF has not been reauthorized since 2010, and states have had to rely on short-term block grant extensions. Waivers granted by the Department of Health and Human Services to help with some of the more stringent work requirements have not been used by any state (Falk, 2013).

SSI (Supplemental Security Income) was originally an amendment to the Social Security Act, created by Nixon in 1972 to standardize payments to the blind and disabled that were considered inefficient and unfair. A federal program funded by general taxes rather than social security taxes, the program experienced rapid expansion in the 1990s. The rapid growth for SSI also led to reform under PRWORA, restricting eligibility in cases of drug and alcohol addiction, childhood disability, and excluding aliens (Berkowitz & Dewitt, 2013). Today, clients' assets must not exceed 2000 dollars.

The Food Stamp program, or SNAP, was started in 1939 by USDA director Henry Wallace to put agricultural surpluses to use during the depression. The program ended in 1939. During the Johnson Administration, the program was reauthorized and fully funded through the Food Stamp Act of 1964, which also contained price subsidies for a variety of commodities. The program, which can be waived by states, generally expanded until the 1996 PRWORA legislation, which also imposed time limits on able-bodied adults. Both Food Stamps and subsidies were historically used as leverage to reach compromise on each Farm bill, until the recent decoupling from the House. The George W. Bush administration's 2002 Farm Bill made it easier for states to administer the program to recipients, and the 2008 Farm Bill increased benefit levels (Congressional Budget Office, 2012). The American Recovery and Reinvestment Act of 2009 (ARRA) (P.L. 111-5, 2009) used \$45 billion to expand SNAP benefits. Forty-six states took advantage of the waiver during the 2008/2009 recession (Robertson, 2012).

Medicaid is by far the largest expenditure of the four

programs (see Table 2). Medicaid was created 1965 by the Johnson Administration by amending the Social Security Act as an entitlement program to help states provide medical coverage for low-income families (Katz, 1996). States have to match up to half the federal funds (the average is 57%), and states may bundle benefits with S-CHIP, the program that assists with children's health care. Federal payments vary from state to state, according to state per capita income, ranging from 50-82% federal matching (Kaiser Family Foundation, n.d.). Most states choose to use private providers and establish their own rates for providers. As cost and enrollment have steadily grown, states have cut pay to providers and tightened eligibility. Medicaid funding has become a major budgetary item for many states in fiscal crisis, with states spending 18-20% of state budget on the program. In 2012, 13 states cut Medicaid to balance their budgets (Kaiser Health News, 2012). As part of the Affordable Care Act, starting in 2014, people with income of up to 133% of the poverty line can qualify for coverage, including adults without dependent children. State governors who opposed the Affordable Care Act did not participate in the Medicaid expansion.

The cash program Earned Income Tax Credit (EITC) was initiated by Gerald Ford in 1975 and expanded and indexed to inflation by Ronald Reagan in 1986 (Alstott, 2010). The program eliminates the income tax liability of low-income workers, an idea originally credited to Milton Friedman. Twenty-seven million income tax filers received \$63 billion in federal refundable credits in the tax year 2012 (Flores, 2014). The EITC is thus a costly program which leads to errors on tax returns (Faler, 2014). The program is also implicated in creating disincentives to marriage and work, and increasing the ranks of people exempt from tax liabilities (Alstott, 2010; Faler, 2014). However, the work requirements and Republican heritage of the program have made it largely exempt from attacks, and there is currently no pending legislation for EITC program reforms.

Methods

Our investigation is informed by the following research questions:

1. Does the Federal or state-matched structure of the program influence program spending?
2. How well did the programs respond to the 2008/2009 recession?
3. How does political affiliation and associated economic policies influence the state-level program expenditure?

To address the first question, we analyze state and regional trends in enrollments and expenditures, and calculate state and regional variations in program expenditures through continuously compounded growth rates, commonly used for population growth, compound interest, and forecasting. We calculate growth rates for the years 1999-2011, the last available date from the same time series, and growth rates for the last and current administrations 2000-2008, and 2008-2011. Some authors of the most alarmist transfer payment program growth rates (Eberstadt, 2012) have not clearly disclosed what type of technique they used to calculate the resulting numbers. In all likelihood, the high rates of growth were calculated through relative change. Relative deltas calculate the difference as a percent of the base value between two end points, and thus can overestimate growth among high values, and respond poorly to negative numbers, which the programs such as SSI, TANF have had in many years in the last decades. In contrast, continuously compounded growth rates take the natural log. The number of compounding periods per year increases without limit, the *continuous compounding* referred to in the term.¹ The natural log (\ln) is the effective annual rate of growth, the amount of time needed to reach a certain level of continuous growth. This measure is preferable, since variables like expenditure, GDP, and population growths are often exponential and non-linear. This measure is also preferable to relative-change percentages because the rise and fall of growth rates are not symmetrical.

For regions, we use the Bureau of Economic Analysis (BEA) operational definition of U.S. regions. We calculate yearly rates of change for the program expenditures for Medicaid, SNAP, TANF and SSI, from BEA's time series record of "Personal

Current Personal Transfer Receipts (SA-35) (U. S. Bureau of Economic Analysis, n.d.).

In order to assess programs' responses to the 2008/2009 recession, we calculate a yearly rate of change for real GDP, Medicaid, SNAP, SSI and Medicaid for the years 1997-2011. We compare and plot the yearly program change against GDP. We adjust all the required time series for constant dollars with GDP deflators, also available from the BEA.

In order to study the relationship between political affiliation and associated economic policies and state-level program expenditure, we construct an OLS regression model. The model tests the hypothesis that the rhetoric of a small-state footprint, advocated more by proponents of RTW legislations and Republican leadership, is indeed implemented in state-level practice. In other words, RTW status and political affiliation with the Republican Party is hypothesized to be negatively associated with means-tested transfers, as we have assumed that the preference for a small government informs state-level redistributive policies. RTW status has been used in previous studies as a proxy for business friendly policies, specifically increased labor market flexibility, and less regulation (Holmes, 2000; Lafer & Allegretto, 2011; Zullo, 2011). The composite measure "Income Maintenance" from the BEA includes TANF and SNAP, as well as some other smaller programs such as Women, Infants, and Children (WIC); total Medicaid amounts from the BEA are the outcome variables. We do not model TANF and SSI individually, as the expenditures are relatively small in comparison to SNAP and Medicaid.

The two outcome variables are modeled as a 1990-2011 growth rate, and Medicaid as a capita amount in 2011 (per capita income maintenance is too small an amount to have an effect). Explanatory variables modeled are: 2011 population, continuously compounded Income Growth (as measured by growth in Per Capita Personal Income) and GDP growth (U.S. Bureau of Economic Analysis, n.d.), percent of all ages in poverty in 2011, percent of African Americans in 2011, percent of Hispanics in 2011 (<http://www.census.gov/>), regional dummies for the BEA regions, a dummy for Republican measured by voters' preference in the U.S. Electoral College in the last four consecutive Presidential elections (2000-2012) (which captures consistent "red" states), and a Right-to-Work dummy

to control for states' preference for business friendly policies and labor market flexibility. Indiana is not treated as a RTW state in our paper due to the data years we analyze. Our study is limited by the very broad measures of political affiliation and economic performance used. More differentiated measures for state-level economic performance, such as exports, sectorial composition, and measures that capture recent policy innovations need to be developed for useful comparisons.

Results

General Description and Overview

In order to determine how spending on income maintenance programs and Medicaid compare across states, we look at all government transfers as a percentage of personal income. The percentage of all government transfers in income range from 12% (North Dakota) to 26% (West Virginia). In 22 states, government transfers do constitute nearly a fifth of income, ranging from 19-26%. Total income maintenance, however, only ranges from 3% to 1% of personal incomes in the 50 states. Pensions, Disability and Social Security constitute the larger percentage of personal income, ranging from 5-8% of personal income. Medicare ranges from 1-5% of personal income, and Medicaid from 1-3% (not shown in Table). With the exception of Maine, the remaining 10 states where government transfers are above 20% have poverty rates well above the national average of 15.9% and high percentages of minority populations (see Table 1).

Currently, thirteen states have slashed Medicaid and other matched programs to balance strained budgets (Kaiser Health News, 2012). Programs intended for low income populations are targeted for cuts in national and state budget proposals. Continuously compounded growth rates from 1990-2011 show a decline for both TANF and SSI, the programs targeted by welfare reform in 1996. We find 6% growth for Medicaid and 8% growth for SNAP. Enrollment for programs ranges from a low of 1.5% and 2.5% of the U. S. population for TANF and SSI, and 14.4% for SNAP. Medicaid by far has the highest program expenditures, as well as largest enrollments at 17% of the population (see Table 2).

The growth rates show an interesting political effect that

responds to our research question whether program structure affects spending levels. Programs that require state funding grew slower both in dollar amounts and enrollments (enrollment growth not shown). The Federal program SNAP experienced the most growth, whereas the state-matched program TANF declined from 1990-2012, and Medicaid grew modestly. It is important to note that while Medicaid expenditures grew even faster than SNAP, it did not significantly grow in enrollment between 1990-2011. The Medicaid expenditure growth was primarily driven by dramatically rising costs of healthcare, a widely-noted phenomenon (Jacobs & Skocpol, 2002), as state governments have continuously restricted eligibility and cut cost to providers.

Table 1. Government Transfers as Percent of Personal Income 2012.

State	All Govt. Transfers % of Pers. Income	Income Maint. % of Pers. Income	% in Poverty	% African American Population	% Hispanic Population
West Virginia	0.26	0.03	18	3.2	0.7
Mississippi	0.24	0.03	23.8	36	1.4
Arkansas	0.23	0.02	19.6	15.5	3.2
Kentucky	0.22	0.03	19.3	7.2	1.5
Alabama	0.22	0.03	19	29.2	1.7
South Carolina	0.22	0.03	18.3	28.9	2.4
Maine	0.22	0.02	14.4	0.5	0.7
Michigan	0.21	0.03	17.4	14.1	3.3
New Mexico	0.21	0.03	20.6	13.3	42.1
Tennessee	0.20	0.03	18	16.1	2.2
Arizona	0.20	0.02	18.7	5	25.3

The yearly rate of change in dollar values for the last three decades similarly shows different patterns for matched and federally funded programs. Medicaid growth has

generally been below 10%, barring the flexibility expansions under President Bush in 2001. TANF growth since the 1996 welfare reform, barring the extra ARRA funding during the recession, has been a modest 2-3%, with 10 years of the 30 showing declines in funding.

Table 2. Program Participation, Average Monthly Benefit, and Expenditure Growth Rates, 1990-2011.

Program	Amount (in billions)	Average Monthly Benefit	Enrollment 2011 (in millions)	% of U.S. Population	Type of Program	Growth 1990- 2011 Cont. Comp.	Growth 1990- 2011 Rel. Change
SNAP	78	\$287	45	14.4%	Federal	8%	228%
TANF	30.6	\$378	4.6	1.5%	State/ federal	-1%	-28%
SSI	47	\$478	7.7	2.5%	Federal	-2%	101%
Medicaid	404.1	\$6,775	52.9	17.0%	State/ federal	6%	244%

Growth for federally-funded programs, unlike TANF and Medicaid, is positive for the three decades. Growth for SSI expenditures since the 1990s has mostly ranged from 2-6% following the restrictions from the 1996 welfare reform (see also Table 3). With the exception of 1996 welfare reform, the open-ended Federal program, SNAP, has grown rather quickly both under the George W. Bush and Obama administrations. Clearly, states have put the brakes on growth in programs that are partially states' responsibilities and taken advantage of the easier access and program waivers instituted by the Bush and Obama administrations for Food Stamps. Looking at the growth of programs in U. S. states and regions, we find slightly higher growth for all four programs for the Rocky Mountain and Southwest regions, very likely due to the states that have high percentages of Hispanic populations. States such as Arizona (25.3%) Colorado (17.1%), New Mexico (42.1%), and Nevada (19.7%) are represented among the top ten in growth for these programs (tables showing individual rates of growth in states and regions available upon request).

Are programs targeted to low-income populations responsive to economic contractions, given the means-tested nature

of the programs? Given increased need in times of recessions and increasing unemployment, we would expect a decrease of programs in periods of economic expansion, and an increase in funding during the recent recession. Looking at program expenditure plotted to GDP yearly change, TANF and SNAP do respond to the 2008-2009 recession by expansion (see Figure 1). It is important to note that program expenditures were increased and access to the program eased legislatively by both the George W. Bush and the current administration's expansion of the 2009 Recovery Act (ARRA). Medicaid and SSI, however, only moderately expanded in the 2000-2001 and 2008-2009 recessions. During the 2008-2009 recession, SSI increased a modest 3.8%, and Medicaid 4.8%. Due to the restrictions placed on Medicaid, few adult people who lost their employer-based health care transferred to Medicaid. The increase mainly reflected children covered (Holahan & Chen, 2011). TANF and SNAP grew 7.2% and 28% respectively (see Table 3).

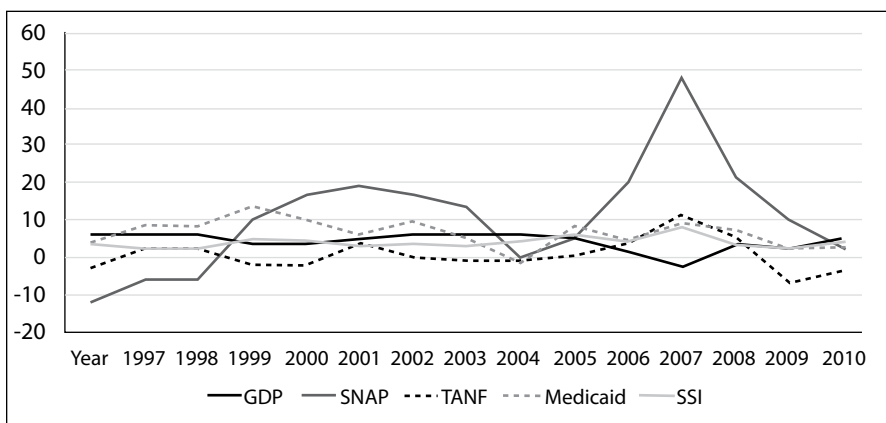
Table 3. GDP, SSI, SNAP, TANF and Medicaid Expenditure Yearly Rate of Change, 1997-2012.

Year	GDP	SSI	SNAP	TANF	Medicaid
1997/1998	5.52	4.01	-12.1	-2.51	4.33
1998/1999	6.41	2.31	-6.02	2.82	8.44
1999/2000	6.43	2.1	-5.87	2.9	8.09
2000/2001	3.38	4.69	9.63	-1.81	13.92
2001/2002	3.47	4.53	16.57	-2.33	10.01
2002/2003	4.69	3.04	18.87	3.86	5.81
2003/2004	6.38	3.85	17.27	0.28	9.56
2004/2005	6.49	3.14	13.67	-0.34	5.04
2005/2006	5.98	4.29	-0.35	-0.7	-1.74
2006/2007	4.87	5.76	5.21	0.99	8.38
2007/2008	1.84	4.3	19.77	3.91	4.36
2008/2009	-2.28	8.1	47.87	11.18	9.14
2009/2011	3.74	3.32	21.46	5.44	7.42
2010/2011	3.97	2.41	9.34	-7.23	2.23
2011/2012	4.05	4.27	2.93	-3.31	2.86

Note: Data during and after the Great Recession years are italicized.

SSI, a relatively small program, tracks GDP growth almost perfectly, increasing during economic expansion, and contracting along with economic downturns. These results indicate that Medicaid and SSI, programs that address healthcare and disability, were only moderately increased in times of economic downturns. SNAP, the open-ended federal program with the least restrictions in terms of eligibility, is the most expanded program in the 2008/2009 recession (see Figure 1).

Figure 1. GDP and Medicaid, SNAP, SSI and TANF % Yearly Change, 1997-2011



Political and Economic Determinants of Expenditure Growth

Our analysis looks for evidence on how the purported preference for small government informs state-level redistributive policies, and whether business-friendly economic policies, namely RTW legislations, influence state-level program expenditure.

Table 4 illustrates the effects of our main variables (i.e., *RTW* and *Republican*). In regression model I, the composite variable *Income Maintenance Growth* shows a positive, statistically significant effect of RTW legislations. This finding indicates that the lower wages associated with RTW legislations generally need to be mitigated through increased transfer payments over time.

Actually, RTW states also experience faster per capita *Income Growth*, which reduces *Income Maintenance Growth*.

However, this faster *Income Growth* is not enough to offset the overall impact of lower wages. Even when we remove *Income Growth* from our control model, RTW states still experience

Table 4. Regression Coefficients for Income Maintenance Growth, Medicaid Growth, and Per Capita Medicaid Expenditure.

Independent Variable	Model I Income Maintenance Growth	Model II Medicaid Growth	Model III Per Capita Medicaid 2011
RTW Dummy	1.759*** (.000)	.041	-.272* (.035)
Republican	.297	.202	-.043
BEA Regions	.022	.183	-.066* (.017)
Population (in millions)	-.091*** (.001)	-.090** (.004)	.011
% AA	-.004	.018	.002
% Hispanic	.056* (.012)	.100*** (.000)	-.003
Poverty	-.069	-.033	.070* (.014)
Income Growth	-1.838*** (.000)	-1.082* (.014)	--
GDP Growth	.013	.102	--
Log PCPI	--	--	1.162* (.035)
Log GDP	--	--	-.131
Intercept	12.652*** (.000)	9.318*** (.000)	-10.081 (.101)
R Square	.643	.518	.502
Adjusted R ²	.563	.410	.390

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

higher growth in income maintenance transfers (see model I in Table 5). One tangible reason is that per capita *Income Growth* is unevenly distributed by concentrating on the upper-income populations. Therefore, the results here suggest that, at a state level, pursuing higher, aggregate *Income Growth* by permitting lower wages and increased labor flexibility would likely lead to an aggregate increase in transfer payment needs in the state population in the long run.

Per Capita Medicaid shows a significant but negative association with RTW dummy variable. This result indicates that RTW states tend to adopt the policy of cutting Medicaid. RTW legislations and Republican leadership are associated with lower personal incomes and higher poverty rates in most RTW states. Nine out of 10 states that occupied the lowest PCPI ranks in 2011 were all Republican states, and seven were RTW states. But the funding amount per capita is generally less in RTW states; indeed, model III shows this pattern to be true even when the poverty rate is controlled for. The lesser expenditure thus clearly indicates a state-level policy preference rather than the extent of social need.

For a political effect, the variable *Republican* in the last four elections is not statistically significant with the dependent variables. The *Republican* variable becomes significant when we remove the RTW dummy variable, which is highly correlated with Republican ($r = .60, p = .000$). Of the 24 Republican states, the following seven did not have RTW statuses as of 2011: Alaska, Georgia, Indiana, Kentucky, Missouri, Montana, and West Virginia. Of the 22 RTW states, the following three did not have four consecutive Republican administrations: Florida, Iowa, and Virginia. In a stepwise analysis not shown here, we find that the effects of RTW and *Republican* behave similarly when the other variable is not present, but RTW is a better predictor than *Republican*, yielding higher R square values in all models. RTW legislations may thus be a more important predictor on transfer payments patterns than political affiliations.

BEA Regions, specifically the prosperous Far West region, California, Washington and Oregon, is negatively associated with *Per Capita Medicaid*. This result indicates an interesting difference in those states' willingness to fund Medicaid programs

compared to their Northeastern counterparts. Race has an independent effect as well. Both the composite *Income Maintenance Growth* and *Medicaid Growth* variables are positively associated with *Percent of Hispanic* population. Individual states with high percentages of Hispanics are represented among the top ten in individual program growth expenditure (tabular data available upon request). These results cause concern: they indicate that Hispanics are inadequately integrated into the labor market and require medical and income assistance.

These results have been checked against the potential risks posted by multicollinearity. The variance inflation factors (VIF) of all models in Table 4 are below 5.0, which is below the standard 10.0 threshold. In addition, we have run models by removing several highly correlated variables that are near or above .60—specifically, *Log PCPI* and *Log GDP*, which correlate with *Poverty* and *Population* respectively; *Republican*, which correlates with *RTW Dummy* at a .60 level; and *Poverty*, which correlates with *Percent of African American*.

Conclusion

Where do we go from here in terms of reforms for means-tested programs? In concrete terms, which policies and programs should receive support in the interest of a more equitable society? Our results show growth for the programs from 1990-2011 has been relatively modest, with the exception of SNAP, the food stamp program. The structure of the program clearly affects program spending: the state matched programs of TANF and Medicaid grew modestly, and TANF has been in decline for many consecutive years. Clearly, states use programs they have to match less freely: forty-six governors of all political persuasions availed themselves of SNAP waivers during the recession. States visibly limited Medicaid spending: adjusted for inflation, growth for the U.S. was a modest six percent, and much, if not all, could be attributed to the rise in cost.

Given this context, turning SNAP into flat-funded state block grants, an effort repeatedly led by House Republican legislators, would in all likelihood lead to consistently lower levels of funding and restrict the program's accessibility. SNAP could possibly follow the TANF pattern of enrollment and funding

growth since 1996, a scenario that would in all likelihood increase food insecurity among the most needy populations. In the recent recession, SNAP, the open-ended federal program, was the only program meaningfully expanded. TANF, SSI and Medicaid only moderately expanded. SNAP therefore has provided an important safety net for the needy, and should thus be vocally supported. What other program could be as responsive as SNAP to expand the safety net in economic downturns? State budget shortfalls and cutbacks targeting poverty programs will most likely continue in the foreseeable future, requiring continued need for a federal program.

Income maintenance programs show an interesting geographical and political discrepancy between the need for poverty programs and the publicly-professed political aversion. At the very heart of the debate over income maintenance programs is the argument that less focus on redistribution and more on business-friendly policies increases economic growth. Findings show the contrary: the lower wages associated with RTW policies are associated with increased income maintenance growth and increased need for state-sponsored health care in the long term (even if the needs may not always be met).

While such states may gain income growth for the upper-class residents and labor flexibility, the system is inequitable because such gains need to be mitigated by all U.S. taxpayers through federal programs, burdening residents in non-RTW states disproportionately. These measures also seem to come with increased transfer payment dependency. Missouri and Michigan recently passed RTW legislations, and Pennsylvania and Alaska are the current battlegrounds for similar legislations. The push to pass RTW legislations should be resisted. Of special concern are states with large minority populations, specifically Hispanic populations, which show accelerated levels of income maintenance and state assisted medical care. The adoption of RTW laws, combined with cutbacks in state funding, would clearly affect these vulnerable populations.

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Endnotes:

1. Growth $N = N_0 e^{rt}$. Where: r is the rate of natural increase. N_0 refers to the initial amount of expenditure. N is the amount of

expenditure after a certain time, t , has elapsed. e is the constant 2.71828... (the base of natural logarithms). As the Natural Log (\ln) is the amount of time needed to reach a certain level of continuous growth, interpretation of the resulting number is straightforward, as it is the annual growth rate.

2. For example, the budget increase from \$100 to \$120 may be an increase of 20%, but for a subsequent budget cut from \$120 to \$100, the percentage change would be -16%. Assessing growth rates in fluctuating situations by taking a natural log would remedy the shortcoming: both $\ln(120/100)$ and $\ln(100/120)$ are symmetrical (0.1823 and -0.1823, respectively). This measure thus offers more precision for our assessment.

Understanding Fringe Economic Behavior: A Bourdieusian-informed Meta-ethnography

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This paper is a meta-ethnography of four low-income communities in order to explore fringe economic behaviors. Rejecting the interpretation of fringe economic behaviors as irrational, we affirm these behaviors as viable alternatives for people marginalized in the mainstream economy. Using a meta-ethnographic method and employing the concepts of sociologist Pierre Bourdieu, we identify the habitus and social capital values of each community as distinct Bourdieusian fields and conclude that an awareness of the localized development of a fringe economic cluster with distinct goals and rules undermines one-size-fits-all social welfare programs.

Key words: meta-ethnography, social capital, economic security, financial stress

Evidence suggests that the social work profession's embrace of cultural competence as an ethical issue (Code, 2008) and practice competency (CSWE, 2008) has not been fully extended toward socioeconomic and class differences. Hodge (2003) noted a lack of research on social class while documenting substantial value differences between social work professionals and the working and middle classes. More recently, Strier, Feldman, and Shdaimah's (2010) content analysis of 50 social work introductory textbooks argued that the profession "has overlooked or even denied the relevance of social class" (p. 406). To the extent that socioeconomic and class differences may be under-represented in the social work literature, we offer a partial corrective in our focus on those marginalized from the mainstream economy. This paper is a first attempt to describe the contours of economic behaviors outside of the

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mainstream and relies upon ethnographic studies in the hope that greater depth of understanding of these economic behaviors may provide a foundation for theory building and policy formulations.

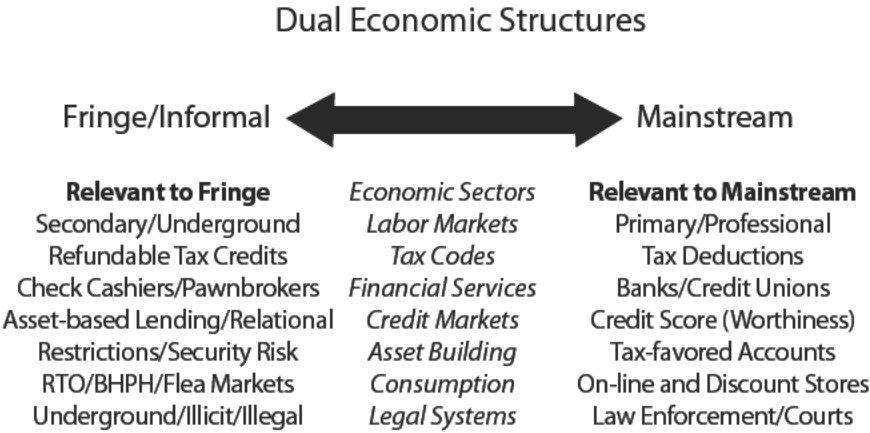
Economic sectors outside of the mainstream economy include the *fringe economy* and the *informal economy*. In the narrowest sense, the fringe economy is a synonym for alternative financial services (i.e., payday lenders, check cashiers, rent-to-own stores, buy here–pay here used car dealers, and tax refund lenders) that serve as a legitimate and regulated predatory barrier to full participation in the mainstream economy (Karger, 2005; Rivlin, 2010). In contrast, the informal economy has been described as “a process of income-generation ... unregulated by the institutions of society, in a legal and social environment in which similar activities are regulated” (Castells & Portes, 1989, p. 12). However, the distinction between fringe economy and informal economy is not relevant to this study, because the fringe and informal economies share some of the same customers (people with low incomes) and geographies in an economically developed nation like the United States (Karger, 2007; Mann, 2012; McMillian, 2012).

The fringe economy, narrowly defined, cannot be understood in isolation from the informal economy because of the extensive social, geographical, and economic affinities that are shared. Accordingly, the use of fringe economy in this paper is intentionally an expansion of the term to include the informal economy in order to emphasize the marginalization of people excluded from the mainstream economy (Figure 1). In comparison to the mainstream economy, the fringe, so understood, has less social legitimization and greater affinity toward secondary and tertiary labor markets (legal, but characterized by low wages, few benefits, short tenures, and inadequate career pathways), means-tested social welfare, reliance on charitable services, illicit employment (employment that would be legal if employer and employee complied with all regulatory requirements), and illegal activities (Dohan, 2003). The mainstream economy is supported and maintained by formal legal structures (law enforcement, courts, contract law); however, the fringe economy, except for alternative financial services, is supported and maintained by informal social structures that are geographically bounded (Dohan, 2003; Sherman, 2009;

Venkatesh, 2006).

While there is an extensive body of literature on the macroeconomic components and implications of the informal and fringe economies (see Danesh, 1991), there is less about why people participate in it. That said, two theories can inform our understanding of why the fringe economy is utilized. The political economist Hirschman (1970) contends that under deteriorating conditions, human beings will “exit” the system or gain “voice” to challenge and improve the system. In the case of the social economy, therefore, when one cannot be sustained through formal work, one will turn to acquiring resources through the informal economy. Additionally, rational choice theory can be used to understand participation in the fringe economy. Rational choice theory is a theory of human behavior regarding choice-making, and is based in neoclassical economic theory (Arrow, 1989; Becker, 1978). Rational choice theory is based on the assumption that, when making a choice, people will calculate the benefits and costs of one decision over another, with the ultimate attempt to maximize utility (i.e., benefit), while minimizing cost. The theory is also used to explain seemingly irrational choices, such as the choice to buy cigarettes instead of food (see Suranovic, Goldfarb, & Leonard, 1999).

Figure 1: Dimensional Distinctions between Mainstream and Fringe Economies



Consistent with the perspectives of Dunlap, Johnson,

Kotarba, and Fackler (2010), we understand the financial behaviors of people in the fringe economy to be viable alternatives to mainstream avenues of acquiring social capital and income. Fringe economic behaviors are neither irrational (counter to the thought of most behavioral economists, e.g., Camerer, Lowenstein, & Rabin, 2004) nor uninformed, as the Financial Literacy and Education Commission assumes (FLEC, 2011). We reject understandings of fringe economic behavior based on interpretations of these behaviors as deficient and assert that fringe economic behaviors are rational, adaptive, and protective from the perspective of people who intersect with this sector of the economy. We contend that understanding fringe economic behaviors is a prerequisite to establishing anti-poverty programs and policies that will lead to self-sufficiency and greater participation in the mainstream economy.

It has been suggested that the work of French sociologist Pierre Bourdieu is relevant to the complex social issues that define the field of social work (Garrett, 2007a, 2007b). Bourdieu's work consistently emphasizes the dynamic interplay between social structures and social actors, and this "primacy of relations" defines social reality (Bourdieu & Wacquant, 1992, p. 15). This theoretical analysis deepens social work's core frame of human behavior in the social environment by asserting that there are human *behaviors* in social *environments*.

Bourdieu proposes three concepts that are fundamental to understanding how individuals cope with imposed social structures: habitus, field, and social capital. To Bourdieu, field refers to a social space in which interrelationships are structured through competition for various forms of capital (i.e., power in the form of economic capital, cultural capital, social capital, and symbolic/moral capital) and in which the rules of the game (or habitus) are constructed and creatively engaged by the individual. Habitus is constituted by individual action and is "creative, inventive, but within the limits of its structures, which are the embodied sedimentation of the social structures which produced it (Bourdieu & Wacquant, 1992, p. 19)." Accordingly, habitus escapes the determinism that rigid social structures might impose on the individual, yet provides form to subjective interpretations of social expectations within

a specific field. Quoting Houston (2002), Garrett insists that “habitus acts as a very loose set of guidelines permitting us to strategize, adapt, improvise or innovate in response to situations as they arise” (2007a, p. 229).

These concepts can help us understand the fringe economic behaviors of persons-in-the-fringe-economy-environments that inform our perspective (Garrett, 2007a, 2007b). We suggest that fringe economies can be understood as Bourdieusian fields, and that, accordingly, an understanding of fringe economic behavior must be built upon inquiry into the field-specific goals associated with these behaviors (i.e., various forms of capital accumulation) and field-specific rules of the game (Emirbayer & Johnson, 2008).

One caveat should be emphasized. We understand Bourdieu’s concepts in a manner consistent with Emirbayer and Johnson (2008), in which a Bourdieusian field is not static, but rather is “a dynamism of potential innovation and a motor for ceaseless change” (p. 17). The potential within a Bourdieusian field stems from the competitive interplay between forces seeking to conserve the existing distribution of capital and forces acting to redistribute the various forms of capital. Therefore, the discussion of fringe economic behaviors that follows is intentionally descriptive rather than normative and emphasizes the innovative adaptations constructed within a fringe field to counterbalance marginalization from the mainstream.

Our goals follow the first two levels of Lum’s (2007) framework for culturally competent practice by advancing awareness and knowledge of fringe economic values and behaviors. An understanding of behaviors within specific contexts can lead to development of theory, more effective interventions, and policy innovations to desegregate the fringe and the mainstream. Our research question is as follows: What can we learn about fringe economic values and behaviors by using a Bourdieusian lens to synthesize fringe ethnographies?

Method

Noblit and Hare (1988) developed the meta-ethnography as an interpretivist method for researchers to synthesize

qualitative research. Meta-ethnography has been evaluated to be a useful tool to draw out patterns from multiple ethnographic accounts, allowing researchers to extract further findings of studies in relationship to each other or under a new lens (Campbell et al., 2011). This is considered to be the most sophisticated method for synthesizing qualitative research (Britten et al., 2002). It has been used in the medical and nursing fields to further understand ethnographic accounts on the same subject (see Feder, Hutson, Ramsay, & Taket, 2006). In the case of this paper, the lens consists of the Bourdieusian concepts of field, habitus, and social capital. Our method followed Noblit and Hare's 1998 seven-step framework.

The motivation for this study was rooted in the dissertation research of the co-authors (Caplan, 2013; Kindle, 2009) and fueled by Karelis (2007), who argued that economic decision matrices for poverty are distinctly different from those of the affluent. The search for empirical evidence relevant to Karelis' arguments resulted in the discovery of a small number of book-length ethnographies of high quality.

Inclusion and exclusion criteria for selection of source ethnographies relied heavily on our subjective assessment of the depth of analysis, rich detail, and diversity provided across each study. Because the primary focus of this study is to enrich our understanding of fringe economic behaviors in a specific social setting, the ethnographers had to commit significant attention to the economics of daily life in such a setting, but co-residence for a year with the research participants was also considered an important criteria. Excellent studies were omitted because of a narrow focus on a segment of the population instead of a community (Duneier, 1999; Edin & Lein, 1997), and high quality journalistic accounts without a community focus were also omitted (Ehrenreich, 2001; Shipler, 2004).

The ethnographies selected were appraised for quality in a manner consistent with Toye, Seers, Allcock, Briggs, Carr, Andrews, and Baker (2013) that demands conceptual clarity and interpretative rigor. We make no claim for exhaustive or comprehensive coverage in the selection of Dohan (2003), Sherman (2009), and Venkatesh (2006); however, we do believe that these three selections are illustrative of the rich variety of social capital and habitus operative within fringe fields and

are, therefore, a reasonable starting place from which to understand fringe economic behaviors.

Three ethnographic studies of pseudonymous settings form the basic source material for our analysis. Venkatesh (2006) spent part of eight years with the residents of Maquis Park, an inner city, African American neighborhood in south Chicago. Sherman (2009) lived for a year in Golden Valley, a small, White, rural community in northern California experiencing economic hardship and isolation. Dohan (2003) spent two years researching distinctly different Mexican barrios in California—Guadalupe and Chávez. The first was a first-generation Mexican immigrant community in San Jose, and the second was a second- and third-generation Mexican American neighborhood in East Los Angeles. Each book was read multiple times with detailed notes taken on each reading. Reviews written by the first author were published for two of the ethnographies (Kindle, 2011, 2012).

Data analysis followed Creswell's (2007, pp. 150-155) spiral analogy that begins with comparing and contrasting the source materials, extrapolating key ideas, recursively questioning the preliminary conclusions, and developing the emerging themes. Preliminary results were presented at the Annual Program Meeting of the Council on Social Work Education, and substantial attendee feedback was received (Caplan & Kindle, 2011).

Through the iterative and recursive data analysis process, many different grids were developed comparing and contrasting the characteristics of the four fields reported on in our source materials. Bourdieu's concepts of habitus, field, and social capital (Garrett, 2007a, 2007b) were the organizing framework for translating the studies into one another.

Table 1 summarizes the synthesis of the source materials that are explained in substantial detail in the Results below. This paper is an attempt to express the synthesis for the first time.

Results

For the purposes of our study, the pseudonymous communities of Maquis Park, Golden Valley, Guadalupe, and Chávez

are considered individual and distinct Bourdieusian fields. Our analysis will answer the following questions: “What are the various forms of capital that serve as goals of fringe economic behavior?” and “What are the rules of the game (or habitus) that operate in each field?” Table 1 provides a convenient comparison of each field.

Table 1: Comparison of Bourdieusian Fields

	Maquis Park	Golden Valley	Guadalupe	Chavez
Social and Moral Capital Goals	Household stability Neighborhood safety	Traditional gender roles	Upward economic mobility in Mexico	Upward economic mobility in America
Acceptable Forms of Underground Income Generation	Safety net receipts Unreported wages Vice (some discomfort) Ghettoware Housemates Space usage Money lending Hustling Regulating/ Mediating	Informal work Subsistence activities Spousal employment Family assistance Unemployment Disability Charity	Low-wage work Illicit day labor Overwork Flea markets Barrioware Family assistance	Career work Strategic welfare Balanced hustling Family assistance
Non-monetary Forms of Currency	Reciprocity and Mutuality	Reputation	Work	Work with Opportunity
Unacceptable Forms of Income Generation	Greed Drugs Predation	Welfare Food stamps Illegal activity (drugs) Relocation	Welfare Illegal activities not endorsed by legalization	Dead end work
Rules of the Game	Permeable boundaries Balance legitimate and illicit Reciprocity Mutuality Don't take more than your share Appeal to outsiders only as last resort	Gendered distinctions Individualism Self-sufficiency Manual labor Family first Earn your own way	Moral foundation of adulthood is work Family first Local preferred over outsider Legalization through employer facilitation	Moral foundation of adulthood is work Family first Local preferred over outsider Porous boundaries

Maquis Park

Venkatesh (2006) provided an exceptionally rich description of the underground economic activity in this poor, urban, and African American community. Comprising 10 blocks on the south side of Chicago, Maquis Park was a stereotypical inner city ghetto. Middle- and upper-class African Americans had largely fled the community that was dominated by a low-income housing complex where economically vulnerable families subsisted on less than \$10,000 a year. Jobs were scarce; youth gang activity was extensive; and home-owners were likely outnumbered by the homeless. Single parent households were the norm.

From a Bourdieusian perspective, the social institutions that comprised Maquis Park were the local street gang, the local churches whose congregants resided in the community, the households that were commonly headed by women, the commercial sector, and the block club which developed local leadership to cope with the presence of gangs. These social institutions were indigenous to the field, and the competition for social and moral capital within the field took place primarily in these institutions. Other institutions served as forms of resource support or external constraint but were not bound by the field-specific expectations. These included law enforcement, social services and related agencies, outsiders supporting the gang-sponsored drug trade, and even churches with congregants who lived outside the community.

Concern for financial stability and security by Maquis Park residents influenced the shape of the social and moral capital goals they pursued and the socially acceptable means by which they pursued them. Two mutually reinforcing goals can be identified: household stability and neighborhood safety. Each of these goals depended on establishing and maintaining substantial levels of social and moral capital in Maquis Park against a backdrop of illegal and predatory gang activity; however, it is essential to recognize that the gang members were Maquis Park insiders. The gang itself was a legitimate institution in the fringe setting, even if all gang activities were not because the gang members were from the neighborhood. Constraints on gang activities depended almost entirely on the social and moral influence that the other community insiders could bring to bear in negotiations with the gang leader.

Householders tended to place their primary focus on household financial stability based on establishing reliable financial supports by cobbling together legitimate employment, safety net resources, and illicit income generation. For householders, neighborhood safety was a strong secondary focus. Neighborhood safety was defined by the socially-sanctioned usage of public space for recreation, commerce, and "hot spots" where illicit and illegal activities were permitted. Clergy invested considerable energy mediating agreements and disputes related to neighborhood safety and the use of public space. The commercial district included business entrepreneurs and street hustlers who valued and relied upon an intricate network of personal connections that sustained access to customers, public space, and credit. Street hustlers seemed to provide an important role as regulators of public space use. In summary, "the manner of earning income and the ways of regulating it are both outside the societal mainstream" (Venkatesh, 2006, p. 382).

Within the environs of Maquis Park, residents' efforts to maintain their livelihood often came into direct conflict with their values: "Because the underground economy plays such a key role in bringing resources into the home, household members are often caught between their desires to live a just life and their needs to make ends meet as best they can" (Venkatesh, 2006, p. 61). The social boundaries between legal employment and illicit and illegal income generation were permeable. Steady jobs were scarce, and virtually no stigma was associated with reliance on safety net resources. The inadequacy of the safety net led householders to supplement their incomes in myriad illicit or illegal ways. Clergy brokered day care and domestic work that generated unreported wages. Virtually any personal skill or personal asset was converted into "ghettoware"—foodstuffs, homemade clothing, counseling and psychic services, social security cards, hairstyling, hair care products, pirated movies, kitchen supplies, resumes, tax returns, gambling venues, party space, handicrafts, and artistic products. Automobiles became unlicensed taxis; spare rooms and even couches were leased. The financial stability of the household was paramount, and it took considerable creativity to generate sufficient household income to achieve this goal. Even participation in the sex trade, despite some discomfort

among some of the women in the community, did not result in ostracism. Female solidarity was too important to sustaining any level of neighborhood safety. The material foundation for the field's moral capital did not follow the contours of conventional morality, and this moral flexibility represented a significant field-based adaptation in Maquis Park.

The commercial sector in Maquis Park was as unconventional as the income-generating activities of the householders. Conventional business credit was rarely obtained, which created a setting in which the personal networks were essential. Linkages between legitimate businesses and the illicit activities included unreported employment or sales, using backroom space for illegal activities (e.g., gambling, prostitution, or weapon storage), and money lending. These activities, however, did not take place without constraint. Both business owners and street hustlers abided by socially sanctioned codes of conduct that undergirded economic behaviors. Every commercial transaction, whether legitimate or illicit, contained an expectation of reciprocity because "men and women see their own chances of [economic] success as predicated on their capacity to bring others along with them" (Venkatesh, 2006, p. 103). Participants in the commercial sector understood that financial feasibility required cooperation more than competition. The expectation of reciprocity was a major constraint on participation in some illegal activities, because few were willing to be that closely associated with the worst of the gang behaviors. This formed the basis for another adaptation—a degree of mutuality in Maquis Park that is not typical of mainstream exchange.

It would be a mistake to understand commerce in the Maquis Park fringe as a monetary economy. Reciprocal networks of obligation and favors were the currency that mattered most, so the material foundation for competition for social and moral capital was measured by fidelity to the expectations of reciprocity and mutuality. "The cash economy abuts a world where trading and payment occur through verbal promises, in-kind payments, and barter ... [that comprise] highly intimate exchange networks, where personal connections and impersonal contractual exchanges coexist" (Venkatesh, 2006, p. 93). Failure to abide by the informal rules of commerce, whether by a business owner or a street hustler, could easily result in the

loss of social and moral capital, social isolation, and absence of willing transactional partners that would threaten household financial stability.

Accordingly, the fringe economy in Maquis Park was an intricate network of interlocking obligations. Idealization of this reciprocity and mutuality as some form of charitable compassion is contrary to reality. Every participant had to contribute something to this web of expectations, regardless of the dearth of resources or limited capacities he or she possessed. By contributing, one gained social and moral capital in the community.

Golden Valley

Far from the inner city of Maquis Park, Sherman (2009) lived for a year in a White, rural town in northern California suffering "rapid industrial decline, severe job loss, and persistent poverty" (p. 2) due to the cessation of timbering to protect the spotted owl. Two-thirds of the residents had annual household incomes under \$30,000, which put most at or below the poverty line. About 30 percent of the adults were unemployed, 78 percent were married or cohabitating, and 88 percent had children. Most jobs were either seasonal or temporary.

From a Bourdieusian perspective, ethnic, cultural, and economic homogeneity among the 2,000 residents eliminated most of the determinants (e.g., income, position, wealth, and education) of social capital except for the symbolic. The residents of Golden Valley "rely heavily on moral concepts and moral discourses to make sense of their lives, to create and sustain a sense of success, and to configure their social worlds" (Sherman, 2009, p. 3). Foundational to their sense of moral capital is their commitment to this place, despite the financial hardships. Living in Golden Valley meant separation from the competitive aspirations of the suburban middle class and the complexities of ethnic and racial diversity. Competition for moral capital was anchored in a form of rural exceptionalism in which family came before finances and White country folk eschewed the welfare, drug use, and crime they associated with ethnic urbanism. Despite the prejudice supported by this form of rural exceptionalism, the social cohesion and sense of community in Golden Valley represented significant social capital, often demonstrated by local charity, extended family

care, and other forms of direct material assistance.

Moral capital within this Bourdieusian field was highly gendered and traditional. Adjacent to a national forest, the local culture valued the mythology of individualism, self-sufficiency, and work in the form of manual labor. "[W]orking poverty has been a fact of life in Golden Valley for generations," although "unemployed poverty has long been unacceptable" (Sherman, 2009, p. 57). Closure of the last lumber company resulted in massive male unemployment, but this did little to de-stigmatize safety net resources. For men, subsistence work such as hunting, fishing, cutting one's own wood, raising animals, gardening, and gold/gemstone mining was preferable to any other means of coping with job loss. It mattered less that one had little than that one had earned whatever one had. Having a reputation as a hard worker and good provider, even if only through subsistence activities, was the primary means for male accumulation of moral capital, and moral capital could become economic capital. "Those who are perceived as having lower moral worth are often denied access to the community's increasingly rare jobs, as well as to many forms of community-level charity" (Sherman, 2009, p. 65). The currency of the fringe economy in Golden Valley was a reputation for working hard.

In declining order, it was somewhat acceptable to cope with poverty through spousal employment, family assistance, or the receipt of unemployment benefits or disability payments. The association of unemployment and disability with earlier work efforts made them acceptable; however, under no circumstances was it acceptable to receive welfare (TANF or food stamps) or to participate in drug activities as a seller or user. Ironically, illegal poaching on federal land did not carry the same stigma as illegal drug activity in Golden Valley. Even federal park rangers were complicit in permitting this fringe economic activity. Although bartering was common in Golden Valley, Sherman (2009) does not mention the presence of a flea market for informal exchange comparable to Maquis Park's ghettoware.

Female moral capital was related to the maintenance of a functional and stable family. Although Sherman (2009) goes to great lengths to show that traditional, family values have never been the norm in Golden Valley, that mythology dominated

the moral order. The pathways to accumulating moral capital for women, at least until they entered the labor market, were: (a) creating a stable home where children are safe; (b) placing restrictions on substance abuse, drinking, and domestic violence; and (c) focusing free time on family activities instead of individual pursuits.

Guadalupe and Chávez

Dohan (2003) conducted his fieldwork in two distinctly different Mexican barrios in southern California. He spent almost a year in Guadalupe, a community of first-generation Mexican immigrants in San Jose, and another year in Chavéz, a community of U.S-born Mexican Americans in East Los Angeles. Most residents of Guadalupe were undocumented, and employment opportunities included positions as janitors, landscapers, and home healthcare workers in nearby Silicon Valley. Over 20 percent of the residents had incomes under the poverty line. Chavéz, in contrast, mimicked Maquis Park with an active youth gang, significant public drug activity, public housing, and a poverty rate over 50 percent.

Dohan's (2003) analysis of the social institutions that shaped the Bourdieusian field for each community focused on the informal social networks that determined attitudes toward legitimate employment, indigenous organizations that included illicit income-generating activities (street corner day labor sites, flea markets, and gangs), and the welfare subcultures that permitted a reluctant justification for the use of safety net resources. Chavéz mimicked Maquis Park in the inclusion of the gang as a legitimate social institution without endorsing all gang activities.

In both communities, work was "an organizing principle for their home and social life" (Dohan, 2003, p. 66). Work was the primary means of garnering social capital, and any form of aid that was not familial or work-related (i.e., welfare) eroded one's social capital. Perhaps the most important value in each field was based on the understanding that adulthood meant to desire and contribute to household finances through employment. Despite the poverty in Guadalupe and the persistent poverty in Chavéz, residents were not driven to merely survive. Instead they "focused their economic activities on

the problem of advancement" (Dohan, 2003, p. 97). The daily economic life in both Guadalupe and Chavéz was dominated by the fringe, yet the aspirations for economic advancement complemented mainstream economic goals. In different ways, the drive for advancement undergirded each barrio's rationale for integrating "illegal activities into everyday community life" (p. 13). "Guadalupe and Chavéz did not lack the social organization to rebuff crime; rather, their social organization included crime and its associated institutions" (p. 153).

Guadalupe. Comprised of Mexican nationals who had immigrated to the United States to pursue economic opportunities unavailable in Mexico, the Bourdieusian field relevant to Guadalupe was shaped by immigration enforcement and a transnational context. Low-wage work was the only legitimate income-generating activity and the primary means of acquiring social and economic capital in Guadalupe. Long hours at multiple low-wage jobs were the primary strategies for economic advancement, and were justified by "the value of the dollar conferred by transnationality" (Dohan, 2003, p. 91). This kind of overwork made sense, because residents of Guadalupe intended to return eventually to Mexico. The shadow of immigration enforcement resulted in the community's disapproval of most illegal activities, as well as significant stigmatization of any form of welfare receipt. With the exception of employers, engagement with social institutions outside of the field was always risky and was discouraged.

Illicit employment without legal documentation to work in America was legalized in Guadalupe through employer facilitation (hiring without documents or acceptance of obvious forgeries as adequate), ready access to forged documents, and social networks that knew which employers would help. Street corners for day laborers provided access to facilitating employers, and informal flea markets where Maquis Park-like "barrioware" could be traded provided both income-generating opportunities and access to low-cost commodities. Illicit activities in Guadalupe that were sanctioned included work without documentation, selling without a business license, false documentation, and purchasing products that had been acquired through theft.

Chavéz. The U.S.-born Mexican-American residents of this

community rejected the overwork strategy for economic advancement embraced in Guadalupe, but tended to understand social capital in economic terms. In Chavéz, work was equally valued, but included "an expectation of upward mobility" (Dohan, 2003, p. 68). Dead-end jobs without career pathways and escalating wage opportunities were of little interest to the residents who self-consciously distinguished themselves from communities like Guadalupe, where even dead-end jobs were valued. Accordingly, social capital in Chavéz did not accrue to the worker without an evaluation of the quality and nature of the employment. Low-wage work that required little more than punctuality and that provided little more than unreliable hours, fluctuating paychecks, negligible security, and safety risks could result in a loss of social capital in the community, especially if that employment did not provide economic access to commodities out of reach to other residents. Social capital was closely associated with a material base and resulted in a porous boundary between legal and illegal activities.

Because jobs that paid a living wage were scarce in Chavéz, and because the residents rejected overwork as a reasonable pathway to economic advancement, alternative financial strategies were common. As in Maquis Park, residents wove a personal and complex financial strategy from the variety of legitimate, illicit, and illegal income-generating opportunities in Chavéz. For men, the dominant strategy was "hustling" or illicit and illegal "flexible earning strategies" (Dohan, 2003, p. 71). Opportunities for profits from hustling may have been infrequent and unpredictable for most; however, the short-lived profits could be spectacular, especially in the drug trade. With the exception of the local gang, hustling was not a "whole way of life; it was merely the logic behind everyday decisions ... made in pursuit of economic opportunities" (p. 82) and "represents one sensible economic strategy for people struggling to satisfy high expectations for success in an environment of poor opportunities" (p. 221). For women, welfare provided an alternative strategy, despite the stigma as "residents familiar with the routine of public assistance know that welfare checks arrived with relative certainty ... and left time to gain additional income through unreported work" (p. 74).

A sense of balance was central to the justification of illicit, illegal, and welfare income generation in Chavéz. Each

opportunity to increase income had to be carefully weighed against the risks, and the risks were mitigated by the local gang. The local gang concentrated on automobile thefts and drug distribution, thereby leaving other petty crime to the residents, and provided some monitoring of outside law enforcement for the benefit of all illicit activities in the community. Career aspirations, flexible earning strategies, and segmentation of illegal/illicit earning opportunities, when joined with gang oversight, created a lower risk environment for fringe economic behaviors.

Discussion

Fringe economic clusters like Guadalupe, Chavéz, Golden Valley, and Maquis Park arise from the failure of the mainstream economy to meet the financial needs and aspirations of the residents. Secondary and tertiary labor markets do not often provide the income stability foundational to household economic advancement (e.g., Chavéz), and legitimate safety net resources are woefully deficient when work is not available (e.g., Golden Valley and Maquis Park). The legal and social fabric that sustains the mainstream economy (e.g., banking, law enforcement, courts, and contracts) is inadequate to that task in a fringe cluster. Marginalization from the economic mainstream leads inevitably to the construction of a fringe cluster with localized and informal institutions, social norms, and socially-approved aspirations that we have interpreted to be Bourdieusian fields. Maquis Park, Golden Valley, Guadalupe, and Chavéz clearly demonstrate the great variability in fringe adaptations apart from the mainstream economy.

The mainstream-like aspirations for economic advancement that dominate the quest for social capital in Guadalupe and Chavéz are virtually nonexistent in Golden Valley and are quite foreign to the daily striving for household stability and neighborhood safety in Maquis Park. The traditional gender roles that defined moral capital in Golden Valley could not be more irrelevant to the female householders in Maquis Park, and in Chavéz and Guadalupe, the value placed on extended family networks was subsumed within the work-first pursuit of economic advancement. The unique forms of social and moral capital that were most valued in each field helped

define the habitus that determined socially-approved and disapproved forms of income generation. Attitudes toward employment, illicit work, illegal activities, and welfare receipts differed in each community as well.

Each fringe cluster created its own customizable safety net from the various income-generating possibilities available. No field rejected legitimate forms of employment; however, Chavéz residents did redefine "legitimate" to include the possibility of advancement. The stigmatization of welfare receipt varied greatly in the communities, from the near absence of stigma in Maquis Park to an extreme form of welfare rejection in Golden Valley. Chavéz differed from Guadalupe in the degree of justification for single/abandoned mothers to use welfare. Acceptance of welfare in Chavéz did not carry the high social costs associated with welfare receipt in Guadalupe.

Each field informally legitimized some forms of illegal or illicit activity, but no field embraced illegality without limits. Guadalupe and Golden Valley were the least receptive to illegal activities; however, both accepted certain forms of illegal behavior in pursuit of the social capital most valued in that field. Guadalupe legitimized false papers as necessary to find employment, and Golden Valley supported poaching as an appropriate response to unemployment. In comparison to these fields, Chavéz and Maquis Park seemed to have a broader embrace of illegality; however, both had limits. In Maquis Park, the reciprocity required by participating in exchanges set distinct boundaries on illegal activities because few were willing to become obligated to the local gang. In Chavéz, the local gang's monopoly on automobile theft and drugs also constrained some behaviors.

We conclude that each field developed organically from the local economic conditions, despite sharing in the broader political economy. The residents of each community developed unique adaptations in order to thrive. The tacit knowledge required to safely negotiate the hot spots and gang activity in Chavéz and Maquis Park would be of little use in Golden Valley or Guadalupe. A reputation for hard physical labor may have been equally valued in Guadalupe and Golden Valley, but was viewed with distain in Chavéz unless it generated opportunity and economic advancement. The relationships essential to financial survival in Maquis Park were as nontransferable as

the reputations in Golden Valley.

We further conclude that an awareness of the localized development of a fringe economic cluster with distinct goals and rules undermines the establishment of one-size-fits-all social programs. Guadalupe and Golden Valley would be unlikely to benefit from improvements in formal safety net programs because these programs were outside the local habitus, but increased redistribution of resources through safety net programs would find ready acceptance in Maquis Park. An increase in the minimum wage might be highly valued in Guadalupe, but neither Chavéz nor Golden Valley would care much about a higher minimum wage because Chavéz wanted quality jobs and Golden Valley had few jobs of any kind.

Fringe economic behaviors differed in each community because each field was unique, but within each field, the economic behaviors and regulations were adaptive social mechanisms to structure social life in each community. Fringe economic clusters cannot be reincorporated into the mainstream economy by something as simple as an injection of additional financial resources without a sensitivity to local conditions. Social development might theoretically create substantive numbers of jobs in the primary labor market, but this alone is unlikely to eliminate the local and informal adaptations. As Bourdieusian fields, fringe economic clusters have established informal mechanisms for social regulation of risk, unique forms of social capital, and different social expectations. Social programs aimed at moving fringe economic clusters toward the mainstream should begin with a higher level of respect for the complexities of economic life within each field.

This meta-ethnography of four distinct low-income communities was conducted utilizing the concepts of sociologist Pierre Bourdieu that were developed as he conducted his own ethnographic research (Bourdieu, 1990). Readers should note our interpretative slant as a potential limitation of this study, along with the obvious limitations associated with the small number of ethnographies included. Ethnographic research, although potentially providing rich insights, is subject to several limitations associated with researcher subjectivity and an absence of generalizability (Rubin & Babbie, 2011). In the four ethnographies included in this meta-ethnography, only

one community (Chavéz) was investigated by a researcher of the same ethnicity and immigration status as the subjects. Accordingly, an etic perspective should be assumed when interpreting these results. The meta-ethnographic attempt to construct generalizable results from research that is not designed to be generalized is in itself a substantial limitation.

Conclusion

In the mainstream economy, a financial decision is effective when made in the consumer's "own financial interest" (Mandell, 2006, p. 2). This non-reflective imposition of an economic maximization boundary on assessment of financial decision making permeates the literature on financial literacy, and judges all economic behavior as deficient that does not comply with economic maximization. This meta-ethnography suggests that economic maximization is a poor framework through which to understand economic behavior of people living on the fringe. Economic concerns were important in these four communities, but not without significant moral, value, and cultural accretions that together comprise Bourdieu's social capital. Culturally competent social work practice with people living on the fringe must be informed about the locally constructed social expectations and social goals of the community. Social programs implemented without this awareness should expect to be ineffective and irrelevant to the lives of the people we intend to serve, as the mixed results of financial education programs seem to suggest (e.g., Gale, Harris, & Levine, 2012).

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Tactical Decision-Making: Community Organizers Describe Ethical Considerations in Social Action Campaigns

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Social work curriculum on social action-oriented organizing methods is often devoid of content on the day-to-day role of the organizer in recruiting diverse participants, facilitating group decision-making, and planning and implementing campaigns. Little attention is paid to how tactical decisions are made and how the ethical implications of these decisions are weighed. In this study, professional organizers were interviewed about how they viewed their work, their relationships with their constituents, and the values and ethical principles used to make tactical decisions.

Key words: social action, community organizers, ethics, tactics

Community organizers engaged in social action often choose from a range of strategies and tactics that can include consensus-oriented actions to protests and civil disobedience (Staples, 2004). Contest or confrontation tactics are often used to dramatize issues, attract allies to a cause, and force an

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opponent to negotiate. They can also be used to intimidate targets and throw the other side off-guard (Homan, 2011). For example, some organizers believe that the seriousness of the issue (risk of death or injury to innocent populations) could require the escalation of confrontation-related tactics such as the use of civil disobedience (Mondros, 2005). Conway (2003) defines civil disobedience as "a specific form of extra-parliamentary political action involving the deliberate, principled, and public breaking of a law that is perceived to be unjust" (p. 508).

In some cases, participants may actually intend to put themselves at risk of arrest as a means of calling attention to social problems or political oppression (McAdam & Tarrow, 2000). In addition to arrest, participants in social action campaigns may also risk losing their jobs, harassment, or physical harm by opponents or the police. Given the possible ramifications associated with using these methods, little discussion has taken place in the social work literature about the ethical implications involved in applying these tactics. In addition, there are few resources available that assist newly employed organizers or social work students in reconciling differences between tactical procedures used in social action campaigns, personal values, and the ethical principles contained in the National Association of Social Workers (NASW) Code of Ethics (2008). Curriculum in schools of social work on community organizing often excludes content on social action in favor of less controversial approaches that rely on consensus-building such as community development and social planning (Fisher & Corciullo, 2011). Consequently, social work students often have a limited understanding of how tactical decisions are made in social action campaigns and who makes them (Mott, 2008).

This is especially problematic for social workers employed as community organizers in grass-roots organizations that engage in social action. Often ethical reference points are limited to Saul Alinsky's (1971) ethics of "means and ends" (Reisch & Lowe, 2000). Alinsky, in his description of how tactical decisions should be made, implied that efforts to put pressure on opponents are always justified if they are used to help disadvantaged communities gain power. However, most

contemporary community organizations influenced by Alinsky's approach define appropriate tactics much more narrowly, focusing on legal, nonviolent methods and using civil disobedience sparingly (Bobo, Kendall, & Max, 2010). Given that organizing work often involves complex issues and multiple individuals and groups, efforts to resolve ethical dilemmas are often made on a case-by-case or situational basis in consultation with the organization's constituents and coalition partners (Barretti, 2009; Ganz, 2009). However, for an inexperienced organizer, it may be difficult to determine "where to draw the line" in terms of risky tactics, especially when working with groups who may have different perspectives about using methods that may not be either safe or legal (Conway, 2003).

In this paper, the processes through which community organizers and their constituents make tactical decisions in grass-roots organizations are explored. Qualitative interviews were conducted with 13 community organizers. The research questions focused on how organizers employed in social action organizations make ethical decisions and what individuals and groups are consulted in the decision-making process. Participants were also asked to identify situations in which confrontation-oriented tactics should be used and to describe the ethical implications of those actions. Staples (2004) defines social action as "bring[ing] people together to convince, pressure, or coerce external decision-makers to meet collective goals either to act in a specific manner or to modify or stop certain activities" (p. 9). Grass-roots organizing originates in local communities and decisions about organizing campaigns include "those who are directly impacted by the issues that the group is fighting to change" (Schutz & Sandy, 2011, p. 27).

The Setting

All of the organizers interviewed were employed in the San Joaquin Valley in central California at the time of the interviews. This region is primarily rural, but contains a number of small and mid-size cities. The San Joaquin Valley has historically been an entry point for immigrants and refugees from Mexico, Central and South America, China, and Southeast Asia (Kohl-Arenas, Martinez Nateras, & Taylor, 2014). The primary industry is agriculture, with many large farm

operations located in surrounding rural areas; the majority of the population is Latino. However, the political establishment in the region is politically conservative and primarily White.

The San Joaquin Valley of California is also home to the United Farm Workers (UFW). Although the UFW successfully fought for the right of farm laborers to form unions and for the implementation of state regulations to ensure that workers have access to good sanitation, clean water, and rest breaks, there is much work still to be done to ensure that farm workers and their families obtain economic security (Ganz, 2009). Many of the Latino farm workers are undocumented, have almost no legal rights, are at constant risk of exploitation and live in fear of arrest by local police or immigration officials and deportation to Mexico and Central America (King & Punt, 2012; "Sober but unlicensed," 2011). While agriculture creates enormous wealth in this region, the farm labor force is paid subsistence wages. Kohl-Arenas et al. (2014) succinctly describe historic patterns of discrimination and inequality in the San Joaquin Valley:

Many immigrants first found their way to the region with the promise of finding a better life, working on valley farms and saving enough to support their families both here and abroad. Yet, since before the California Gold Rush racist immigration, land ownership and labor policies and practices prevented immigrants from owning land, marrying, educating their children, and participating in political life. (p. 8)

Undocumented immigrants may not legally work unless they have qualified for the temporary Deferred Action program implemented by the Obama administration in 2012 (National Immigration Law Center, 2013). While California has passed legislation that permits undocumented students to attend college and qualify for financial aid, few of these students actually complete high school and have access only to marginal, "off-the-book" employment (Gonzalez, 2011). Drop-out rates are high for most children of color, with many students attending segregated, underfunded schools that provide a poor quality of education (Stifter, 2013). Consequently, unemployment rates are high due in part to the continued

reliance on agriculture and the failure of local efforts to attract diverse industries. According to the California Department of Public Health (2014), the San Joaquin Valley contains census tracts with high rates of concentrated poverty, neighborhoods in which over 40% of the residents live below the poverty line. Poverty rates are highest in communities of color. While most of these neighborhoods are in rural farming communities in which most residents are farmworkers, some urban neighborhoods also have high rates of concentrated poverty (Cytron, 2009).

The San Joaquin Valley contains census tracts with high rates of concentrated poverty, neighborhoods in which over 40% of the residents live below the poverty line (California Department of Public Health, 2014). People who live in communities in which concentrated poverty is high are likely to experience numerous harmful effects:

Poor people are more likely to live in dangerous or under-resourced environments and to work in hazardous conditions, with greater risk of injury, and greater exposure to pesticides, lead, and outdoor air pollution. Low income people are more likely to be uninsured and to have limited access to quality health care; are more likely to suffer from chronic diseases like diabetes and heart disease, acute and chronic stress, and to die prematurely. (p. 1)

Indeed, Valley residents are assaulted by multiple sources of pollution in the land, water, and soil. According to recent data prepared by California's Office of Environmental Health Hazard Assessment (2014), about a quarter of the Valley's census tracts are among the most polluted and most vulnerable in the state. The San Joaquin Valley air basin competes with Los Angeles for most polluted in the nation, with its major metropolitan areas regularly ranking in the top 10 most polluted for particulate matter and ozone (American Lung Association, 2014). The eight-county San Joaquin Valley has some of the most contaminated aquifers in the nation (Dubrovsky, Kratzer, Brown, Gronberg, & Burow, 1998). Much of this contamination is from nitrates, which are linked to the agricultural sector's heavy use of fertilizers and flood irrigation, with

confined animal feeding operations also contributing (Moore et al., 2011). Thus the Valley's bountiful agricultural production comes laced with rampant concentrated poverty and high levels of toxic pollution, an everyday reality that organizers work within whatever the cause.

Methods

Thirteen organizers were interviewed over a six year period, 2005 – 2011. Although the study was originally conceptualized as using snowball sampling, few organizers referred to one of the authors as prospective participants agreed to be interviewed, due to the sensitive nature of the research questions. In the course of the study, the research team was expanded to include two local organizing experts. All three authors employed their personal networks in order to recruit participants for a purposive sample of urban and rural organizers in the region under study.

Of the 13 organizers interviewed, eight were Latino, 1 was African American, and 4 were White. There were 4 females and 9 males. Three of the respondents were Mexican immigrants; 2 of these interviews were conducted in Spanish. One respondent held an MSW degree and all but three of the respondents had attended or graduated from college. Organizational affiliations ranged from employment in local chapters of national organizations to positions in very small, local nonprofit community organizations operated by one or two staff members. Two of the respondents worked on environmental issues, one was a union organizer, one worked with youth, two worked on variety of urban issues, and one worked primarily on behalf of African Americans. One respondent combined organizing on policing issues with a focus on immigration and three worked primarily with immigrants. Two of the respondents were retired from organizing work and spoke retrospectively; one of these organizers had been employed by organizations focused on Alinsky-style organizing, while the second had worked for the UFW during the early part of his career and was later involved in organizing in low-income, urban communities.

The poverty of the residents is directly related to the structure, stability, and financing of local community organizations.

While some of the organizers for this study have been or were previously employed by established community organizations, several of the respondents worked for poorly funded or marginal organizations and often raised their own salaries or worked second jobs to support their work. These itinerant organizers worked within their own ethnic communities to promote social justice and civil liberties.

The qualitative research questions focused on how tactical decisions were made, the people typically included in decision-making, ethical frameworks for making decisions, the consequences of making a bad decision, whether any tactical methods could be viewed as unethical, and whether and in what circumstances civil disobedience should be used as a tactical method.

A process of open-coding was used to organize the interview data into themes (Berg, 2009). In order to increase the trustworthiness of the data, an audit trail was maintained (Guba & Lincoln, 2001). Data were analyzed separately by two of the authors and differences among the two analyses were reconciled. Interviews were conducted until the data reached "saturation," the point at which the information collected became repetitive and did not result in additional categories or reinterpretation of the data (Padgett, 2008).

Results

Respondents perceived tactical decision-making to be an interactive and dynamic process, involving both the organizers and constituency group members likely to be involved in carrying out the action. However, the respondents had strong convictions about ethical decision-making and the role of organizing staff in making sure the preferences of constituents were respected and any risks to participants during organizing campaigns were kept to a minimum. Six themes were identified in the data: (1) Tactics are situational; (2) Tactical decisions should be made by constituents; (3) Tactical decisions should be made by consensus; (4) Morality, faith-based values, and personal principles are important for the success of the organizing process; (5) Ethical organizing involves minimizing risks; and (6) Civil disobedience should only be used when no other options are possible.

Tactics are Situational

Nearly all of the respondents described tactical decision-making as depending on the situation at hand, the context in which the decision is made, the resources possessed by the organization, and the amount of economic and political power held by members of the constituency group. Several of the organizers described the process as “strategic,” making sure it is going to be worth doing and that it “falls in line with the organization’s mission and vision.” An organizer working on environmental issues said:

To me, it’s kind of difficult to talk about tactics in a vacuum apart from broader strategies and the social situation. You figure out what you need. I’m sure that other organizers have talked about this. You have relationships to build with each other. You figure out what you need and what your goals are and a strategy to get there, escalating certain pressure tactics to reach those goals.

One organizer described her approach to developing tactical methods for an organizing campaign in the following way:

As far as the issue goes, I always try to focus on the need. Another thing is, when I try to choose an issue to organize, lots of times they are emergent situations, for example, when I find out that a law is going to be approved that is going to benefit or cause damage to a large group of immigrants, that is an issue for me to try and organize.

Although respondents emphasized that the choice of individual tactics should not be pre-determined by the organizer, several conceded that the organizing model used by the organization in which they were employed often served as a framework for making tactical decisions. For example, a union organizer described his organizing approach:

There is a certain set of standard outreach mobilizing tactics that we are used to, the places that we organize and the people that we organize. There is a certain standard, stock set of tactics that we are going to use to educate and agitate people... Beyond that I think

it depends... You have an actual target or opponent or some sort of outcome that you're trying to reach, a point you are trying to make with your action.

Assuring a successful outcome was also a consideration in the decision-making process. One respondent described his desired outcome as obtaining something "usually for people left out of the system or [who] should have got something that they weren't getting." Some of the respondents also spoke about weighing the costs or consequences of tactical decisions against the potential benefits of goal achievement. However, a few organizers felt goal achievement was not the only consideration that determined if the organizing effort were successful; the degree to which members of the constituency group were affected by their engagement in social change was also important. For example, one respondent stated that an organizing effort could be considered successful, "If I see that the people that participated in the organizing drive are much more empowered. If I see they are asking more questions."

Tactical Decisions Should be Made by Constituents

Nearly all of the respondents described how tactical decisions were made by focusing on the role of constituents. Constituents were often described as the primary decision-makers for most types of decisions. One respondent said organizing decisions were made by "the people who live in the community. I get feedback from them and basically they're the ones who make the decisions." Some of the respondents described the participation of constituents as essential because they are the people who carry out the action. Consequently, a good tactic was viewed as one that constituents were comfortable with or that "fit" with the experiences and values of participants. Tactics that did not meet with the approval of the constituents or were not appropriate to the situation were viewed as likely to backfire. One respondent described a "bad tactic" used at a rally that focused on [then] California Governor Arnold Schwarzenegger's decision to veto legislation allowing undocumented immigrants to have driver's licenses:

One thing that we believed to be simple, for example, to break piñatas that contained the governor's name, or to burn or throw away video tapes the governor

had been in, we believed it was going to be an action that would be morally accepted by the people. And we later figured out it was not as so; many mothers and children were frightened by that. They saw it as being very violent.

For many of the respondents, the facilitation of inclusive decision-making processes was viewed as one of the primary ethical responsibilities of the organizer. For example, one respondent felt it was essential that any campaign be “lead by the people for other people.” A number of respondents felt this principle was critical for recruiting and retaining participants because “when you do something that’s staff driven, the leaders don’t take it and you continue pushing it, it is demoralizing for leaders. You don’t build anything and you lose people.” A few of the respondents reported that they also consulted mentors or community leaders before making strategic decisions. One respondent gave a detailed rationale for the inclusion of constituents in decision-making and also described the role of the organizer in providing background information about the situation to be addressed:

For example, when we wanted to get the police to stop calling the border control. We have to change the policy. Having to get the people to understand how the system works. Having to get the people to the table to negotiate with the [police] chief. Having to come up with language for the policy. Having them understand the language so that they are able to change the policy. I would feel like they are the ones I work for. If I don’t explain to them what’s going on, how it happens, what is going on, the impact, I’m not doing my job. It’s easier to do it myself. But I want them to take over if I’m not around. They will be able to call the chief.

Decisions Should Be Made by Consensus

Most of the respondents described tactical decision-making as taking place in the context of dialogue among the organizer and constituency group members in order to achieve a consensus. One respondent provided a rationale for making collective decisions that focused on group maintenance: “What happens is that in reality, if one sole individual decides

what to do, then there is no organization." A youth organizer provided another rationale for constituent involvement as:

making sure that we're not putting them in jeopardy for any decision that is made on a tactic, discussing it as an organizer and the folks we organize so that we all have a good understanding and making sure we make a collective decision.

An organizer for a congregation-based organizing effort described the process as interactive; the organizer must balance the views of leaders and constituency group members. Respondents also indicated the dialogue process helped shape and refine the decisions made because there was often a diversity of viewpoints that should be considered. An immigration organizer felt that dialogue was essential because "[the] interchange of points of views, precisely helps to understand the problem in its totality or at least in its great majority. Why? Because different points of views can help to discover something that I do not see." Another organizer stated:

You know sometimes you may start out with an ideal decision, but once you open it up and have a conversation and everybody gets to discuss whatever that had to do with that decision or not even about the decision, but about the material, the topic, or the activity or the situation, then at the end of that you have a more "real" decision to make.

Some of the respondents described how they went about facilitating consensus-oriented decision-making. A former organizer who had a long career working for a number of social action organizations said:

We might involve advisors—other people from other organizations who had had similar experiences in how things would work, sort of trainers, consultants, that sort of thing—people from other neighborhoods or communities who had done that so that they could say yeah this can work. We could do this. The ultimate decision was with the people themselves.

Another respondent described the inclusion of additional groups in decision-making as a "long process" because "we dedicated time to inter-ethnic work. Bringing groups of immigrants and nonimmigrants together. We need the support of non-immigrant groups. Issues of non-immigrants need to be addressed."

The Importance of Morality, Faith-based Values, and Personal Principles in the Organizing Process

When respondents were asked to describe ethical decision-making, in addition to the importance of constituent inclusion, many focused on the role of morality and faith-based values as well as personal principles. Four of the respondents worked with faith-based organizations and a fifth routinely worked with church groups. One of these respondents described how faith inspired the organization's choices: "one of our pieces is going to be Micah which is undoing injustice so ... we are going to be asking officials to work with us, make a more just society, through scripture that speaks to us." Another respondent spoke about her parent organization's religious commitment to pacifism: "In general, people we work with are against violence. Based on that principle, we don't want to perpetuate anything that we're against."

Additional values and ethical principles incorporated into the organizing process included liberty, justice, the NASW Code of Ethics, and personal commitment to help the poor, the oppressed, or members of the organizer's own community. One respondent, an environmental organizer, talked about the values that motivated him. "You want the movement to show an example for the next generation and it's all about dignity, it's all about democracy and all about peace. It's all about justice and you want that to be consistent in your actions." The one respondent in the study with an MSW degree stressed the importance of professional values:

I know the Social Work Code of Ethics. The ones about doing no harm. The ones that are technical like confidentiality. I try to find ways not to be stymied by those. Organizing needs to be real open so that there are no hidden agendas. I try to get approval from them so that I can use their names. That we are all in agreement.

For several of the organizers, the negative effects of doing nothing about social injustices that harmed individuals and families or proactively "taking the side" of people who were marginalized were the primary motivators in taking action. Several of the respondents described their commitment to helping members of their own ethnic communities improve their economic status or overcome oppression. One of these respondents said that as a Chicano, he felt that "the strongest influence I will have will be with all those youth that I can relate to the most."

Commitment to helping marginalized community members was universal among the respondents, regardless of ethnic background or length of time working in the San Joaquin Valley. One respondent, originally from the Midwest, described himself as utilitarian, believing in the greatest good for the greatest number. He described his views about the morality of tactical methods used in environmental organizing in the following way:

We knew the woman with five kids, all of whom had asthma, and she was having respiratory problems herself. She didn't need a study done to tell her to move She didn't want to be exposed to more trucks. So if you take all that seriously, the question of what's right or wrong; it's so clearly what's right. The only thing that's wrong is to choose the wrong tactic and mess up the strategy. I've never really thought about morality in terms of breaking windows or something. Everyone talks about that. That's never been an issue for me.

Another respondent also had an "ends justify the means" approach, describing his ethical framework in terms of tactical methods that he had used effectively in previous campaigns; "militant, nonviolence, noncooperation, and disruption gets results and wins concessions."

Ethical Organizing Involves Minimizing Risks

The organizers identified a number of unethical tactics including violence, property destruction, slander, manipulation, degrading opponents, lying, name calling, and the use of profanity. Nearly all of the respondents talked about methods

they utilized to minimize or do no harm to participants in organizing efforts. The philosophy of “do no harm” had a dual focus, ensuring that *constituency group members* were fully informed about or protected from negative consequences associated with their actions and making sure *opponents* were not harmed in the course of the organizing effort, particularly when pressure tactics were utilized.

The organizers interviewed were especially concerned about ensuring that constituents were fully informed about any risks they may face in the organizing effort. Providing this information to members of the constituency group was viewed as the responsibility of the organizer; ensuring the safety of participants was also viewed by respondents as part of the organizer’s role. For example, one respondent said, “One is a bad leader, he who by his actions does not measure the consequences that they may have on the people.” Many of the respondents specifically mentioned potential manipulation by the organizer as a form of unethical practice, misinforming or failing to inform participants about both the positive and negative consequences. Another respondent stated:

It is anti-ethical for example, that you know beforehand that you are heading a protest and you know that up ahead there are a group of agitators or police agents waiting for you with clubs in their hands, ready to strike and you know that your people are unprotected [and] you nonetheless still insist on taking them to get beat.

Several respondents described the potential consequences of using confrontation-related tactics or civil disobedience as much more severe for low-income people and undocumented immigrants than middle and upper-income activists. Consequences for undocumented immigrants can include loss of employment, deportation, and potential harm to family members. A Latina respondent differentiated between potential consequences for herself and for her constituents:

It doesn’t affect me. It affects others. I have the privilege of being an American. I own a home. Other people don’t have those luxuries. The biggest [negative consequence] is being in jail without an attorney because we didn’t

plan it correctly. Being deported for them. Coming up with the fines. Missing work. The consequences for our people are greater than people [middle income activists] who got arrested for the [protest against a retail outlet chain that uses sweatshop labor]. Missing one day of work, when it's seasonal work.

A youth organizer who is also a person of color described his concerns when participating in civil disobedience that involved trespassing on private property and "people chaining themselves to things." He felt that potential repercussions would not be the same for all participants:

Especially 'cause a lot of us were like people of color and stuff like that and low income folks—But there were some other folks who were White and kind of affluent and they all were really down for it. But we were hesitant because of our backgrounds because we knew if anything was to go down we would probably be punished more severely than other folks.

Some of the organizers were also concerned about the well-being of their opponents; the respondents talked about making sure there were limits in terms of how they challenged or even spoke to those people who were the targets of social change efforts. For example, one respondent said:

We had a strong sense that even though we would personalize issues and even though we would have enemies [we wouldn't demean them]. Even though they would speak in that language, I never liked it. We always said 'Today's opponent is tomorrow's ally.' We never wanted, just pragmatically, we never wanted to depersonalize a person.

Another respondent stated he felt it was important to protect "by-standers or otherwise innocent people implicated or involved in the outcome of what you're doing." One respondent whose organization typically used confrontation tactics to pressure opponents described both ethical and pragmatic considerations given to various tactical options:

Are you in a point in your campaign where you have

exposed your target and now that you think that you should start putting their picture up everywhere and personalizing it or maybe slandering them a little bit more? Does that seem appropriate or is that going to backfire on you because a lot of people would be more defensive of that target? Another thing would be, for example, if you came up with an idea like "how about we do a hunger strike or civil disobedience directed at this target?" It would be unethical to force other people to do it if they did not believe in it because you are now asking people to put themselves at risk.

Use Civil Disobedience When No Other Options Are Possible

Respondents described civil disobedience as specific actions taken to challenge unjust laws. One of the organizers described it as "intentionally breaking a law for some sort of broader purpose, concern, [or] broader moral considerations." Most organizers interviewed felt civil disobedience was just one of the tools to be considered in the organizing process. Several respondents felt that civil disobedience should be used only "when you've exhausted all of your legal remedies and you've built a campaign where you've tried every respectable mechanism to get your point across." Other respondents believed it was necessary to use civil disobedience in order to gain leverage on opponents or force the opposition to come to the bargaining table. For example, one respondent defined civil disobedience "as breaking an unjust law....but at the same time accepting the consequences of breaking it, in order to call attention to that law and its consequences and its injustice and get it changed."

The former UFW organizer interviewed gave the following rationale for using this type of tactical method:

By and large, our society has a lot of laws promulgated or implemented by those in power. One of the reasons for that is to keep others from obtaining that kind of power. The only way you can fight against that is by some degree of civil disobedience.

An environmental organizer also focused on the role of civil disobedience in giving a voice to the powerless. He felt civil disobedience should be used:

When there's no other way, you know, when you can't negotiate because they're not listening, they are not letting you in to sit at the table, they're not taking you serious[ly] as a stakeholder, then you have to have a strong action that will gain attention to their unfairness.

Respondents repeatedly emphasized that they would need buy-in from participants before initiating any action that could involve arrest or any other type of risk. One respondent described how he would solicit support from members of his organization to take action to address issues related to the use of excessive force against persons of color by local police:

I would again call people to the table and explain to them the amount of time, the number of years that we have been at this. The lives of our children. The integrity of our community. We [the city] were losing millions of dollars in excess lawsuits and this and that. The civil rights violations. The time was now. That I would have felt [that was] the time [to act]. Even if we had to go to the International Court to prove our point.... We can't keep going like this. Something has to be done. I would have presented it like that.

Civil disobedience was also described as necessary because of the resource and power disadvantage often experienced by many small organizations representing people from low-income backgrounds. Several respondents talked about difficulties associated with obtaining permits or insurance for public marches or rallies that often involved fees that the organizations struggled to pay. In addition, they felt that public authorities were often uncooperative when they received requests for permits. This often made civil disobedience necessary. One respondent described a demonstration planned to protest the deaths of several farmworkers due to unsafe working conditions.

We had all of the documents; we tried to submit to them in order. We had the check they had requested. We told them, you did not want to let me march, you do not want to let me practice my right to express myself

publicly, here are all the documents of all the agencies that we went to speak to and nobody responded, so let us march. That is what you wanted to do and we marched. That is a form of disobeying. Our pain was greater and our desire to demonstrate, what we felt, than the fear of being arrested.

The on-going oppression of communities of color was also referenced by one of the Latino organizers interviewed:

Civil disobedience/direct action may be the tactic to take and people may feel uneasy about it, but that may be for fear of pushing the 'envelope' or ruffling some feathers, but I say we need to push that envelope and ruffle feathers because working 'within' the system has its limitations and just working 'with' the people that are oppressing us just doesn't make sense.

Conclusions

The organizers interviewed for this study used very clear ethical principles to guide their work, especially in terms of their responsibilities toward constituents and how organizing campaigns are planned and carried out. All of the respondents described the ethical dimensions of their actions as incorporating principles similar to those contained in the NASW (2008) Code of Ethics: self-determination, respect for the individuals and community they served, empowerment, informed consent, and risk minimization. They also described how they developed organizing campaigns and selected tactical methods in response to situational demands and in consultation with the constituents responsible for carrying them out. Such consultation promotes innovation, helps constituents develop leadership skills, and builds collective identity and a sense of personal empowerment among group members (Ganz, 2009). The group process also builds on the previous knowledge and experience of constituents and ensures that constituents are comfortable with the strategies and tactics chosen for the campaign. In this way, too, all participants are fully informed about the consequences and potential risks of social action. For all the organizers interviewed, civil disobedience was to be used when no other options were available or

when social class, ethnic background and/or the lack of political power narrowed their tactical choices. For financially strapped organizations, risks to participants were viewed as necessary in order to challenge authority.

The findings from this study may be somewhat unique in that the organizers interviewed represented marginalized groups from one region of the U.S., with a quarter of the respondents running small, resource poor organizations; 9 of the 13 respondents were persons of color who were organizing in their own communities and identified heavily with the struggles experienced by their constituents. Although most of the respondents were college-educated, only one held a social work degree. However, the diversity of educational backgrounds among the respondents is consistent with research documenting the education and training of professional organizers. According to Mott (2008), most organizers have limited, if any, professional training or received their education from public health, urban planning, or other professional programs.

Recently, Boehm and Cnaan (2012) advocated for the development of an alternative model of community organizing to be used by social workers that focuses on constituent strengths and assets. This model is also designed to involve constituents in deliberations concerning strategies and tactics and to construct organization-specific models of practice. However, as demonstrated in this research study, such a framework for practice is often used by grass-roots organizations engaging in social action and has been described in a number of studies of organizing practice by non-social workers including Ganz (2009), Polletta (2002), and Swarts (2008). More importantly, the principles and practices described by respondents are part of the "professional culture" associated with organizing work, disseminated in training institutes and through personal interactions and meetings with others, on the job-learning guided by supervisors and mentors, or through praxis-based knowledge (Conway, 2004; Freire, 1970).

The findings from this study suggest that social work educators should develop curriculum that is consistent with and respectful of the day-to-day activities and knowledge held by both organizers and their constituents, incorporating best practices used in community organization and disseminated in training institutes with formal academic knowledge. In

addition, community practice instructors should not simply focus on such tasks as research, planning, and evaluation, but also teach organizing students the relational skills such as assessment, interviewing, motivating people to take action, negotiation, and group work that are needed to recruit constituents and engage in organizing campaigns (ben Asher, 2003).

There are only a handful of recent studies in the social work literature that involve interviews or surveys with community organizers about what they actually do (Bayne-Smith, Mizrahi, & Garcia, 2008; Mizrahi, 2006, 2007; Rothman & Zald, 2008). Consequently, more research is needed that documents the actual practice of community organizing by social work practitioners as well as organizers without social work backgrounds. Researchers should also pay more attention to how organizing work is conducted in communities of color and how tactical options may vary based on the ethnic backgrounds or social class of participants (Young Laing, 2009).

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Relieving Human Suffering: Compassion in Social Policy

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Human suffering is always present in society. There is general consensus that action should be taken to address suffering, but there are differing views as to the appropriate means of doing so. In this paper we utilize a classical understanding of the virtue of compassion to answer the research question: How does contemporary U.S. policy address human suffering through compassionate response? To answer this question, we conduct a critical analysis of three policy domains (hospice care, domestic violence, and disaster relief) to determine variation in response to human suffering. Comparisons among the domains suggest the various ways in which compassion can be observed within formal social policy. We discuss the implications of a compassion-focused approach to analysis of policies that address human suffering, and more broadly, the use of a virtue-oriented perspective on policy.

Key Words: critical policy analysis, compassion, virtue ethics, human suffering

Human suffering is always present in society. Although it may take different forms in different historical and societal contexts, there are elements of suffering even in the most advanced and prosperous societies. Indeed, modern prosperity, while reducing some forms of suffering (e.g., widespread hunger) may engender other types of suffering (e.g., alienation, social

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isolation). Furthermore, although individuals may experience suffering, there are societal implications as well. Suffering “is always morally regrettable” because it clearly suggests that society is not operating at its best level (Comte-Sponville, 2001, p. 106). To address suffering as a societal problem, the question for policy makers then centers on the appropriate policy response.

Although compassion is a term widely used by both professional and lay audiences, it is more narrowly defined within moral philosophy. One contemporary philosopher (Comte-Sponville, 2001) explains that compassion is a form of sympathy; it is sympathy in pain or sadness—in other words, participation in the suffering of others. Furthermore, within some perspectives, all suffering deserves compassion; acting compassionately does not imply that one approves of the sufferer or that the reasons for the suffering have met a standard of deserving a compassionate response. Rather, to act compassionately “means that one refuses to regard any suffering as a matter of indifference or any living being as a thing” (p. 106).

In this article we use compassion as the central concept of a critical analysis of three social welfare policies that address different forms of human suffering. To provide background we first give a brief description of virtue ethics as applied to social work and social policy and we introduce some recent treatments of compassion within the policy literature.

Virtue Ethics in Social Work and Social Policy

Although the study of virtue is traced to antiquity, in modern scholarship Alistair MacIntyre (1981) is credited with providing a contemporary approach to the study of virtue and impacting the study of virtue across many disciplines. Thus, in addition to coverage in modern philosophy, there is increasing study of virtue in fields related to social policy, such as political science (Bartlett, 2002), policy analysis (Lejano, 2006; Szostak, 2002, 2005), and organizational studies (Dutton, Worline, Frost, & Lilius, 2006; Manz, Cameron, Manz, & Marx, 2008; Weaver, 2006). Social work scholars, also, have begun to examine the reality and potential of virtue frameworks. Banks and Gallagher (2009), scholars in the United Kingdom, have

provided a book-length treatment of virtue ethics in social work and health care professions. In the U.S., the attention has been more limited but appears to be growing (Adams, 2009; Chamiec-Case, 2013).

Adams (2009) notes that historically social work ethics has focused on the resolution of dilemmas in practice; he then articulates the role of virtue ethics as critical to social work. As Adams identifies, modern virtue ethics, consistent with the older tradition of Aristotle and Aquinas,

conceive a human life as a history in which each choice we make disposes us to make similar choices in the future, so that ethical conduct becomes a matter of dispositions or character—virtues and vices acquired by practice and lost by disuse—rather than episodic, purely rational choices. (2009, p. 85)

Virtues are stable dispositions and character traits; these are what matter to social work—“how well we act, as a matter of habit and will in the professional use of self, in ways required for and developed by practice within the profession of social work” (Adams, 2009, p. 88). Chamiec-Case (2013) makes a similar case in regard to social work education and the need to move beyond the more observable practice behaviors to the cultivation of virtuous character.

Discussion of “values” is more common to social work, but values and virtues are related concepts. Chamiec-Case (2013) helpfully distinguishes virtues from values.

Although values and virtues have some important similarities ..., values are *beliefs* about what is most important to us, what we consider our priorities, and what we believe has worth. Virtues on the other hand, are the deeply ingrained *traits or dispositions* which form our character—what fundamentally makes us who we are and is manifested in our actions. (p. 259, emphasis in original)

Virtues’ focus on character is also applicable at the larger macro level. Organizational mission, for example, identifies the character of the agency that will impact the deci-

sions it makes and actions it takes. Dutton et al. (2006) discuss this specifically in regard to the virtue of compassion at the organizational level. In the same way, policies can be indicative of the character of a society. One example at the municipal level is the U.S. Conference of Mayors' recent statement adopting compassion as an effective policy for their communities (U.S. Conference of Mayors, 2013).

Virtue of Compassion in Politics and Public Policy

Other virtues are more commonly articulated in policy discussions; examples include justice and mercy (especially within criminal justice systems), self-sufficiency (within welfare policy), and forgiveness (in discussions of reconciliation of national or racial/ethnic groups). Compassion does not get as much attention in policy discourse but may have a role in undergirding policies in more subtle ways. In his *Book of Virtues*, William J. Bennett (1993), typically a conservative commentator, states a belief that the virtue of compassion may have once been undergirding America's immigration policy: "Lazarus's poem [The New Colossus], like the Statue of Liberty, came to popularize America's mission as a refuge for immigrants. Here is compassion as a national policy, one of America's great national policies" (p. 179).

In the U.S., both conservative (Olasky, 2000) and liberal (Nussbaum, 2001) voices have articulated the potential for compassionate responses to relieve human suffering. Olasky sees potential for compassionate responses through community volunteers and faith-based organizations and Nussbaum through institutional structures and educational strategies.

Through compassionate conservatism, Olasky advanced a specific position, promoted by President George W. Bush, on the role of government in responding to human need that called for government action in partnership with churches, synagogues, mosques and charities to support compassionate responses delivered by friends, families, professionals, volunteers, or strangers (Olasky, 2000; Pilbeam, 2003). As compassionate conservatism became defined by the 2000 presidential campaign of George W. Bush, compassion meant "suffering with the poor and acting on the consciousness of your suffering" with the role of government to "shift power

away from the bureaucracy to the people in the compassionate community, who actually deal with these problems" (Olasky, 2000, p. 13).

Compassionate conservatism as stated by Olasky (2000) emphasizes a diminished role of "big government" in responding to needy Americans through programs, and prescribes a government role that supports civil society and religious actors to perform this front line work. Olasky also stresses the transformational power of responding compassionately for the giver of compassion, as well as for the recipient. As the term compassionate conservatism suggests, the attention to "compassion" is combined with prescriptions for behavioral modifications in the needy or the poor (described as "challenges to change") associated with the goals of social conservatives and with attention to costs, effectiveness and outcomes associated with concerns of fiscal conservatives. Thus, most of the recent attention to compassion in social policy has been situated within the discourse on compassionate conservatism as initially articulated by Olasky and adopted by the G.W. Bush administration. Much of the scholarly literature has examined the resulting faith-based initiatives, their promise, politics, and impact (e.g., Biebricher, 2011; Persons, 2011).

While compassionate conservatism has been the most recent dominant discussion of compassion in public life, more liberal perspectives also utilize compassion as central concept. A liberal standpoint would suggest that, like other manifestations of social assistance, compassionate action historically occurred within the family and community. As societies become more complex, however, government has taken on responsibilities previously held by smaller units, such as the family and community. Social welfare policy literature, for example, describes the way industrialization necessitated creating government structures to assist individuals as family and community structures changed (Huber & Stephens, 2001; Pampel & Williamson, 1989; Wilensky, 1975; Wilensky & Lebeaux, 1958). Economic and social changes wrought through the industrialization process included geographic mobility, smaller families, dislocation from traditional communities, and new structures of work. The increasing wealth of the state from tax revenues provided resources with which the state could address the needs of individuals who could no longer rely on extended

family and community networks for assistance.

Addressing compassion specifically, Nussbaum (2001), in contrast to conservative perspectives, suggests that compassion should be approached at both the level of individual psychology and institutional design. According to Nussbaum (2001) prescriptions for institutional design include such things as the basic structure of society, choice of its distributional principles, and legislation at a more concrete level (e.g., tax code, welfare system, duties of rich nations toward poorer nations). Institutions also teach citizens "conceptions of basic goods, responsibility, and appropriate concern, which will inform any compassion that they learn. Finally, institutions can either promote or discourage, and can shape in various ways, the emotions that impede appropriate compassion: shame, envy, and disgust" (2001, p. 405).

Application to Policy Analysis: Values and Virtues

Public policy analysis has historically tended to focus on narrow rather than "big" questions. It is client-oriented and therefore the ends and goals are provided, and it has tended to emphasize method over theory (Radin, 2000). Consequently technical, quantitative approaches are dominant. Yet, Carrow, Churchill, and Cordes (1998) argue that "social values" should be at the center of both public debate and policy analysis. Social values are one of the many factors that influence policy choices, design, and implementation. Lipset's (1996) major work on the specific values that inform welfare policy, contrasting individualism in the United States to more communitarian values in European welfare states, exemplifies the traditional way that values-based policy analyses have been conducted.

Because virtue approaches emphasize character, behavior and action rather than mere value perspectives, they may be better suited for analyzing policy. Situated within ethical evaluation, virtue ethics emphasizes moral character, in contrast to ethical analysis, which focuses on either duties or rules (deontology) or the consequences of actions (utilitarianism) (Hursthouse, 1999). Szostak (2005) suggests that virtue-based approaches to policy analysis represent a form of "process ethics." Lejano (2006) states, "Virtue is actually a strong component in policy discourse, though it may be masked as other

things" (p. 141).

Elsewhere we have identified examples of the virtues of mercy, self-sufficiency and compassion within contemporary policy (Collins, Cooney, & Garlington, 2012). Justice is a virtue that receives extensive attention in both academic (philosophy) and applied (legal) discourse (e.g., Rawls, 1971; Reilly, 2006). Our purpose in this paper is to present a policy analysis with the virtue of compassion at the core. To do so, we examine three policy domains in which suffering is likely to occur and provide a descriptive analysis of relevant policies targeted toward those affected. We then compare across the domains to identify areas of variation. Although we have selected one virtue for analysis, we recognize that compassion is not the only relevant virtue to guide public policy. It is, however, central to improving the human condition and is consistent with social work's commitment to vulnerable populations. In our conclusion, we address how compassion might interact with other relevant virtues.

Methods

The recognition of suffering and compassionate response should be aimed at circumstances in which there has been a loss of "truly basic goods" (Nussbaum, 2001, p. 374) such as life, loved ones, freedom, nourishment, mobility, bodily integrity, citizenship, shelter. Similarly, Porter states the losses leading to suffering must be non-trivial: "serious pain, anguish, torture, misery, grief, distress, despair, hardship, destitution, adversity, agony, affliction, hardship, and suffering" (2006, p. 100). Following this scholarly guidance, we selected fairly unambiguous instances of suffering for examination: terminal illness, violent victimization, and community disaster. We then identified specific, relevant federal domestic policies that address these types of suffering: the Medicare Hospice Benefit, the Violence Against Women Act, and the Stafford Disaster Relief and Emergency Assistance Act.

In this section we provide a description of these policies organized according to the following criteria: (1) form of aid; (2) eligibility criteria; (3) service delivery system; (4) role of religion; (5) language cues in the policy regarding suffering and compassion; and (6) implementation challenges. Table 1 identifies key elements of the policy according to the identified

Table 1: Characteristics of Policies

Policy domain/ Legislation	Form of aid/Eligibility determination	Service delivery system	Role of religion/religious organizations	Explicit language of suffering and compassion	Implementation challenges
Hospice: Medicare hospice benefit (1982)	Palliative care to provide comfort; eligibility: terminally ill, certified by doctor, patient decision to seek hospice care and end treatment of disease.	Medicare reimbursement to private contractors providing hospice services/Hospice services include doctors, nurses, social workers, pastoral staff, and volunteers.	Death is central concept in religious beliefs; dignity of human life; pastoral care has key role	Explicit goal is to ease suffering and reduce pain, not to treat the disease.	Factors (societal difficulties dealing w/death, medical emphasis on cure) may prolong treatment and delay hospice.
Domestic violence: VAWA (1994, 2000, 2005)	Coordination of multiple systems; crisis care, shelter, legal assistance, emotional support; emphasizes linguistic and culturally specific services. Eligibility: determined by individual service providers but must be victim, (usually women), emphasize non-discrimination based on other issues.	Federal grants to states and communities: formula grants and specialized grants./ Professional (social workers, counselors), paraprofessionals and volunteers. Advocates committed to the cause.	Culturally-bound perspectives on problem can be a barrier to service; religion as key element of culture could be central to intervention	"Victim" and "empowerment" language rather than "suffering" and "compassion."	Services provided in context that can be ambivalent about the problem; cultural differences regarding violence, gender, etc.; service recipients are a disempowered group.
Stafford Disaster relief: DREA A (1988)	Coordination of multiple federal, state, local systems: crisis care for individuals (food, shelter, counseling); eligibility: Presidential determination.	FEMA coordinates with state and local agencies. Red Cross key component. Coordination w/ police, fire, public health, etc., Other private professionals (doctors, nurses, social workers) and community volunteers.	Primarily through the role of community volunteers who may be related to congregations; focus on provision of concrete assistance (food, shelter); some instances of resource coordination	"Responsive and compassionate care for disaster victims is FEMA's top priority."	Extensive coordination of multiple complex systems; by definition response occurs on an "emergency" basis; potential politics in declaring federal emergencies.

criteria.

Comparative analysis across the domains highlighted consistencies and differences in policy approaches. These observations led, in turn, to operating assumptions regarding the role of compassion in public policy. Our discussion is based on this comparative analysis.

Findings

Terminal Illness: Medicare Hospice Benefit

U.S. policy regarding the use of hospice care is primarily in the form of the Medicare hospice benefit which provides payment for care related to terminal illness. The hospice philosophy is the provision of comfort and support to terminally ill people and their families when a life-limiting illness no longer responds to cure-oriented treatments (Myers, 2002). This comfort includes multiple domains (physical, psychic, social, and spiritual comfort) and aims neither to hasten nor postpone death (Mesler & Miller, 2000). When the conditions are met (see below), a plan of care is devised by an interdisciplinary team. The benefit covers reimbursement for the following services: skilled nursing care; medical social services; physician services; patient counseling (dietary, spiritual, other); short-term inpatient care; medical appliances and supplies; drugs for pain control and symptom management; home health aide services; homemaker services; therapy (physical, occupational, and speech); inpatient respite care (providing a limited period of relief for informal caregivers by placing the patient in an inpatient setting like a nursing home); family bereavement counseling; and any other item listed in a patient's care plan as necessary for the palliation and management of the terminal illness (Medicare Payment Advisory Commission [MedPAC], 2004).

The hospice benefit falls under Part A of Medicare, which the beneficiary receives automatically with Medicare coverage. Three conditions must be met: (1) the patient's physician and the hospice medical director certify that a patient is terminally ill, with a life expectancy of 6 months or less; (2) the patient chooses to receive care from hospice rather than treatment for the terminal illness; and (3) care is provided by a hospice program certified by Medicare. A recognized source of

ambiguity is that no common language exists for determining if and when end-of-life care (hospice admission) is appropriate (Brickner, Scannell, Marquet, & Ackerson, 2004).

Hospice care under Medicare became law as part of the Tax Equity and Fiscal Responsibility Act passed in August 1982. Miller and Mike (1995) provide an historical summary of the Medicare hospice benefit. A major impetus of the federal legislation was the recognition that death is expensive; hospice care could offer humanitarian help and also save Medicare funds. Although in early years there was concern about the low use of the benefit, in more recent years it has grown rapidly (MedPAC, 2004).

Hospice services require coordination, but this occurs at the individual case level in terms of a team approach to service delivery. The policy is explicit regarding the interdisciplinary nature of the team (registered nurse, medical social worker, physician, and pastoral or other counselor). A hospice nurse and doctor are on-call 24 hours a day. The use of volunteers is also required; volunteer service must constitute five percent of paid staff hours.

Explicit reference to easing suffering and reducing discomfort are provided in the legislation. Easing suffering is the primary goal of the policy with attention to multiple aspects of suffering. The legislation also recognizes the suffering of family members with provisions for respite and for bereavement counseling after the patient's death. In addition to language, there are visual images in policy documents that also convey compassion. The official government booklet describing the Medicare hospice benefit has a picture of hands-holding-hands on the cover (Centers for Medicare and Medicaid Services, n.d.). Such imagery reflects the "suffering with" concept of compassion.

The main implementation challenges associated with hospice care are societal and cultural factors that can make it difficult for people to address impending death. Physicians have expressed concerns that referral to hospice communicated "giving up" on a patient (Mesler & Miller, 2000). Some types of death have specific associated stigmas and misunderstandings (Shega & Tozer, 2009). Minorities are less likely to utilize hospice care, potentially due to differences in culture related to views of death, differences in religion, and lack of

access to health care and health facilities (Crawley et al., 2000)

In summary, hospice care seems to be a good fit with the classical definition of compassionate response, "to be with in suffering." Moreover, issues related to death (and afterlife) have obvious relevance to religious beliefs. The hospice team is consistently available through the time period of care until the time of death, including some follow-up with surviving family members. All team members are presumably committed to the hospice philosophy. Explicit inclusion of counseling-oriented staff (e.g., social workers, pastoral care) ensures attention to emotional needs in addition to technical aspects such as pain management.

Domestic Violence: Violence Against Women Act

In the 1970s, domestic violence shifted from a private family matter to a public social issue through the work of feminist grassroots organizations. Over the next twenty years, civil protection orders became more available to victims of domestic violence and non-arrest policies of local police departments began to change (Sack, 2004). The Violence Against Women Act of 1994 (P.L. 103-322) (VAWA) was passed by Congress and signed into law by President Clinton. It has been reauthorized by Congress in 2000 and 2005. VAWA created national legal structures for enforcing domestic violence as a crime and provides funds to states for services. While VAWA discusses extensive systems-level change (e.g., arrest policy, prosecution protocol), the community programming-oriented policy is most relevant to the discussion of compassion.

Under VAWA, the federal government provides grants to states for the funding of community organizations (Rosewater & Goodmark, 2007). The Office on Violence Against Women, located within the U.S. Justice Department, administers grants under VAWA and develops federal policy around domestic violence and related issues. Domestic violence was the primary initial focus of VAWA; however, the focus has expanded to other forms of violence disproportionately affecting women, such as stalking, workplace violence, and victimization of specific groups, such as elderly or disabled individuals.

Victim services specific to domestic violence are provided by community organizations. These services include: crisis hotlines; medical and legal advocacy; temporary housing; mental

health counseling; and coordination with other services. The core operation of these domestic violence organizations is to provide support, whether material or emotional, in the form of shelters and other aid. Women disproportionately experience domestic violence (Tjaden & Thoennes, 2000), hence the majority of programs offer services only to women. Other eligibility requirements may apply, such as income, geographic residency, drug and alcohol history (Sack, 2004), but VAWA emphasizes the need for assisting all victims in crisis, regardless of other characteristics.

Delivery of domestic violence victim services occurs through a combination of government and private grants to community organizations, as well as the coordination of community services with other service systems (police, social services, court, etc.). Providers include social workers and other social service personnel, paraprofessionals (for example, shelter workers), and trained volunteers. Service providers have a range of roles, from counseling to legal and medical advocacy to coordinating broader services (such as long term housing, etc.).

Because of the potential for severe physical harm, domestic violence services focus initially on the safety of the victim. As part of this, VAWA language emphasizes the suffering of the victim and the need to address this suffering. However, VAWA also focuses on empowering the individual beyond her victim status. Implementation challenges range from cultural differences in the understanding of domestic violence to drug and alcohol use to persistent violent relationships (Burman, Smailes, & Chantler, 2004).

Services to domestic violence victims require some coordination, but this typically occurs at the community level, as opposed to the individual case-level, through the establishment and maintenance of coalitions. Religion is closely connected with culture, and religious leaders (e.g., ministers, etc.) are often on the front-line in addressing problems that face women and children. Consequently, issues related to faith can have an important role in addressing the needs of victims, and religious organizations, therefore, are important in coalition efforts (National Resource Center on Domestic Violence [NRCDV], 2007a). The coalition approach has been central to this policy domain, reflecting both an effort to coordinate

services and also to be a stronger political force in the fight for justice. Domestic violence services, particularly through shelters, emphasize interpersonal contact between sufferer and service providers. Within a shelter, the milieu approach facilitates a physical nearness with the suffering and potentially can be fairly long-term. The interaction of service providers and clients, and between clients, provides the emotional element of compassionate response.

Explicit language of suffering and compassion was not found in the VAWA legislation. Instead, use of empowerment language was common. This is consistent with more of a rights-based strategy of achieving justice. This legislation and its service system have been highly intertwined with advocacy for victims, seeking not only potentially compassionate care but also justice in both courts and relationships.

The main implementation challenges associated with compassionate response in domestic violence are related to continued societal ambivalence regarding this type of violence as a social problem versus a private problem. Moreover, although in reality there is little religious justification for marital violence (NRCDV, 2007b), an abusive mentality may aim to use religious traditions to justify abusive actions. Victims, themselves, may struggle to regard their own circumstances as worthy of compassionate response. Furthermore, as our analysis pointed out, compassion does not appear to be the primary response desired. Empowerment and consequently, justice, appear to be the overriding considerations of intervention.

Community Disaster: Stafford Act

The key federal policy in this domain is the Robert T. Stafford Disaster Relief and Emergency Assistance Act. (P.L. 93-288, as amended, 42 U.S.C. 5121-5207). This legislation provides statutory authority for most federal disaster response activities, especially as they pertain to the Federal Emergency Management Agency (FEMA). More recent legislation in response to the September 11th terrorist attacks and the aftermath of Hurricane Katrina (i.e., Homeland Security Act and Post Katrina Emergency Management Reform Act) also has implications for disaster management.

Title 1, Sec. 101(a) of the Stafford Act states:

Congress hereby finds and declares that—(1) because disasters often cause loss of life, human suffering, loss of income, and property loss and damage; and (2) because disasters often disrupt the normal functioning of governments and communities, and adversely affect individuals and families with great severity; special measures designed to assist the efforts of the affected States in expediting the rendering of aid, assistance, and emergency services, and the reconstruction and rehabilitation of devastated areas, are necessary.

Both “emergency” and “major disaster” are defined in the legislation. In both cases the determination of the President is required to assess that the scale is beyond the capabilities of state and local efforts to address alone.

FEMA works in partnership with other organizations to form the nation’s emergency management system. Partners include state and local emergency management agencies, 27 federal agencies and the American Red Cross. FEMA’s core operations include: service to disaster victims; integrated preparedness; operational planning and preparedness; incident management; disaster logistics; hazard mitigation; emergency communications; public disaster communications, continuity programs. As identified, services to disaster victims is listed first and is described as follows: “Responsive and compassionate care for disaster victims is FEMA’s top priority.” The website of the American Red Cross identifies the organization aim of “preventing and relieving suffering.” Moreover, in addition to their role in domestic disaster relief, they offer “compassionate services” in other areas (such as educational programs that promote health and safety).

The overall service delivery system is highly complex and involves a variety of entities and professional groups (e.g., civil engineers, public health, police and fire). Coordination is an obvious central element. Moreover, each of the individual core operations would call upon different types of skills and expertise. The focus on services to disaster victims (as opposed to hazard mitigation) would be the “operation” where compassion might be expected. This operation alone, however, still

suggests extensive collaborative efforts would be required.

Roberts (2010) provides a discussion of the evolution of national disaster policies and the relevant implementing organizations in the U.S. Partially in response to the uncoordinated nature of many agencies, in 1979, President Carter established FEMA by executive order, which merged many of the separate disaster-related responsibilities into a single agency. More recent developments have been in response to the terrorist attacks of 2001 and the highly public and widely criticized failures of FEMA during and after Hurricane Katrina. FEMA became part of the Department of Homeland Security in 2003.

The coordination of disaster management is extensive and involves all levels of government and the private sector. Moreover, because disaster management must anticipate a wide range of disasters and emergencies, planning involves a number of units that may or may not be actually called upon in a disaster.

Within the disaster relief domain, the nearness to the sufferer and the potential for long term involvement would appear more variable than in the case of hospice and domestic violence. Partially this is due to the characteristics of emergencies—they are sudden and of varying types. Moreover, in the immediate emergency, priority may be given to concrete assistance, particularly if danger is still imminent. Long term assistance, both concrete and emotional, would generally not be provided, but one role of the service delivery system would be to link persons with other potential sources of help. Research into the activities of churches during and after the events of Hurricane Katrina, for example, show that faith-based organizations played an equally significant role, compared to FEMA and other secular organizations, in providing assistance to victims both in short and long term capacities (Cain & Barthelemy, 2008; Hurst & George, 2009).

The main implementation challenges associated with compassionate response in disaster management are the extensive coordination of multiple systems, preparation for events which often occur suddenly, and the potential politics involved in declaring federal emergencies.

Discussion

Each of these policy domains included some elements of interpersonal connection, but utilized differing means of providing this connection. Furthermore, coordination was central in each domain, but the mechanisms of coordination and the relevant parties involved in coordination were sources of variation. The compassionate delivery of aid is found within each of these three policy areas, but in each case it is a small part of a much larger policy. This is particularly the case for hospice (which exists in the large Medicare program) and disaster management (in which service to victims is one of several core operations). Other areas in which we found variation that has relevance to providing authentic compassion include policy origins, mechanisms of interpersonal connections, social constructions, time horizon, and the primacy of government role in addressing suffering. These are discussed further below.

Policy Origins

Each of the three cases reflects quite different policy origins. The hospice benefit was a development within Medicare, a widely enrolled and supported program within the Social Security Act. Although hospice care is well-connected to known conceptions of compassion, interest in providing it as a benefit through public policy was also largely related to cost considerations. VAWA had different origins. This legislation was the culmination of long-standing grassroots efforts to acknowledge the social problem of domestic violence, and consequently provide assistance to its victims. Stafford legislation evolved from numerous, earlier, largely uncoordinated efforts to prepare for and respond to both natural disasters and other large-scale emergencies.

Each of these policy areas has continued to develop, especially VAWA and the Stafford Act. These developments have come about in response to new knowledge development as well as political considerations. For instance, VAWA reauthorizations have included attention to specialized groups (e.g., immigrant communities, elders), which may provide unique considerations, and Stafford reauthorizations have recognized the changing nature of threats (e.g., terrorism), updated technologies, and post-Hurricane Katrina outrage at the ineffectiveness

of FEMA. In comparison, the Medicare Hospice benefit has remained relatively unchanged, although policy discussions surrounding health care reform included some focus on end-of-life decision-making.

Interpersonal Connection

The definitional element of compassion, “to be with in suffering” requires nearness to the sufferer and the essential element of human contact. This distinguishes a compassionate response from other types of helping, such as charitable aid to ease financial distress. Furthermore, some length of time might also be implied. In circumstances where suffering is of a long-term nature, a caring response that is too brief may not fit with an understanding of “being with” in suffering.

Each of the policy domains examined provides for interpersonal contact with sufferers, both through professional intervention and the use of volunteers. This is particularly important because the common use of the term “compassion” often does not recognize the necessity of the interpersonal relationship required. In each of the three policy domains, those on the front lines doing the bulk of the compassionate work would need to handle the emotional demands of being with people as they are suffering. It is not easy to sit with people who are dying, have been battered, or are in emotional distress because of a community emergency. A human instinct is often to recoil from such pain. Individuals have varying capacities to approach people in physical or emotional distress. Professional training (social work, nursing, ministry) typically provides targeted attention to helping individuals become emotionally capable of handling grave distress. Moreover, professionals generally choose the kind of work they are comfortable doing, and thus can avoid these types of activities if they perceive themselves unable to handle certain types of situations (e.g., imminent death).

Volunteers are central to service delivery (e.g., spend time with the sufferers) in each of the domains. Religion is a central motivation for many volunteers, and churches are often the conduit for connecting individuals with volunteer opportunities. It is this nexus where compassion, based on religious tradition, has the potential to be most conspicuous. But volunteers may only be capable of certain types of helping. The

type of training volunteers receive is likely to fall far short of the emotional and technical capacities needed to assist in circumstances of real suffering. Additionally, as Evans (2011) has noted in her discussion of the UK's Big Society, volunteers are not free. The infrastructure needed to recruit, train, manage, and support volunteers can be costly.

Social Construction of Problems/Populations

Classic writing of Ryan (1976) gave prominence to the phrase "blaming the victim" and outlined some of the psychological and social processes that result in attributing blame for an individual's misfortune to actions or characteristics of that individual rather than to social conditions. Ryan emphasized the sociological aspects of victim-blaming process, i.e., maintenance of current class structures and their inequalities as a primary motivation for defining social problems as residing within individuals rather than larger systems.

Even within the three relatively unambiguous cases examined—terminal illness, violent victimization, community disaster—there can be efforts to blame the victim for his/her misfortune and, therefore, to negatively affect the delivery of compassionate response. The aftermath of Hurricane Katrina provides the most drastic example of this (Napier, Mandisodza, Andersen, & Jost, 2006). In the case of domestic violence, VAWA was enacted due to long-term efforts to change victim-blaming in domestic violence cases. Through the advocacy work of VAWA-funded coalitions, this work continues. The case of terminal illness is less likely to result in victim-blaming, although there can still be psychological and societal pressures to avoid illness and death.

Victim-blaming inclinations are entwined with beliefs about deservedness, i.e., whether one is responsible for the difficult circumstances they are in and, consequently, whether they should receive assistance. Discussions of this have a long history and cross many disciplinary and professional boundaries. Our review of the literature suggests division as to whether deservedness is needed in order to obtain a compassionate response. Nussbaum (2001), for example, suggests the reason for the suffering is relevant in determining whether compassion is appropriate, whereas others (e.g., Comte-Sponville, 2001; Whitebrook, 2002) suggest that a lack of attribution of blame is

characteristic of a compassionate response and contributes to its moral weight.

In policy discussions, “deservedness” and “power” are key concepts to the social construction of target populations; those considered more deserving and more powerful are likely to get more favorable treatment in social policy (Schneider & Ingram, 1993). Those affected by community disaster, those who have been victims of violence, and those who are near death are all likely candidates for a compassionate response. Yet, the circumstances leading to this suffering may be considerations as to whether compassion is the predominant virtue observed and supported by the political environment.

Time Horizon

“To be with in suffering” provides no indication regarding the appropriate time period for engaging in compassionate action. Some suffering occurs over a long period of time. The hospice care benefit is unique regarding the time horizon; while terminal illness has qualities of both pain and fear of death that deem it worthy of compassion, the benefit is explicitly limited to cases in which death is determined to occur within six months. This quality imposes a short-term need for compassionate response that likely contributes to its political popularity.

Other types of suffering may have far longer time horizons. Domestic violence victims are often engaged in abusive relationships for extensive periods of time. Victims often make several efforts to end abusive relationships before they are able to fully gain their independence; some never do (Arias & Pape, 1999; Humphreys & Thiara, 2003). These realities are known to experienced workers in the domestic violence field. Responses to community disasters also have a complicated time horizon. The distinction between emergency response and later efforts at rebuilding are relevant. Scenes of devastation are generally effective at eliciting a response that is a combination of concrete aid and emotional support. There is typically widespread consensus of public support for intervention. But public attention, and consequent support, often wanes as the effort for rebuilding becomes more complicated.

Government Role

Some political positions espouse the need for greater emphasis on societal-level actions that take care of people and encourage people to take care of each other. Other positions emphasize the primacy of the individual and his/her freedom to decide when and how to engage with others. These perspectives are common in contemporary political dialogue, but have long-standing, even ancient, predecessors and shape policy responses to suffering even in these three cases where some level of compassion is undeniably appropriate.

In respect to the role of government, these three policy examples partially bridge the liberal-conservative divide by providing national policy structure and funding but orienting services at the community level and facilitating community leadership. Each of these three policy areas involves the use of community-based agencies and volunteers in the delivery of compassionate response.

Conclusion

Despite the extraordinary resources and privileges accorded to the American people, suffering abounds. Actions to relieve suffering may take many forms. In addition to the interpersonal connection highlighted in each of these policy domains, concrete assistance (food, safe shelter, pain medication) is also typically needed to be effective in easing suffering. But a requirement of compassionate response is an element of "shared suffering." Explicitly, compassionate response does not allow those enduring pain and loss to deal with it alone. Networks of family and community appropriately provide the bulk of compassionate response. But in many instances, the level of suffering is beyond the response capacities of these units. Therefore, compassion appears to be a relevant virtue for government policy.

Compassion-oriented policy requires federal and state funding infrastructure to support community-based networks of professionals (social workers, physicians, emergency management personnel), para-professionals (nursing assistants, group home staff), and volunteers (advocates, mentors). Professionals are central for several reasons. Serious suffering

is often extremely difficult to be around and professional training typically (but not always) can help individuals develop the capacity to withstand some of this very serious suffering. Also, professionals are trained to engage with the large, complex systems (e.g., hospitals, government bureaucracies, courts); understanding of these systems is needed in order to effectively secure resources and conduct case and systems advocacy.

There are additional policy elements that are necessary to achieve a sense of “shared suffering.” There needs to be formal policy recognition that suffering does occur and that those suffering have a right to the alleviation of suffering. Moreover, there needs to be sustained funding to allow continuity of assistance throughout the period of suffering. As noted, suffering can occur over a very long period of time.

In modern complex societies, no one virtue should undergird all of public policy. Such an approach would be simplistic. Reconciling the variety of virtues and determining associated policies is the role of sophisticated political leadership and an engaged citizenry. Our analysis has focused on one virtue. We do so for analytic purposes; we do not argue it is the only necessary virtue relevant to public policy. Many virtues are relevant to society. Sabl (2005) has argued that some virtues are necessary for basic functioning of a liberal democracy (e.g., justice) and that others are more specialized, needed in certain circumstances. An ongoing challenge to the role of virtue in civic life is that virtue lists can be fluid, with the most critical virtues being dependent on the specific social context (MacIntyre, 1981). Yet some remain fairly core to the human condition. Our choice of compassion for analysis is due to the recognition of suffering among vulnerable populations and our social work commitment to these populations.

How does compassion interact with other virtues? In one of the examples that we provided we observed an interaction of compassion and justice in the case of domestic violence. It does not seem necessary to choose one over the other. Compassion might be the dominant early response in domestic violence but may take a secondary or more episodic role as the machinery of justice is engaged. Greater attention regarding how virtues interact in various policy domains would be a fruitful area of inquiry.

As a second example, self-sufficiency is a valid virtue, and has been central to social welfare policy in the last two decades. Some have asserted that it has become so dominant in policy discourse that it is no longer even questioned (Hawkins, 2005). Elsewhere (Collins et al., 2012) we have provided some thoughts as to how the self-sufficiency aspect of welfare policy might be enhanced if there were more attention to compassion in our various poverty policies. More generally, resolution of a variety of problems might occur earlier and with a more sustained focus if compassion were delivered initially and with more visibility. This might be the case with victims of violence, national disaster, or the surviving loved ones of those who have died. It might be the case with other populations—foster children, refugees, homeless individuals—as well.

We have not argued that any of these policies are or are not effective in their delivery of compassionate response. A virtue-based approach, however, is focused more on “being” than “doing” and consequently more on “process” than “outcome.” Efforts to ease suffering are considered part of a compassionate response; but even when unable to effect a change in the conditions that cause the suffering, compassionate action is still a worthy endeavor. Some circumstances, wounds, and burdens may not improve (e.g., terminal illnesses, imprisonment). In these cases, the sharing of suffering is the outcome. Sometimes the compassionate act exists largely in the ability to be present with those suffering pain or loss. An inordinate preoccupation with measuring objective outcomes (e.g., employment) ignores the potential benefit of intervention aimed at the subjective reduction of suffering.

Virtue-based frameworks move to the forefront societal questions about our ethical relationships towards others and the building of better societies. Use of virtue-based language forces us to confront these bigger questions motivated by values and vision. Equally, they can force difficult decisions about sustained character that may withstand reactive policy-making to meet an immediate need or to respond to political tension. Thus discussions of compassion within a virtue-framework emphasize morality and ethics. Because of the sense of “character” reflected in virtues, this manner of examining policy speaks more to the sustained, dispositional sense of our nation. The more typically used policy metaphors such

as “sticks and carrots,” or investment and prevention, are relegated to secondary status.

Our analysis considered cases of largely unambiguous suffering and, therefore, there is likely to be greater consensus that action should be taken to alleviate suffering. Consideration of additional cases would add further detail to our emerging framework. Other relevant policy areas might include homelessness, immigration, bullying, and nursing home care. Those who suffer in these areas might also be in need of compassionate response. Yet, issues related to social construction of the populations, time horizon of suffering, ideologies regarding role of government, and other factors may result in a more opaque compassionate response.

Additionally, analysis of different virtues reflected in key policies may further clarify the utility of a virtue-based approach to policy development and analysis. We have already noted the virtues of justice and self-sufficiency. Other notable virtues that may lead to intriguing observations include generosity, courage, and humility, for example. We also believe our analysis has application to the development and implementation of policies in many other countries besides the U.S. Indeed, the focus on alleviating human suffering is likely shared across the globe, although specific policies may differ depending on the social, political and cultural context. Comparative analysis across countries regarding the delivery of compassionate response may be useful to identify some of the specific cultural elements related to the practice of compassion in the public arena.

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Self-employment and Public Emergency Work in Urban Labor Markets during the Great Depression: The Case of Industrial Cities

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Self-employment and public emergency work were frequent reactions to the economic dislocations of the Great Depression. Census data for men show that in urban-industrial centers, self-employment reduced the demand for public emergency work by absorbing displaced workers into the entrepreneurial sector. Census data for women reveal that, in these centers, self-employment and public emergency work coexisted due to mutually beneficial relations between women who were self-employed and those women who worked on government projects. The results suggest that, contrary to popular theoretical and ideological views, there is no inherent conflict between private- and public-sector responses to stagnant labor markets.

Key words: self-employment, public emergency work, industrial cities, Great Depression

Self-employment is common in depressed labor markets. Displaced workers in these markets often try to eke out a livelihood in independent income-producing activities, becoming “survivalist entrepreneurs” in response to a pressing need to find a substitute for wage/salary employment (Light & Rosenstein, 1995, p. 213). Over much of the twentieth century, for instance, the national rate of self-employment was directly correlated with the mass unemployment of business-cycle downswings (Steinmetz & Wright, 1989). Consistent with this “disadvantage theory of business enterprise,” self-employment was widespread in the urban industrial centers of the U.S. during the Great Depression of the 1930s, as the collapse of the nation’s manufacturing base led to massive unemployment that stimulated the proliferation of “depression

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businesses," many of which were small stores and shops (Light, 1979, p. 36). Such businesses were, for many dislocated workers in stagnant labor markets, viable alternatives to joblessness and financial destitution.

However, self-employment is but one reaction to the conditions of depressed labor markets. In many cases, displaced workers can also obtain temporary public-sector jobs, which are frequently created to ameliorate the most severe hardships of unemployment. In point of fact, during the Great Depression, numerous "public emergency work projects" that generated paid civilian employment were undertaken by the federal government as well as by state and local government relief agencies. Among the best known of these projects were the federal government initiatives of the Works Progress Administration, Civilian Conservation Corps, and National Youth Administration (U.S. Bureau of the Census, 1943a, p. 3). These projects were instrumental in providing much-needed infrastructure (e.g., hydroelectric power generation) and recreational facilities (e.g., national parks) that continue to benefit American society (Leighninger, 2007). And in the hard-hit urban industrial centers of the nation, such projects offered a means of support to laid-off workers who were desperately searching for a way to make a living in the worst years of the crisis.

Although self-employment and public emergency work are prominent in depressed labor markets, little research has considered how the two responses to economic dislocation might be associated with one another. This neglect is unfortunate because, as the present study will argue, an examination of this association can inform controversial debates, found in social science and policy research, about the relationship between private enterprise and public-sector interventions during times of economic stagnation. Specifically, the present investigation will test hypotheses derived from competing views of these two reactions to labor market distress, analyzing the urban centers that suffered the heaviest losses of jobs during the Great Depression: the industrial cities of the North.

Hypotheses

The first hypothesis is that self-employment is negatively

associated with public emergency work. This hypothesis is grounded in the observation that, despite popular interest in self-employment (Steinmetz & Wright, 1989), most workers shun risky entrepreneurial ventures, preferring, when available, the more secure option of wage/salary employment (Light, 1979, p. 36). This hypothesis comports with the proposition, implied by the disadvantage theory of business enterprise, that in stagnant labor markets, the pressure to become self-employed is reduced by public sector interventions that cushion the blow of economic dislocation (Light, 1979, p. 36). The hypothesis also accords with the view, rooted in conservative ideology, that while people generally desire to be economically independent, self-sufficiency can be stifled by government efforts to aid the disadvantaged (e.g., Murray, 1984). Hypothesis 1 thus predicts that, on the average, the level of self-employment will be lowest in those labor markets in which the level of public emergency work is highest.

A second hypothesis is that self-employment is positively associated with public emergency work. This hypothesis rests on the argument, inferred by the "Third Way" or politically centrist policy perspective, that there is no inherent conflict between the respective activities of the private- and public-sectors and, therefore, self-employment is, in principle, compatible with government programs to reduce unemployment by creating jobs. This argument rejects the assumption, implicit in the reasoning of Hypothesis 1, that displaced or insecure workers are inclined to substitute public employment for private initiative and industry. Indeed, the argument suggests, self-employment and public emergency work are complementary responses to economic distress and are undertaken by different members of a community, with some dislocated individuals starting their own businesses and others gravitating into temporary government positions.

Self-employment and public emergency work may be compatible for several reasons. The norms and values of entrepreneurship, and of work, in general, are bolstered when a population is economically vigorous, that is, when legitimate employment is highly visible, creating a "social buffer" against disorder (Wilson, 1987, p. 144). Hence, the cultural basis for self-employment in stagnant labor markets could be supported by a beneficial social buffer effect of public emergency work.

In addition, the self-employed can be sustained to some degree by the consumer demands of public emergency workers, who as gainfully employed members of the labor force, are more capable of purchasing goods and services than are the unemployed, who tend to be impecunious due to lack of income. In line with this proposition, the Keynesian theory of the economic multiplier effect of government spending (Pearce, 1986, p. 228) implies that private enterprise is spurred by the creation of public-sector jobs during downturns of the business cycle. It follows that Hypothesis 2 is that, on the average, the level of self-employment will be highest in those labor markets in which the level of public emergency work is also highest.

A final hypothesis is that self-employment is negatively associated with public emergency work, but for different reasons than those given for Hypothesis 1. This third hypothesis is based on the argument that the entrepreneurial sector, broadly defined to include the most marginal of legitimate income-producing endeavors, can effectively absorb displaced workers, thus alleviating demands for government involvement in the labor market. This labor absorption thesis is suggested by observations that, in major cities of many developing societies, a remarkably large share of the population is able to avoid joblessness, even during an economic crisis, by becoming independently employed in small enterprises (Friedmann & Sullivan, 1974; Koo, 1976). According to this reasoning, self-employment reduces the need for dislocated or insecure workers to accept temporary public-sector jobs. Hypothesis 3, then, is that, on the average, the level of public emergency work will be lowest in those labor markets in which the level of self-employment is highest.

Data and Variables

Data from the U.S. Census of 1940 are analyzed to capture a year of the Great Depression in which (1) urban labor markets were exceptionally sluggish and (2) the public emergency work programs of the New Deal were firmly in place (Vedder & Gallaway, 1997). The economy had noticeably recovered from the worst years of the Great Depression by 1940, in part because of the mobilization for World War II. But unemployment was still unusually high when the Census was

conducted in April of that year. In fact, the unemployment rates of Whites and non-Whites in the 1940 Census (9.50% and 10.89%, respectively) were higher than those reported in any other decennial census from 1890 to 1970 (Vedder & Gallaway, 1997, p. 272). Moreover, the occupational data needed for the present study are available only in the Census of 1940.

Cities are the units of analysis because they are the spatial arenas in which people tend to conduct their economic activities, including work and the search for work. According to urban economic theory, then, cities accurately represent labor markets (Thompson, 1965). The major cities of the most heavily industrialized U.S. regions, the Northeast and Midwest (hereafter, called the North), are examined because their labor markets were especially hard-hit by the Great Depression due to the collapse of the nation's manufacturing base in the 1930s.

The level of self-employment in a city is measured as the odds that gainfully employed persons in the city are classified as "employers and own account workers" by the Census. Employers and own account workers include "not only the owner-operators of large stores and manufacturing establishments but also small merchants, independent craftsmen, farmers, professional men, and other persons conducting business on their own" (U.S. Bureau of the Census, 1943a, p. 6). City-level data on employers and own account workers (hereafter, for simplicity, called self-employed workers) exist for cities with populations of 250,000 or more and are available for men and women by "color," that is, in Census terminology, for "whites" and "nonwhites" (U.S. Bureau of the Census, 1943b, Table 19). As will be shown below, the vast majority of nonwhites in these data for northern cities are Blacks.

Unfortunately, there are no data on the size of the enterprises owned and operated by the self-employed (e.g., financial assets or number of employees). However, indirect evidence suggests that the lion's share of the enterprises were small, mainly sole proprietorships. There were 9,757,736 self-employed persons out of a total of 45,166,083 employed persons in the U.S. in 1940 (U.S. Bureau of the Census, 1943a, Table 78). Thus, regular employees who worked for wages or salaries comprised by far the largest segment of the workforce. Of the self-employed, most (5,138,537) were in agriculture

(that is, farmers), and of the non-agricultural self-employed (4,619,199), the largest single occupational category was the retail trade (1,632,333). A 1935 national survey of the retail trade reported that 1,474,149 of the 1,653,961 retail stores operating in that year were "independents" as opposed to "chains" (U.S. Bureau of the Census, 1937, p. 6, as cited in Light, 1979, p. 36). It is reasonable to infer, then, that most of the independents—which proliferated during the Great Depression, while the number of chain stores declined—were small-scale proprietorships (Light, 1979, p. 36).

The odds of self-employment will be calculated separately for men and women and Whites and Blacks because of well-known group disparities in entrepreneurship (Boyd, 2005). Owing to gender stratification, men and women tend to participate in different labor markets and have unequal opportunities for self-employment. Consequently, men are more likely to be self-employed than are women. Owing to racial stratification, Whites have privileged access to the resources needed for business enterprise and, hence, Whites are more likely to be self-employed than are Blacks.

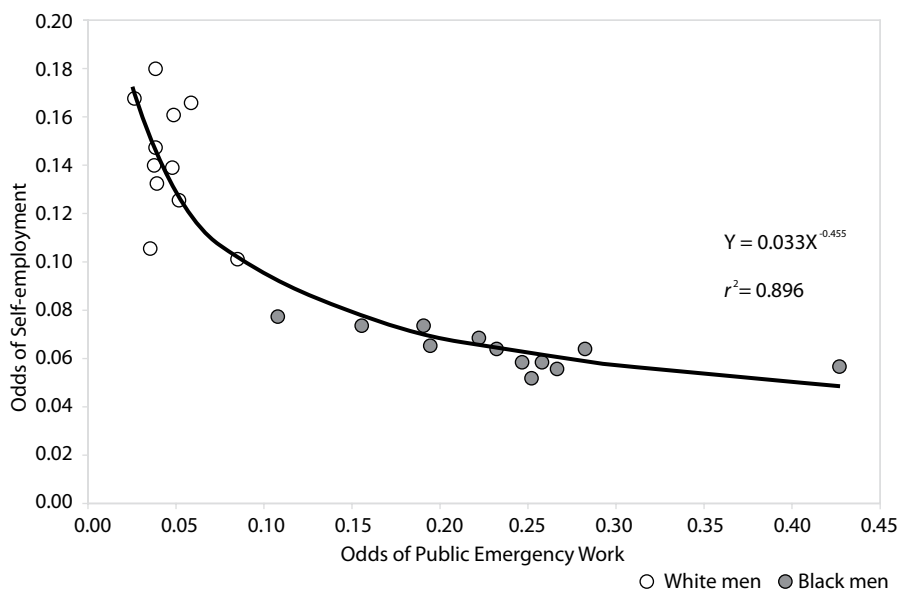
The level of public emergency work in a city is measured as the odds that gainfully employed persons in the city are classified by the Census as "on public emergency work," that is, employed in one of the "public emergency work projects" described above. In 1940, the largest of these projects were the Works Progress Administration, Civilian Conservation Corps, and National Youth Administration, and at the time, there were 2,529,606 people employed on all public emergency work projects (U.S. Bureau of the Census, 1943a, p. 3). City-level data on public emergency work exist for cities of 100,000 persons or more and are available for men and women by race, that is, for Whites and for Blacks, who were called "Negroes" in the data (U.S. Bureau of the Census, 1943a, Tables 44-47). The odds of public emergency work will be computed separately for men and women and for Whites and Blacks.

The northern cities for which Census data exist on both self-employment and public emergency work are: Chicago, Cincinnati, Cleveland, Columbus, Detroit, Indianapolis, Kansas City (MO), New York, Newark, Philadelphia, Pittsburgh, and Saint Louis. These major cities were vital urban-industrial centers in the early twentieth century. But during the Great

Depression, their manufacturing-based economies stagnated, and their labor markets were flooded with thousands of laid-off industrial workers who were desperately searching for a means of livelihood.

In these cities in 1940, “nonwhites” were, overwhelmingly, Blacks. In point of fact, the mean percentage of employed nonwhite men who are Black is 97.6 in these cities. The values range from 99.6 percent in Indianapolis to 89.1 percent in New York. The mean percentage of employed nonwhite women who are Black is 99.7 in these cities. The values range from 99.9 percent in Cleveland to 99.4 percent in Detroit. The self-employment statistics for nonwhites, then, are reasonable proxies for Blacks’ self-employment.

Figure 1. Scatterplot of the Odds of Self-employment and the Odds of Public Emergency Work: White and Black Men, 1940



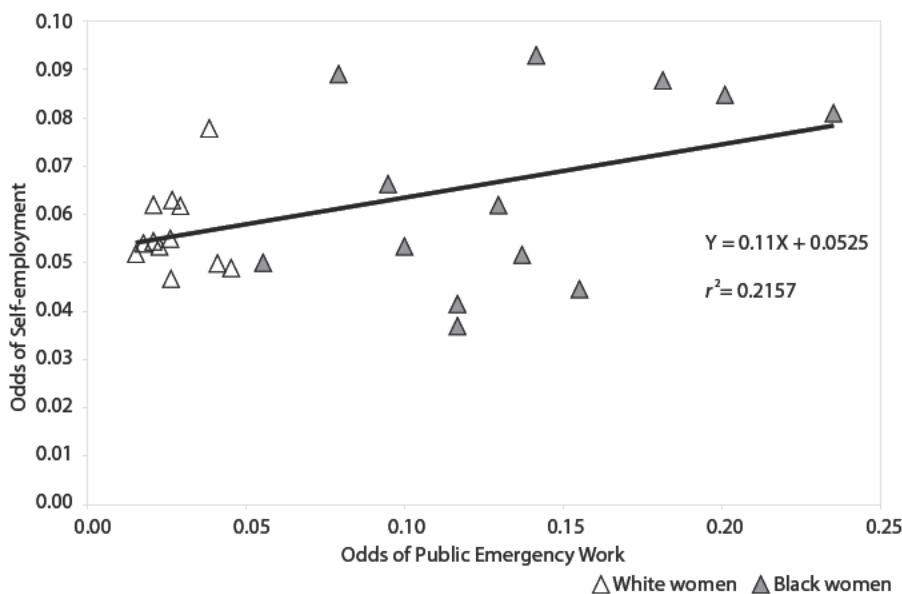
Descriptive Statistics

Race and gender differences for the above cities are described in Tables 1a and 1b and 2a and 2b. These data show that White men have higher mean odds of self-employment (0.142) than do Black women (0.066), Black men (0.064) and White women (0.056). These data also show that Black men

have higher mean odds of being employed on public emergency work (0.236) than do Black women (0.136), White men (0.045) and White women (0.027).

To describe the association between the odds of self-employment and the odds of public emergency work, the data from Tables 1a and 1b and 2a and 2b are displayed in the scatterplots of Figures 1 and 2, respectively. The scatterplot for men shows a strong and statistically significant negative relationship between the variables ($r^2 = 0.896$, $p < 0.001$), suggesting that self-employment and public emergency work were alternative responses to labor market distress. The scatterplot for women, however, shows a weak yet statistically significant positive relationship between the variables ($r^2 = 0.216$, $p = 0.022$), implying that self-employment and public emergency work were complementary responses to labor market distress.

Figure 2. Scatterplot of the Odds of Self-employment and the Odds of Public Emergency Work: White and Black Women, 1940



Regression Analyses

Results for men. The multiple regression analyses of the data for men are presented in Table 3. The nonlinear relationship between the odds of self-employment and the odds of

public emergency work, observed in Figure 1, is modeled by logarithmically transforming the values of these variables, following a standard practice (Agresti & Agresti, 1979, pp. 371-375). A dummy variable for race (black observation = 1) is included as an independent variable to take account of the racial differences discussed above. City population (logarithmically transformed to amend its skew) is included as an independent variable to take account of population-size differences across the cities examined (U.S. Bureau of the Census, 1942, Table 12).

Table 1a. White Men: Self-employed and on Public Emergency Work, 1940.

City	White Men Self-employed		White Men On Public Emergency Work	
	Number	Odds	Number	Odds
Chicago	108,064	0.13246	34,853	0.03920
Cincinnati	14,424	0.14733	4,144	0.03831
Cleveland	21,242	0.10093	18,112	0.08480
Columbus	9,025	0.13889	3,379	0.04784
Detroit	43,614	0.10569	15,596	0.03539
Indianapolis	11,794	0.13988	3,491	0.03769
Kansas City, MO	14,897	0.16597	5,791	0.05858
New York	295,441	0.18003	71,314	0.03823
Newark	14,658	0.16077	4,904	0.04859
Philadelphia	65,069	0.16756	11,725	0.02655
Pittsburgh	17,505	0.12561	7,771	0.05212
Saint Louis	25,313	0.13985	7,481	0.03762
Means	53,420.5	0.142082	15,713.4	0.04541
Medians	19,373.5	0.139866	7,626.0	0.03875

The estimates of Equation 1 in Table 3 are in line with Hypothesis 1. They indicate that the odds of men's self-employment (the dependent variable) are, on the average, lowest in those cities in which the odds of men's public emergency work (the main explanatory variable) are highest ($b = -0.2681$, one-tailed $p = 0.0054$). Perhaps as the disadvantage theory of business enterprise suggests, government

programs that soften the impact of joblessness do weaken the motivation for self-employment in depressed labor markets. Of course, it is possible, too, that the negative association reflects a dearth of self-employment opportunities.

Table 1b. Black Men: Self-employed and on Public Emergency Work, 1940.

City	Black Men Self-employed ^a		Black Men On Public Emergency Work	
	Number	Odds	Number	Odds
Chicago	4,106	0.06390	15,050	0.28232
Cincinnati	696	0.05572	2,777	0.26679
Cleveland	1,154	0.05703	6,399	0.42686
Columbus	524	0.06396	1,640	0.23174
Detroit	2,081	0.05206	8,469	0.25219
Indianapolis	799	0.06902	2,247	0.22184
Kansas City, MO	650	0.05928	2,377	0.25733
New York	7,869	0.07373	15,428	0.15558
Newark	555	0.05904	1,966	0.24606
Philadelphia	3,470	0.07775	4,683	0.10786
Pittsburgh	811	0.06521	2,161	0.19493
Saint Louis	1,824	0.07275	4,306	0.19062
Means	2,044.9	0.06412	5,625.3	0.23618
Medians	982.5	0.06393	3,541.5	0.23890

^aData are for "nonwhites."

The substantive significance of these estimates can be illustrated by computing predicted odds of men's self-employment. A change of the odds of men's public emergency work from (say) 0.05 to 0.10 is associated with a predicted change of the odds of men's self-employment from 0.1134 to 0.0942. These values are computed in the following manner. Substituting into Equation 1 the natural logarithm of 0.05 for the odds of men's public emergency work (-2.9957), and the mean values of the other independent variables, yields -2.1769 for the predicted natural logarithm of the odds of men's

self-employment, and $e^{-2.1769} = 0.1134$. Substituting into Equation 1 the natural logarithm of 0.10 for the odds of men's public emergency work (-2.3026), and the mean values of the other independent variables, yields -2.36277 for the predicted natural logarithm of the odds of men's self-employment, and $e^{-2.36277} = 0.0942$. The mean value of the dummy variable for race is 0.50, and the mean value of the natural logarithm of city population is 13.7289.

Table 2a. White Women: Self-employed and on Public Emergency Work, 1940.

City	White Women		White Women	
	Self-employed		On Public Emergency Work	
	Number	Odds	Number	Odds
Chicago	19,854	0.05379	6,703	0.01754
Cincinnati	2,353	0.05322	1,027	0.02255
Cleveland	4,072	0.04866	3,790	0.04514
Columbus	1,846	0.06162	900	0.02912
Detroit	7,399	0.05479	3,603	0.02595
Indianapolis	2,397	0.06282	1,051	0.02660
Kansas City, MO	3,477	0.07761	1,771	0.03808
New York	39,609	0.05172	12,021	0.01515
Newark	2,034	0.04652	1,170	0.02624
Philadelphia	9,849	0.05423	3,881	0.02069
Pittsburgh	2,879	0.04964	2,396	0.04097
Saint Louis	5,311	0.06176	1,848	0.02066
Means	8,423.3	0.05637	3,346.8	0.02739
Medians	3,774.5	0.05401	2,122.0	0.02610

Applying these values to two hypothetical cities of 100,000 employed men each reveals that the city with 4,329 more men on public emergency work is predicted to have 1,578 fewer men who are self-employed. These values are calculated as follows. For a hypothetical city, a value of 0.05 for the odds of men's public emergency work is equivalent to 4,762 men employed on public emergency work ($4,762 / 95,238 = 0.05$), and a value of 0.10 for these odds is equivalent to 9,091 men

employed on public emergence work ($9,091 / 90,909 = 0.10$). Subtracting 4,762 from 9,091 equals 4,329. Also for this city, a value of 0.1134 for the odds of men's self-employment is equivalent to 10,184 men who are self-employed ($10,184 / 89,816 = 0.1134$), and a value of 0.0942 for these odds is equivalent to 8,606 men who are self-employed ($8,606 / 91,394 = 0.0942$). Subtracting 8,606 from 10,184 equals 1,578.

Table 2b. Black Women: Self-employed and on Public Emergency Work, 1940

	Black women		Black women	
	Self-employed ^a		On Public Emergency Work	
City	Number	Odds	Number	Odds
Chicago	2,627	0.08763	5,005	0.18133
Cincinnati	287	0.04439	907	0.15518
Cleveland	651	0.08085	1,658	0.23534
Columbus	213	0.05130	525	0.13672
Detroit	1,198	0.09270	1,750	0.14145
Indianapolis	387	0.06187	762	0.12959
Kansas City, MO	433	0.06655	601	0.09482
New York	4,087	0.04981	4,508	0.05523
Newark	208	0.03671	614	0.11673
Philadelphia	1,725	0.05321	3,112	0.10029
Pittsburgh	411	0.08448	884	0.20128
Saint Louis	1,118	0.08895	1,003	0.07908
Means	1,112.1	0.06654	1,777.4	0.13559
Medians	542.0	0.06421	955.0	0.13316

^aData are for "nonwhites."

Yet, the estimates of Equation 2 in Table 3 accord with Hypothesis 3. They indicate that the odds of men's public emergency work (the dependent variable) are, on the average, lowest in those cities in which the odds of men's self-employment (the main explanatory variable) are highest. Comparing the slope of this relationship ($b = -1.0543$,

one-tailed $p = 0.0054$) with the one of the corresponding relationship in Equation 1, moreover, implies that the relationship in

Table 3. Regression Results: Men, 1940

<i>Equation 1</i>				
Dependent variable: Odds of Self-employment, logged (men)				
Independent variables	Slopes	t-ratios	One-tailed p-values	Betas
Odds of Public Emergency Work, logged (men)	-0.2681	-2.8074	0.0054	-0.5578
Race (Black observation = 1)	-0.3485	-2.1009	0.0243	-0.4143
City population, logged	0.0008	0.0246	0.4903	0.0017
Intercept	-2.8162			
R-squared	0.9165			
Adj. R-squared	0.9040			
F-statistic	73.1815			
p of F-statistic	< 0.0001			
<i>Equation 2</i>				
Dependent variable: Odds of Public Emergency Work, logged (men)				
Independent variables	Slopes	t-ratios	One-tailed p-values	Betas
Odds of Self-employment, logged (men)	-1.0543	-2.8074	0.0054	-0.5068
Race (Black observation = 1)	0.8098	2.5696	0.0091	0.4627
City population, logged	-0.0797	-1.3750	0.0922	-0.0864
Intercept	-4.1126			
R-squared	0.9241			
Adj. R-squared	0.9128			
F-statistic	81.2216			
p of F-statistic	< 0.0001			

Equation 2 is the stronger one. That is, the estimated decrease of men's public emergency work associated with an increase of men's self-employment is greater than the estimated decrease of men's self-employment associated with an increase of men's public emergency work. Thus, it appears, as the labor absorption thesis argues, that survival entrepreneurship reduces the demand for temporary government jobs in distressed labor markets by incorporating displaced workers into the

small-business sector.

The substantive significance of the estimates of Equation 2 can be illustrated by computing predicted odds of men's public emergency work, using the same procedures described above. A change of the odds of men's self-employment from (say) 0.05 to 0.10 is associated with a predicted change of the odds of men's public emergency work from 0.1933 to 0.0931. Applying these values to two hypothetical cities of 100,000 employed men each shows that the city with 4,329 more self-employed men is predicted to have 7,683 fewer men on public emergency work. In support of Hypothesis 3, then, the analyses of the data for men indicate that the predicted decrease of public emergency workers associated with an increase of self-employment is markedly greater than the predicted decrease of self-employment associated with the same increase of public emergency workers (7,683 vs. 1,578).

Results for women. The multiple regression analyses of the data for women are displayed in Table 4. The estimates of Equation 3 are in agreement with Hypothesis 2. They indicate that the odds of women's self-employment (the dependent variable) are, on the average, highest in those cities in which the odds of women's public emergency work (the main explanatory variable) are also highest ($b = 0.1567$, one-tailed $p = 0.0410$). Perhaps as the politically centrist or "Third Way" policy perspective asserts, self-employment and government job-creation programs are complementary reactions to labor market distress. The jobs created by these programs might be social buffers that cushion the cultural shocks of economic dislocations. Such jobs might also bolster consumer demands that stimulate petty entrepreneurship in urban economies that are otherwise stagnant.

The substantive significance of these estimates can be illustrated by calculating predicted odds of women's self-employment, again following the procedures described earlier. A change of the odds of women's public emergency work from (say) 0.05 to 0.10 is associated with a predicted change of the odds of women's self-employment from 0.0565 to 0.0644. Applying these values to two hypothetical cities of 100,000 employed women each reveals that the city with 4,329 more women on public emergency work is predicted to have 696 more women who are self-employed. Hence, while the

relationship between these two responses to distressed labor markets is positive, it is fairly modest, substantively as well as statistically.

Table 4. Regression Results: Women, 1940

Equation 3

Dependent variable: Odds of Self-employment (women)

Independent variables	Slopes	t-ratios	One-tailed p-values	Betas
Odds of Public Emergency Work (women)	0.1567	1.8312	0.0410	0.6615
Race (Black observation = 1)	-0.0068	-0.6150	0.2728	-0.2207
City population, logged	0.0019	0.5798	0.2843	0.1155
Intercept	0.0264			
R-squared	0.2389			
Adj. R-squared	0.1247			
F-statistic	2.0925			
p of F-statistic	0.1333			

Equation 4

Dependent variable: Odds of Self-employment (women)

Independent variables	Slopes	t-ratios	One-tailed p-values	Betas
Odds of Public Emergency Work, logged (men)	0.0708	1.1904	0.1239	0.5048
Race (Black observation = 1)	-0.0033	-0.2574	0.3998	-0.1085
City population, logged	0.0015	0.4547	0.3271	0.0949
Intercept	0.0321			
R-squared	0.1701			
Adj. R-squared	0.0456			
F-statistic	1.3663			
p of F-statistic	0.2817			

To demonstrate that this positive association is gender-specific (that is, unique to women's economic activities), the odds of women's self-employment are regressed on the odds of men's public emergency work and the other independent variables. The estimates of Equation 4 in Table 4 show that while the odds of women's self-employment are, on the average, highest in those cities in which the odds of men's

public emergency work are also highest, the association is relatively weak and not statistically significant (one-tailed $p = 0.1239$). Alternative model specifications (e.g., using logged values of the variables) produced the same, non-significant results. This non-significance is noteworthy, because the respective odds of women's and men's employment in public emergency work are, as one would expect, highly correlated ($r = 0.920$). It is, therefore, reasonable to attribute the positive association between women's self-employment and women's public emergency work in Equation 3 to a distinctive, gender-based relationship among women in the paid labor force.

Discussion

Self-employment and public emergency work were frequently undertaken in the stagnant labor markets of large industrial cities during the Great Depression. Analyzing the relationship between these two common reactions to job displacement, the present study tested hypotheses suggested by competing perspectives on the relative merits of private enterprise and public-sector interventions as responses to the economic dislocations of business-cycle downturns. The findings and conclusion cannot be directly extrapolated to present-day policy debates (e.g., discussions over the proposed federal budget of U.S. Representative Paul Ryan, Republican – Wisconsin, Chair of the House Budget Committee), owing to the historically unique circumstances of the Great Depression. Nevertheless, the results do show that, in the urban centers of the nation's industrialized region, the association between self-employment and public emergency work is complex and cannot be explained in simple theoretical or ideological terms.

The findings for men accord with the argument that self-employment and government job-creation projects are alternative rather than incompatible reactions to economic distress. The estimates indicate that the inclination of displaced workers to find an independent means of livelihood is reduced by government initiatives that relieve the hardships of joblessness. This result is in line with the disadvantage theory's claim that most people see wage/salary employment as preferable to self-employment. But it would be premature to agree with the conservative critique that economic self-sufficiency is eroded

by public sector interventions. The estimates also suggest, consistent with the prediction of the labor absorption thesis, that self-employment reduces the pressure on displaced workers to accept temporary government jobs.

These results add to the literature on self-employment and economic dislocation. Past studies, reviewed above, emphasize that self-employment reduces joblessness in stagnant labor markets. The present investigation expands the scope of this research by showing that self-employment also ameliorates the demand for temporary government jobs in such labor markets. In particular, the analysis reveals that, for men in urban centers of the nation's industrial region, the decrease of public emergency work associated with an increase of self-employment is substantially greater than the decrease of self-employment associated with the same increase of public emergency work.

Conversely, the findings for women tally with the assertion that self-employment and government job-creation projects are compatible responses to economic distress. The positive association, while modest, according to the estimates, nonetheless resonates with the contention, found in the progressive approaches inspired by Keynesian economic theory, that public-sector job-growth initiatives can stimulate private enterprise. It is possible that these initiatives, by sustaining the visibility of legitimate employment in depressed labor markets, are social buffers that reinforce norms and values that encourage independent enterprise. It is possible, too, that these initiatives, by supplying an income stream that would not otherwise exist, bolster consumers' demands for the goods or services provided by small-scale entrepreneurs in economically stagnant areas. These possibilities, unfortunately, cannot be empirically explored with the data and methods of the present study; thus, they are left as hypotheses for future research.

The observation that self-employment and public emergency work are positively associated for women contributes a novel insight into the economic activities of women during the Great Depression. It is well documented that, in the midst of the hard times, many women were self-employed, frequently in gender-typed occupations, such as dressmaking, child-care, or beauty culture (e.g., Boyd, 2005). The present study extends these accounts of women's reactions to the economic crisis.

Specifically, by demonstrating that the independent income-producing efforts of women were supported by women's employment in government work projects, the analysis suggests that, in urban centers of the nation's industrial region, self-employed women and women public emergency workers often had mutually beneficial economic relationships. Future research might investigate the possibility that such relationships were gender-specific and based on transactions in which women entrepreneurs provided necessary goods (e.g., clothing) or services (e.g., child-care) to women who were employed in government work projects.

In sum, a complex relationship between self-employment and government job-creation projects existed in the stagnant labor markets of industrial cities during the Great Depression. On balance, for men, self-employment reduced the demand for public emergency work by absorbing displaced workers into the self-employed population. For women, self-employment and public emergency work coexisted due to mutually beneficial relations between women who were self-employed and those women who worked on government projects. Contrary to popular theoretical and ideological views, then, there is little evidence of an inherent conflict between these two private- and public-sector responses to the economic dislocations of the nation's worst economic crisis. Opponents of government interventions should thus rethink the argument, based on conservative policy analysis (e.g., Murray, 1984), that self-sufficiency is stifled in any substantial way by public-sector involvement in labor markets. Furthermore, advocates of government intervention in labor markets (e.g., Wilson, 1987) should also consider supporting policies that facilitate the self-employment of displaced workers, as well as other policies that might help such workers to avoid joblessness and financial destitution.

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Differences in Experiences of Racial and Ethnic Microaggression among Asian, Latino/Hispanic, Black, and White Young Adults

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Racial and ethnic discrimination is a significant risk factor for health and mental health problems among non-White children, adolescents, and adults. Recent evidence suggests that a form of discrimination known as microaggression, characterized by subtle and often unintentional acts of discriminatory behavior, is associated with detrimental effects on the psychological and emotional well-being of non-White individuals. We examined differences in microaggression experiences among a sample of 409 Asian, Latino, Black, and White young adults. The Racial and Ethnic Microaggressions Scale (Nadal, 2011) was used to measure respondents' experiences of racial and ethnic microaggression. Young adults in all the non-White groups reported significantly higher rates of microaggressive experiences than respondents in the White group. Black participants experienced the highest levels of microaggression, followed by Latinos/Hispanics and Asians. Exploratory post-hoc comparisons yielded significant differences in the nature and type of racial and ethnic microaggressions experienced by members of different racial or ethnic groups. Implications for policy and practice are discussed.

Key words: *racial and ethnic discrimination, microaggression, young adults, ANOVA*

Racial discrimination continues to be a vexing problem in the United States. On the one hand, discrimination has become less tolerated both socially and legally in the past several decades. This change in attitude coincides with the growing diversity of the American population in which Caucasian Whites are no longer the majority in many parts of the country and will be outnumbered nationally within a few decades (Craig & Richeson, 2014). In addition, civil rights legislation prohibits discrimination against people of color in all public contexts (Hasday, 2007). Despite these changes, social stratification based on skin color is related to inequities in housing, education, employment, and income in American society (U.S. Department of Health & Human Services, 2001). Racial discrimination is an important determinant of social and emotional well-being among people of color (Paradies, 2006; Williams, Neighbors, & Jackson, 2003). From both a policy and public health perspective, racial and ethnic discrimination is a significant risk factor for many health and mental health problems experienced by people of color. Furthermore, discrimination adversely affects access and quality of health and mental health services for people of color (U.S. Department of Health & Human Services, 2001).

Forms of racial and ethnic discrimination have evolved in the past several decades. One major trend has been that discrimination is now less likely to be overt and/or violent than it was in the past (Dovidio, Gaertner, Kawakami, & Hodson, 2002). However, evidence indicates that an insidious form of discriminatory behavior referred to as *microaggression* has increased. Racial microaggression is characterized by small, insulting occurrences which tend to be subtle, often even unintentional acts of discrimination against people of color (Sue, Bucceri, Lin, Nadal, & Torino, 2007). Understanding the specific mechanisms by which microaggressions are perpetrated and examining the impact of such acts is critical to developing preventive interventions and policies necessary to reduce discrimination and service barriers for non-White people.

Racial and Ethnic Microaggression

The term *racial microaggression* was first introduced by Chester Pierce in the 1970s to refer to minor acts of

discrimination that are experienced frequently by people of color in their daily lives. Microaggression may occur interpersonally or environmentally (Sue et al., 2007). For example, a common interpersonal microaggression experienced by Asian-Americans is when they tell someone they are from somewhere in the contiguous U.S. only to receive the response, "No, where are you *really* from?" The underlying message to many Asian-American citizens is that they are not true Americans and never will be. An example of an environmental microaggression experienced by Mexican-Americans occurs when anti-immigration posters containing photographs of Mexican people are displayed at a place of commerce or business. In some cases, microaggressive acts are manifested by verbal or physical actions intended to inflict harm (Sue et al., 2007). More often, however, acts of microaggression are subtle insults toward people of color that are automatic, nonverbal, and unintended in nature (Soloranzo, Ceja, & Yosso, 2000; Sue et al., 2007).

Sue and colleagues (2007) created a taxonomy of racial microaggressions based on findings from qualitative research and evidence from the social psychological literature on racism. They identified three overarching categories of microaggression: (1) microassaults; (2) microinsults; and (3) microinvalidations. *Microassaults* are acts of racism or discrimination that are enacted knowingly toward others. Such acts include physical or verbal assaults that are racist in nature and intended to inflict harm. The other two forms of microaggression tend to be unintentional and subtle. *Microinsults* are messages relayed interpersonally or environmentally that relay negative, degrading, or exclusionary messages (Sue et al., 2007). Congratulating someone for being the exception to what is stereotypical or positionally expected due to skin color is an example of a microinsult.

The third type of microaggression is *microinvalidation*. This occurs when people say things such as that they do not "see color," or that racism does not exist. This type of thinking is perpetuated in the American myth that everyone has an equal chance to succeed if they simply work hard and embrace core societal values. Such myths often obscure racism and oppression and imply that inequities in society are solely due to the

inferiority of people who simply do not apply themselves hard enough to succeed. The danger in such a proposition is that it fails to acknowledge the presence and influence of oppressive structural forces in society that reinforce the disadvantage and marginalization of people of color (Sue, 2010; Wise, 2013).

Incidents involving acts of microaggression are often complex in nature and elicit a range of responses. Recipients of microaggressive exchanges are frequently confused about the nature of these interactions and are left to wonder about the intent of the exchange. For example, in some cases people may struggle to determine if what they just experienced was actually racist or discriminatory, or if the event was important or severe enough to warrant confrontation. In other instances, microaggressive exchanges trigger emotions from prior experiences. Other recipients may blame themselves or question why they are sensitive to acts that were perhaps unintentional in nature. They may become angry or mistrustful, or may adapt and "get used to it" and learn to expect that such experiences are simply what it means to be a person of color in America. Another response by recipients of microaggressions is to become depressed or to display feelings of helplessness. To confound matters, perpetrators are often unaware or fail to grasp the gravity and consequences of microaggressive exchanges on people of color (Dovidio & Fiske, 2012; Sue, 2010).

Experts note that subtle forms of discrimination are more insidious and harder to interpret, and therefore may cause more harm than blatant forms of discrimination (Dovidio & Gaertner, 2004; Noh, Kaspar, & Wickrama, 2007; Sue, 2010). Investigators have found that racial and ethnic microaggressions are associated with detrimental effects on the psychological and emotional wellbeing of non-White individuals (Brondolo et al., 2008; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Sue, Capodilupo, & Holder, 2008), affect self-esteem (Franklin, Boyd-Franklin, & Kelly, 2006) and contribute to physical health and behavioral problems (Brondolo, Rieppi, Kelly, & Gerin, 2003). Authors have also focused on how educators and clinicians often can perpetrate microaggression that harms students and clients and undermines learning and therapeutic processes (Sue, 2010), as well as creates barriers to non-White people accessing educational, health, and mental health services (Balsam, Molina, Beadnell, Simoni, &

Walters, 2011). Other studies have found that microaggression can lead to unsatisfactory work relationships (Constantine & Sue, 2007) and perceptions of hostility in school (Smith, Yosso, & Solórzano, 2007).

It is important to recognize that experiences of microaggression are also linked to historical patterns of oppression. To illustrate, generations of American Indians and other native populations have experienced several hundred years of discrimination. The historical traumas against American Indians continue to adversely affect current generations of native people. Knowledge about these effects is limited; however, recent scholarship recognizes that the effects are similar to those associated with post-traumatic stress (Evans-Campbell, 2008). Therefore, current derogatory acts toward Native American people are likely to be both reminders and triggers of institutionalized racism and reduced status of native people in America (Evans-Campbell, 2008).

A related consideration in the study of racial and ethnic microaggression is that the specific acts of microaggression experienced by people are based on stereotypes and prejudice unique to each particular racial or ethnic group, pointing to the need to examine the differences in the types of microaggressions and their impacts separately for each group. Unquestionably, there are inherent limitations in categorizing racial and ethnic groups based on socially-constructed phenotypical groupings that actually represent considerable diversity within each group (Smedley & Smedley, 2005). However, members of non-dominant racial and ethnic groups are frequently stereotyped and marginalized based on those socially-constructed groups. Their experiences of how they are oppressed due to what makes them "other" becomes part of their shared identities with people who have similar differences from the majority norms (Young, 2009).

Complex historical and current issues such as these highlight the importance of conducting research aimed at better understanding the experiences of microaggression among members of different racial and ethnic groups. The differences in the experiences of microaggression among non-White people have seldom been studied. Understanding the prevalence and types of microaggression experienced by different racial and ethnic groups is an important next step in

preventing and reducing microaggressive behavior. To this end, we examined differences in microaggression experiences among a sample of Asian, Latino/Hispanic, Black, and White young adults.

Methods

Sample

Participants were 409 undergraduate students ages 18 to 35 enrolled at an urban public college in the western United States. The college roster was stratified by the four largest minority racial and ethnic groups represented in the student body (Asian, Latino/Hispanic, Black, and White) and an oversampling probability procedure was then used to select students who were invited to participate in an online survey. The participants identified themselves in these racial and ethnic categories when they enrolled in the college.

As shown in Table 1, the average age of participants was 24, and 64% of respondents were female. The study sample was diverse; 30% of subjects were White, 25% were Asian, 25% were Latino/Hispanic, and 20% were Black. In addition, 8% of the participants identified themselves as being GLBTQ (gay, lesbian, bisexual, transgendered, or queer). The average year in college for the participants was third year, with approximately 25% indicating they were in their 5th or greater year. More than half (54%) of the participants were in intimate relationships, approximately 46% of the participants were living with one or both of their parents, and approximately 17% of the participants indicated that they were parents themselves. Last, almost 50% of the respondents worked 30 or more hours per week during the past month.

Procedures

All prospective participants received an email invitation with a link to an anonymous survey. Several reminder emails were later sent and all data were collected in a two-month period in the fall of 2011. Participants who completed the survey were given an option to enter their email address in a random drawing for gift cards to Amazon.com. The survey generally took participants between 20 and 40 minutes to complete.

Table 1. Sample Demographics (N = 409)

		N	(%)
Age	18–23	213	(52.1)
	<i>M</i> =24	24–29	168 (33.5)
	<i>SD</i> =4.2	30–35	61 (13.0)
Sex	Male	136	(33.3)
	Female	271	(64.2)
Race/ethnicity	White	123	(30.1)
	Asian	101	(24.7)
	Latino/Hispanic	103	(25.2)
	Black	82	(20.0)
Sexual orientation	Straight	372	(91.0)
	GLBTQ	31	(7.6)
Born in the U.S.?	Student	338	(82.6)
	Mother	251	(61.4)
	Father	250	(61.1)
Year in college	1–2	147	(35.9)
	3–4	165	(76.3)
	5–6	79	(19.3)
	7 or more	18	(4.4)
In an intimate relationship?		219	(53.5)
Who do you live with?	Partner	126	(30.8)
	Mother	169	(41.3)
	Father	127	(31.1)
Number of children	0	341	(83.4)
	1	33	(8.1)
	2	21	(5.1)
	3	10	(2.4)
	4+	4	(1.0)
Hours of work per week in the past month	0	116	(28.5)
	1–29	94	(22.9)
	30–40	76	(18.6)
	> 40	123	(30.1)

Measures

The *Racial and Ethnic Microaggressions Scale* [REMS] (Nadal, 2011) was used to measure respondents’ experiences of racial and ethnic microaggression. The instrument contains 45 items,

consisting of six subscales. The subscale items were not grouped together on the survey. The instructions read, "Think about your experiences with race. Please read each item and think of how many times this event has happened to you in the past six months." Item response choices were on a scale from 1-6: (1) *I did not experience this event*; (2) *I experienced this event 1 time in the past six months*; (3) *I experienced this event 2 times in the past six months*; (4) *I experienced this event 3 times in the past six months*; (5) *I experienced this event 4 times in the past six months*; and (6) *I experienced this event 5 or more times*. The scale and subscale scores are calculated as item means.

The items in the subscale *Assumptions of Inferiority* included eight statements in which someone made assumptions, such as low intelligence and social status, because of their race. For example, "Someone assumed that I would not be educated because of my race."

The subscale *Second-Class Citizen and Assumptions of Criminality* includes seven statements about experiences in which someone acted in ways that demonstrated fear or avoidance because of their race. One item, for example, reads, "Someone avoided walking near me because of my race."

The *Microinvalidations* nine subscale items have to do with experiences in which race and racial difference is minimized or invalidated. For example, "Someone told me that people should not think about race anymore," is one of the items in the subscale.

Exoticization and Assumptions of Similarity includes nine statements that involve experiences in which participation in certain aspects of culture were expected based on the assumption that all people of that race would be the same. For example, one item reads, "Someone asked me to teach them things in my 'native language.'" Other items in this subscale are more about experiences of objectification because of race. An example of this is an item that states, "Someone wanted to date me only because of my race."

The subscale *Environmental Microaggressions* included 7 reverse-scored items about observations of people "of my race" being presented positively in the media or in highly influential social contexts or government positions. For example, "I observed people of my race portrayed positively in movies," and "I observed that someone of my race is a governmental

official on my state." Unlike other REMS subscales that asked respondents to report the number of microaggressive incidents they experienced, *Environmental Microaggressions* is an assessment of young adults' observations of microaggression in their broader environment.

The last subscale, *Workplace and School Microaggressions*, consists of five items that describe experiences occurring in the context of school or work in which there were negative expectations or treatment due to race. One item, for example, reads, "An employer or co-worker was unfriendly or unwelcoming toward me because of my race."

Moderate to strong internal consistency for the total REMS and for individual scales was demonstrated in prior research in which the instrument was administered to 2 different samples of young adults (Nadal, 2011). With the current sample, internal consistency for the total REMs score yielded a Cronbach's alpha of .88. Alpha coefficients were $\geq .75$ for all six subscales of the REMS.

Analytic Strategy

One-way analyses of variance (ANOVA) tests were conducted for the total REMS score and each of the subscales in order to examine differences among the 4 racial and ethnic groups (Asian, Latino/Hispanic, Black, and White) in the study. Tests for normality indicated the data were not statistically normal. Additionally, Levene's tests for homogeneity of variance were significant. Therefore, the Brown-Forsythe test was used to conduct adjusted F-tests due to unequal variances and to provide robustness with the non-normally distributed data. Subsequent pairwise post-hoc comparisons were run with the Games-Howell, a recommended test when there are heterogeneous variances and sample sizes differ between groups (Howell, 2007). Mean scores were compared among the racial and ethnic groups for the microaggression scale and again for each type of microaggression measured by each subscale of the REMS. No adjustments were made to the alphas for the post-hoc comparisons, since Type II error was more of a concern than Type I due to the exploratory nature of this analysis. However, the specific p values are reported, and interpretations are made cautiously with acknowledgement of the potential for Type I error.

Results

Microaggression Experiences among Racial and Ethnic Groups

Mean scores for the total and subscales of the REMS are shown for each of the four racial and ethnic groups in Table 2. Sum scores on the total REMS ranged from 45 to 223 ($M = 95.3$; $SD = 32$) across groups. The average item score for the whole scale was 2.1 ($SD = 0.7$). Participants experienced forms of microaggression in the *Exoticization and Assumptions of Similarity* subscale at the highest rate on average ($M = 2.1$, $SD = 1.1$). Eight out of 10 of the highest scoring items on the REMS were in this subscale. The highest scoring single item in this subscale was "Someone assumed I spoke a language other than English" ($M = 2.7$, $SD = 2.1$). Examples of *Workplace and School Microaggressions* were experienced least frequently by participants ($M = 1.5$, $SD = 0.9$). Item score means on the *Assumptions of Inferiority*, *Second-Class Citizen* and *Assumptions of Criminality*, and *Microinvalidations* ranged from 1.5 to 1.7 for the total sample.

As noted above, scores on the *Environmental Microaggression* subscale reflect participants' perceptions of how people of different racial and ethnic groups are depicted in social media. This scale is reverse-coded so that higher response choices corresponded with more positive experiences with regard to microaggression, and then the items were reversed to calculate the scores. Participants averaged 4.3 ($SD = 1.5$) on this subscale.

Table 2 also reveals that there are important differences in the types of microaggression commonly experienced by racial and ethnic groups. For example, while Latino/Hispanic and Asian participants scored highest on the *Exoticization and Assumptions of Similarity* subscale, Blacks scored highest on the *Assumptions of Inferiority* subscale. Comparisons among different racial and ethnic groups on the total REMS and each of the subscales are reported below.

Differences in Microaggression Experiences among Racial and Ethnic Groups

The overall F-test for the REMS scale revealed a significant difference in scores by racial and ethnic group membership, $F(3, 280.97) = 41.85$, $p < .001$. Post-hoc comparisons revealed

Table 2. Mean Scores and Standard Deviations for the Racial and Ethnic Microaggression Scale (REMS) by Racial/Ethnic Group

		N	M	SD	SE
Whole REM	Asian	96	2.31	0.63	0.06
	Lat/Hispanic	97	2.34	0.65	0.07
	Black	76	2.43	0.79	0.09
	White	117	1.57	0.42	0.04
	Total	386	2.12	0.71	0.04
Assumptions of Inferiority	Asian	101	1.50	0.87	0.09
	Lat/Hispanic	103	2.03	1.20	0.12
	Black	80	2.30	1.42	0.16
	White	121	1.19	0.32	0.03
	Total	405	1.70	1.08	0.05
Second-Class Citizen and Assumptions of Criminality	Asian	100	1.45	0.77	0.08
	Lat/Hispanic	103	1.51	0.71	0.07
	Black	79	2.22	1.42	0.16
	White	120	1.15	0.48	0.04
	Total	402	1.53	0.94	0.05
Microinvalidations	Asian	100	1.54	0.75	0.08
	Lat/Hispanic	103	1.61	0.74	0.07
	Black	79	1.90	1.05	0.12
	White	120	1.48	0.63	0.06
	Total	402	1.61	0.80	0.04
Exoticization and Assumptions of Similarity	Asian	99	2.75	1.22	0.12
	Lat/Hispanic	102	2.43	1.12	0.11
	Black	79	1.91	0.87	0.10
	White	119	1.47	0.66	0.06
	Total	399	2.12	1.11	0.06
Environmental Microaggressions	Asian	100	5.09	0.96	0.10
	Lat/Hispanic	99	4.91	0.97	0.10
	Black	79	4.53	1.12	0.13
	White	120	2.99	1.73	0.16
	Total	398	4.30	1.54	0.08
Workplace and School Microaggressions	Asian	100	1.56	1.01	0.10
	Lat/Hispanic	102	1.53	0.76	0.08
	Black	80	1.84	1.21	0.14
	White	120	1.15	0.41	0.04
	Total	402	1.49	0.89	0.04

that all non-White groups experienced higher levels of perceived racial and ethnic microaggression than their White counterparts at $p < .001$ for all comparisons (Asian $M = 2.31$, $SD = .63$; Latino/Hispanic $M = 2.34$, $SD = .65$; Black $M = 2.43$, $SD = .79$; and White $M = 1.57$, $SD = .42$). There were no significant differences among Asian, Latino/Hispanic, and Black groups on the overall REMS score. Main effects tests of significance and post-hoc comparisons examining differences in microaggression experiences by group membership are shown in Tables 3 and 4 respectively.

Table 3. Main Effects Results of Brown-Forsythe Robust Tests of Equality of Means

	Statistic ^a	df1	df2	Sig.
Whole REMS	41.85	3	280.97	0.000
Assumptions of Inferiority	22.87	3	233.35	0.000
2nd Class Citizen and Assumptions of Criminality	21.37	3	181.17	0.000
Microinvalidations	4.71	3	281.31	0.003
Exoticization and Assumptions of Similarity	34.99	3	326.03	0.000
Environmental Microaggressions	68.78	3	339.62	0.000
Workplace and School Microaggressions	9.74	3	244.32	0.000

a. Asymptotically F distributed.

Statistically significant effects were found among racial and ethnic groups on the *Assumption of Inferiority* subscale, $F(3, 233.35) = 22.87$, $p < .001$. Non-White groups experienced higher levels of this type of microaggression than their White peers ($M = 1.19$, $SD = .32$); $p < .001$ for Black and Latino/Hispanic comparisons and $p = .006$ for the Asian comparison. In addition, Latino/Hispanic ($M = 2.03$, $SD = 1.20$, $p < .001$) and Black participants ($M = 2.30$, $SD = 1.42$, $p = .002$) reported higher rates of this type of microaggression than Asians ($M = 1.50$, $SD = .87$).

Respondents differed significantly by race and ethnicity on the *Second-Class Citizen and Assumptions of Criminality* subscale $F(3, 181.17) = 22.87$, $p < .001$. Post-hoc comparisons indicated

Table 4. Games-Howell Post-Hoc Comparisons for Racial Group Experiences of Microaggressive Types

Scale or Subscale	Race/ Ethnicity	Mean Difference			
		Asian	Latino/Hispanic	Black	White
Whole REM	Asian	–	-0.03	-0.12	0.75($p < .001$)
	Lat/Hispanic	–	–	-0.09	0.78($p < .001$)
	Black	–	–	–	0.87($p < .001$)
	White	–	–	–	–
Assumptions of Inferiority	Asian	–	-0.54($p = .002$)	-0.80($p < .001$)	0.31($p = .006$)
	Lat/Hispanic	–	–	-0.27	0.84($p < .001$)
	Black	–	–	–	1.11($p < .001$)
	White	–	–	–	–
Second-Class Citizen and Assumptions of Criminality	Asian	–	-0.05	-0.77($p < .001$)	0.30($p = .005$)
	Lat/Hispanic	–	–	-0.71($p < .001$)	0.36($p < .001$)
	Black	–	–	–	1.07($p < .001$)
	White	–	–	–	–
Microinvalidations	Asian	–	-0.07	-0.36($p = .051$)	0.06
	Lat/Hispanic	–	–	-0.30	0.13
	Black	–	–	–	0.43($p = .008$)
	White	–	–	–	–
Exoticization and Assumptions of Similarity	Asian	–	0.32	0.84($p < .001$)	1.29($p < .001$)
	Lat/Hispanic	–	–	0.52($p = .003$)	0.97($p < .001$)
	Black	–	–	–	0.44($p < .001$)
	White	–	–	–	–
Environmental Microaggressions	Asian	–	0.17	-0.55($p = .004$)	2.10($p < .001$)
	Lat/Hispanic	–	–	0.38	1.92($p < .001$)
	Black	–	–	–	1.54($p < .001$)
	White	–	–	–	–
Workplace and School Microaggressions	Asian	–	0.03	-0.28	0.41($p < .001$)
	Lat/Hispanic	–	–	-0.31	0.38($p < .001$)
	Black	–	–	–	0.69($p < .001$)
	White	–	–	–	–

that scores for Black participants ($M = 2.22$, $SD = 1.42$) were significantly higher than all other groups (Asian $M = 1.45$, $SD = .77$; Latino/Hispanic $M = 1.51$, $SD = .71$; White $M = 1.48$, SD

= .63) at $p < .001$. All of the non-White mean scores were also significantly higher than the mean scores reported by White respondents ($p < .001$ for the Latino/Hispanic and Black comparison and .006 for the Asian group).

Respondents also differed by race and ethnicity on indicators of the *Microinvalidations* subscale, $F(3, 281.31) = 4.71$, $p = .003$. Post-hoc comparisons indicated that Black participants reported higher rates of experiences of microinvalidations ($M = 1.90$, $SD = 1.05$) than Asian ($M = 1.54$, $SD = .75$) at $p = .05$, and White ($M = 1.48$, $SD = .63$, $p = .008$) participants. No significant differences were found for Latino/Hispanic participants ($M = 1.61$, $SD = .74$) or between White and Asian groups.

Main effects for the ANOVA across racial groups for the *Exoticization and Assumptions of Similarity* scale also revealed significant differences, $F(3, 326.03) = 35.00$, $p < .001$. Post-hoc comparisons revealed that Asian ($M = 2.75$, $SD = 1.22$) participants experienced this type of microaggression more frequently than White ($M = 1.47$, $SD = .66$, $p < .001$) and Black participants ($M = 1.91$, $SD = .87$, $p < .001$). The multiple comparisons for this subscale found the same pattern for the Latino/Hispanic ($M = 2.43$, $SD = 1.12$) participants; Latino/Hispanic young adults scored significantly higher than the White group ($p < .001$) and the Black group ($p = .003$). In addition, Black participants had significantly higher mean scores on this scale than White participants ($p < .001$).

The main effects for the ANOVA test on the *Environmental* subscale revealed statistically significant differences among racial/ethnic groups, $F(3, 339.62) = 68.78$, $p < .001$. Environmental microaggression was scored lower on average by White participants ($M = 2.99$, $SD = 1.73$) than Black ($M = 4.53$, $SD = 1.12$), Latino/Hispanic ($M = 4.91$, $SD = .97$) and Asian ($M = .96$, $SD = .10$) at $p < .001$. In addition, the mean score for the Black group was significantly greater than the Asian group ($p = .004$).

The final REMS subscale, *Workplace and School Microaggressions*, also revealed significant main effects across the racial and ethnic groups, $F(3, 244.32) = 9.74$, $p < .001$. Latino/Hispanic ($M = 1.53$, $SD = .76$) reported significantly more frequent experiences of workplace and school microaggression than White participants ($M = 1.15$, $SD = .41$) at a p value $< .001$. Black respondents' ($M = 1.84$, $SD = 1.21$) mean

scores were significantly higher than their White peers ($p < .001$), as were Asian ($M = 1.56$, $SD = 1.01$) mean scores at $p = .001$. No statistically significant differences were found among the non-White groups for this subscale.

Discussion

We examined differences in microaggressions experienced by Asian, Latino/Hispanic, Black, and White young adults. As expected, non-White racial and ethnic groups experienced racial and ethnic microaggression significantly more frequently than Whites. This pattern was true for the total scale and all of the subscales except *Microinvalidations*; mean scores for only the Black respondents were significantly higher than Whites on this subscale. At the same time, there were no significant differences among the mean scores for the non-White groups on the total REMS, suggesting that in general, microaggression is experienced at similar rates among the different non-White groups. Post-hoc comparisons, however, revealed a number of significant differences in the experiences of microaggression depending on the type of discrimination in question. Differences among types of microaggressions experienced by non-White racial and ethnic groups are discussed below.

Overall, Black participants experienced more interpersonal microaggressions and were less likely to see positive images of their race in various forms of media than other participants, as measured by the *Environmental Microaggressions* subscale. Particularly noteworthy was the finding that Blacks reported significantly higher mean scores on the *Second-Class Citizen and Assumption of Criminality* subscale than any other group; none of the other non-White groups were statistically different from each other for this scale. Latino/Hispanic participants experienced the next highest rates of microaggressions, and endorsed similar rates to Blacks for *Assumptions of Inferiority*, and *Microinvalidations*. Asian participants reported less frequent experiences than the other 2 non-White groups overall for interpersonal microaggressions and indicated that they more frequently saw people of their race portrayed positively in the environment. Finally, Blacks experienced the lowest rates of *Exoticization and Assumption of Similarity* microaggressions, while the mean scores for Asians and Latinos/Hispanics were

similar on this subscale. There were no statistically significant scores between non-White groups on the *Workplace and School* types of microaggression.

The finding that White participants had significantly lower scores on the total microaggression scale than all non-White groups confirms that perceived discrimination is a significant issue for young adults of color. This finding is consistent with literature suggesting that many young people of color experience discrimination in the form of microaggressions in their daily lives (Brown et al., 2000; Rivera, Forquer, & Rangel, 2010; Sue, 2010). It is interesting to note that there were no significant differences among non-White group mean scores on the total REMS score. This finding may not be surprising since prior studies reveal that while different racial and ethnic groups do experience different types of discrimination (Araújo & Borrell, 2006; Brondolo et al., 2008; Solorzano & Yosso, 2000; Sue, 2010; Szalacha et al., 2003), the evidence does not indicate that particular racial and ethnic groups experience more or less discrimination than one another.

The results of the analyses assessing group differences in types of perceived racial and ethnic discrimination indicate that race and ethnicity has an important effect on the experiences and frequency of different types of racial and ethnic microaggression. These findings confirm the importance of examining differences in microaggressive experiences across racial and ethnic groups. As noted earlier, there was no difference in total REMS scores among the non-White groups. Thus, the significant differences found for different types of microaggression would be obscured if subscales had not been examined separately.

Some provisional interpretations of group differences in microaggression experiences can be made based on study findings. First, the results appear to be fairly consistent with commonly occurring racial and ethnic stereotypes occurring in American society. For example, the finding that Latino/Hispanics and Black groups reported high levels of *Assumptions of Inferiority* microaggressions may be consistent with negative stereotypes of Latino and Black people. Most people are likely familiar with stereotypic images suggesting that Latinos and Blacks experience limited success at school and in the workplace (Guyll, Madon, Prieto, & Scherr, 2010; Taylor, & Walton,

2011). The opposite, however, is true for Asians, who are often characterized stereotypically by the “model minority myth,” which imposes expectations of high achievement and ease in learning and acculturation (Gupta, Szymanski, & Leong, 2011). Study findings evidenced by the low reports of microaggression on the *Assumptions of Inferiority* subscale among Asian participants tend to support this characterization.

Asian and Latino/Hispanic participants endorsed higher rates of experiences of *Exoticization and Assumptions of Similarity* than Blacks. These findings may reflect stereotypes and prejudices that are associated with high numbers of recent immigrants from Latin American and Asian countries whose primary languages may not be English and whose cultural practices are less-Westernized. Asian participants experienced *Microinvalidations* at lower rates than Latinos/Hispanics and Blacks; only Black participants experienced such forms of microaggression at higher rates than Whites. These results may have implications about the way in which people perceive “color.” That is, Whites may perceive life in a way that places less value on color (e.g., color is no big deal!). White participants may also hold beliefs that “not seeing color” is equivalent to not being racist. The meaning behind these perceptions may be quite different for Whites and non-Whites. This leads to an interesting consideration of the intersection of the *intent* versus the actual *impact* of microaggressions. That is, well-intentioned people might believe that we are or should be a “post-racial” society, while others may be offended by such a belief because differences in race and ethnicity shape much of their own identities and lived experiences.

Limitations

Further interpretation of these results is guarded for several reasons. As noted earlier, the possibility of increasing Type I errors is present when multiple comparisons such as these are conducted. In addition, further interpretation of the study’s findings with regard to differences in microaggression awaits research that uses larger samples to assess relationships among variables in the various racial and ethnic groups. Another consideration for future research may be to examine how various forms of microaggression impact social, behavioral, and other outcomes among different racial and ethnic

groups. Longitudinal investigations are also needed to assess changes in the type and nature of microaggression over time, and find ways to account for the cumulative effect of microaggressions over the life course as well as inter-generationally. Future studies of the differences in exposure and frequency of microaggression among groups should also consider diversity within racial and ethnic groups. Finally, the concept of microaggression has been expanded in recent years beyond racial and ethnic minorities as a means of understanding and interpreting marginalization related to factors such as religion, sexual orientation, gender, disabilities, and aging (Sue, 2010). The available research on these types of microaggression is very limited and should be included in future research investigations.

Conclusion

Study results have several important implications for practice and policy. Commonalities in microaggression incidents among groups suggest a need for universal interventions in school, community, and family settings that seek to prevent discrimination among all young people. Prevention programs should include education and interactive curricula that expose students to microaggression examples; recognition and skills training may be effective in this regard.

Important differences in microaggression experiences among racial and ethnic groups found in the current study suggest that interventions need to be adapted to meet the needs of young people from different backgrounds. In this regard, high schools, colleges, and universities may be appropriate venues for educating students about the common and unique forms of microaggression across racial and ethnic groups. In addition, medical and clinical agencies are ideally situated to integrate knowledge about common microaggressions through strategies like cultural competency training. Furthermore, broad-based community and education campaigns that use media strategies to convey messages about the adverse effects of microaggression may be an effective policy-level response.

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Health Status, Medicare Part D Enrollment, and Prescription Drug Use Among Older Adults

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To account for potential selection factors in the observed relationship between Medicare Part D coverage and prescription drug use, this study uses data from the 2010 and 2012 waves of the Health and Retirement Study (HRS) to first examine the determinants of Medicare Part D enrollment, paying particular attention to the role of functional health status on the enrollment decision. Next, the study assesses whether and to what extent Medicare Part D coverage moderates the effect of functional health status on prescription drug use and monthly out-of-pocket spending among older adults. As prior studies indicate, the findings reveal that individuals who take up Medicare Part D have poorer (functional) health relative to nonparticipants, and thus, exhibit greater demand for prescription drugs. Taking functional health status into account, Medicare Part D coverage is significantly associated with greater prescription drug use among those with few health limitations, and is also significantly associated with greater out-of-pocket spending among those with the most health limitations. Thus, while prior studies have compared Medicare eligible- to non-eligible individuals to find that Medicare Part D coverage significantly lowers out-of-pocket costs, and therefore, increases prescription drug use, this study compared Medicare Part D enrollees to eligible non-enrollees to generate findings that imply that the presumed effect of Medicare Part D coverage on prescription drug use may be spurious. In turn, advocacy efforts may be best directed at ensuring that the existing coverage gaps in Medicare Part D are continually addressed.

Key words: health insurance, access to and utilization of services, health care policy

In the current climate of massive health care reform in the U.S., older adults potentially enjoy greater access to both prescription drug insurance and to use of prescription drugs. Before health care reform, however, access to both

prescription drug insurance and medications was not so readily available. Researchers estimate that just prior to implementation of the Medicare prescription drug benefit program (Medicare Part D), approximately one quarter of individuals age 65 and over lacked prescription drug insurance coverage (Levy & Weir, 2009). Meanwhile, prescription drug use among older adults had been steadily increasing even before passage and implementation of the Medicare Part D program. According to estimates released by the Center for Disease Control, the rate of prescription drug use among individuals 65 years and over (i.e., the percent of individuals with at least one prescription drug in the past 30 days) had increased from 73.6% in 1994 to 84.7% by the year 2002 (Center for Disease Control, 2014).

Generally speaking, health service use, including the use of prescription drugs, should increase with greater health insurance coverage (Hurd & McGarry, 1997). So the increase in prescription drug use prior to implementation of Medicare Part D in 2006 may have reflected a combination of greater private insurance coverage, along with other factors such as a sicker older adult population, improvements in medicine, and/or more effective marketing by pharmaceutical companies.

Nevertheless, Congress responded to the lack of prescription drug insurance coverage (along with the increased demand for prescription drugs) among older adults by passing the Medicare Prescription Drug Improvement and Modernization Act, which established and implemented the Medicare Part D program effective January 1, 2006 to increase access to prescription drugs among older adults (House Committee on Ways and Means, 2014). With the new program in place, the vast majority of eligible retirees were now covered under some form of prescription drug insurance plan. Thus, by 2010, 89.7% of all individuals 65 years and over reported using prescription drugs (Center for Disease Control, 2014).

Prior research on the impact of the Medicare prescription drug benefit program on prescription drug use among older adults has found that Medicare Part D initially lowered out-of-pocket costs and therefore increased overall use in the early years of the program (Lichtenberg & Sun, 2007; Yin, Basu, Zhang, Rabbani, Meltzer, & Alexander, 2008). These studies generally rely on quasi-experimental designs to compare

out-of-pocket costs and rates of use between Medicare Part D eligible- and non-eligible individuals to show that there was indeed a program effect.

What is not entirely clear from the favorable findings generated by these studies, however, is whether the observed relationship between Medicare Part D coverage and prescription drug use and costs is attributable to potential selection factors that may be confounded for a program effect. To wit, studies examining the factors associated with the initial decision to enroll in Medicare Part D find that Part D enrollees are sicker, are more likely to use prescription drugs, and have higher out-of-pocket spending than those who remain without any prescription drug insurance coverage (Levy & Weir, 2010). Stated differently, the findings suggest selection into Part D that is based almost entirely on health status and use of prescription drugs (Levy & Weir, 2010).

To account for these potential selection factors in the observed relationship between Medicare Part D coverage and prescription drug use, this study uses data from the 2010 and 2012 waves of the Health and Retirement Study (HRS) to first examine the determinants of Medicare Part D enrollment, paying particular attention to the role of functional health status on the enrollment decision. Next, the study assesses whether and to what extent Medicare Part D coverage moderates the effect of health status on prescription drug use and monthly out-of-pocket spending among older adults.

Studies assessing the impact of public programs on health service use are especially important in the current climate of U.S. health care reform, as they provide evidence (or lack thereof) of the extent to which our public policies are effectuating the legislative goals of our new public health care system. With this in mind, the current research extends prior work on the topic by explicitly taking into account possible selection factors that may be interacting with program effects. Moreover, the research uses the most recently available data from a nationally representative sample of older adults, and thus updates prior work that had relied on regional pharmacy chain data. And in lieu of a quasi-experimental design, this research uses multivariate analyses to first identify the ways in which Medicare Part D enrollees are systematically different,

if at all, from non-enrollees, and second, to assess the extent to which the presumed effect of Medicare Part D differs across varying levels of functional health.

The Literature and Conceptual Framework

Most studies that examine the determinants of health service use among older adults are framed around the Andersen Model (1968) which originally describes three sets of factors that predict health service use: predisposing characteristics, enabling resources, and need. Predisposing factors include basic socio-demographic characteristics such as age, gender, race/ethnicity, and marital status. Enabling factors include both personal and community-level resources such as income, health insurance, and the availability of health personnel and facilities. Need refers to both perceived and evaluated need, that is, the individual's perception of care requirements and professional judgment about the individual's health status and his or her need for medical care (Andersen, 1995). In short, the model suggests that people's use of health services is a function of their predisposition to use services, factors which enable or impede use, and their need for care (Andersen, 1995).

A major goal of the Andersen Model, as originally conceived, was to provide measures of access to medical care (Andersen, 1995). Equitable access then, according to Andersen, occurs when demographic and need variables account for most of the variance in utilization (1995). As such, the Andersen Model is a useful framework not only to organize potential explanations for prescription drug use but also to gauge potential inadequacies and inequities in access to prescription drug use.

Of particular interest in this research are factors related to need and enabling resources, and more specifically, functional limitations and Medicare prescription drug insurance coverage. Need is a dimension that has arguably been overlooked in prior research on prescription drug use among older adults, primarily due to the use of quasi-experimental designs that focus specifically on the enabling dimension, i.e., the treatment effects of Medicare prescription drug insurance coverage (Lichtenberg & Sun, 2007; Yin et al., 2008). In the broader context of health service use, however, need, i.e., perceived, diagnosed, and functional health status, represents a

potentially powerful selection factor that may be relevant in the use of health services, including prescription drugs (Hurd & McGarry, 1997). Need is also important to consider since it implicates the issue of equity in access to health services and prescription drugs (Anderson, 1995).

While the dimension of need may have previously taken on a secondary focus to the effect of enabling resources, i.e., prescription drug insurance coverage, in the context of policy studies on prescription drug use, it has nevertheless been recognized as a significant, contributing factor in other relevant contexts (Levy & Weir, 2010). In Levy and Weir (2010), the researchers used data from the 2002 through the 2006 waves of the Health and Retirement Study to estimate a model of Medicare Part D enrollment among those with no prior drug coverage and found that demand for prescription drugs, as measured by the number of diagnosed health conditions, was the most important determinant of the decision to enroll in the program. Stated differently, what this study showed was that Medicare Part D enrollees are sicker than those who do not enroll, thus suggesting that in the realm of access to health insurance, those who may need prescription drugs the most do appear to have access to Medicare prescription drug insurance coverage.

Meanwhile, studies examining the association between enabling resources and the use of prescription drugs have made a strong case for the favorable impact of prescription drug insurance coverage on prescription drug use (Lichtenberg & Sun, 2007; Yin et al., 2008). In one study investigating the effect of the Medicare Part D prescription drug benefit on drug utilization and expenditures (Yin et al., 2008), the researchers estimated prescription utilization and out-of-pocket expenditures attributable to Part D among a sample of persons eligible for the benefit, and found that average monthly drug utilization increased 5.9 percent and out-of-pocket expenditures decreased by 13.1 percent. In another recent study examining the impact of Medicare Part D coverage on prescription drug use by older adults (Lichtenberg & Sun, 2007), the researchers used a difference-in-differences research design and estimated that Medicare Part D reduced user cost among older adults by 18.4 percent and increased prescription drug use by 12.8 percent.

In using quasi-experimental designs, these two studies

follow in the tradition of the RAND Health Insurance Experiment which randomly assigned individuals to health insurance plans that varied in deductibles and co-payments and found that those with the largest cost-sharing had significantly lower health expenditures relative to those with no cost-sharing (Newhouse, 1993). The main difference, however, between the Rand experiment and more recent studies examining the impact of Medicare prescription drug insurance coverage is that the latter studies did not randomly assign sample members into treatment and control conditions, but rather compared elderly to non-elderly (i.e., Part D eligible to non-eligible) individuals.

While comparing eligible to non-eligible persons may be a conventional method of assessing the impact of public programs on health service use (see Cutler & Gruber, 1996; Card & Shore-Sheppard, 2004), in the absence of random assignment, such a comparison may be vulnerable to confounding factors, most notably in the form of selection effects or systematic differences between treatment and comparison groups that may be mistaken for a program effect.

Thus, to account for the possibility that the established relationship between Medicare Part D coverage and prescription drug use among older adults may be due to selection factors, this study first examines the determinants of Medicare Part D enrollment with an eye towards identifying systematic differences between Medicare Part D participants and non-participants. Under the expectation that Medicare Part D participants are indeed sicker than non-participants, the study then assesses whether and to what extent Medicare Part D coverage moderates the effect of health status on prescription drug use and costs. More specifically, the study uses the well-established Katz index of Activities of Daily Living (ADL) to create three separate categories of functional health status to determine whether the effect of Medicare Part coverage differs across these three varying levels of functional health (Katz, Ford, Moskowitz, Jackson, & Jaffe, 1963; Katz, Downs, Cash, & Grotz, 1970).

Data and Methods

Data come from the Health and Retirement Study (HRS),

a nationally representative panel study of persons age 50 and over and their spouses. Section N of the HRS survey, in particular, elicits detailed information about respondents' prescription drug insurance coverage, prescription drug use, out-of-pocket expenses, and health conditions requiring the use of prescription drugs, and is thus well-suited for a study estimating the effects of health status and prescription drug insurance coverage on prescription drug use. The full HRS consists of six cohorts representing persons born before 1960 in the U.S., including those born between 1942 and 1947, i.e., the War Baby (WB) cohort.

The sample is drawn from the 2010 and 2012 waves of the HRS to make use of the most recently available data on Medicare Part D coverage. To ensure that all sample members are eligible for enrollment and use of Medicare Part D, the study draws individuals 65 years and over from the 2010 wave who report Medicare coverage in both 2010 and 2012. The HRS includes 8,985 individuals who satisfy these criteria. Baseline data on sample members are collected for 2010, while outcome data (i.e., Part D enrollment, and prescription drug use and out-of-pocket expenses) are collected for 2012. Any sample member with missing baseline or outcome data is dropped from the analysis. Thus, the final sample to be used for the analysis of Part D enrollment includes 8,456 individuals who are eligible to enroll in Medicare Part D, while the sample to be used for the analysis of prescription drug costs includes a subset of 6,316 individuals who report non-zero out-of-pocket spending on prescription drugs.

Key Measures

This research focuses on three main outcomes: Medicare Part D enrollment, prescription drug use, and monthly out-of-pocket expenses incurred in purchasing prescription drugs. Constructing an appropriate measure of Medicare Part D enrollment or coverage can be complicated, because individuals covered under Medicare Advantage may report coverage under Part D as well. With this in mind, there are at least seven different types of prescription drug insurance options that may be examined: Medicare Part D, Medicaid, Medicare Advantage, Medigap, employer coverage, other drug coverage, and no coverage. Medicare Advantage, Medigap, and

other drug coverage are collapsed into one insurance category for analysis.

The key outcome data for this study come from Section N of the 2012 HRS, which contains detailed questions on both public and private health insurance coverage that can be used to construct the prescription drug insurance options outlined above. In the beginning of this section, the HRS asks respondents a series of straightforward questions regarding public health insurance coverage. Individuals are asked whether they signed up for Medicare prescription drug coverage, whether they are currently covered under Medicaid, whether they receive their Medicare benefits through a Health Maintenance Organization (HMO), and whether the HMO covers or provides help with paying for prescription drugs. While the coding for the first two questions would seem straightforward, if a sample member reports that they receive their Medicare benefits through an HMO and that the HMO covers prescription drugs, then the individual is coded as being covered under a Medicare Advantage plan.

With respect to private prescription drug insurance coverage, this later section of the survey asks respondents to identify up to three private insurance plans that provide health insurance coverage, whether the private plan in question helps pay for prescription drugs, and where the respondent purchased the private plan. If a sample member reports that an identified private plan helps pay for prescription drugs and that the individual did not purchase the private plan directly from an insurance company, then the individual is coded as having employer coverage. If the respondent reports that an identified private plan helps pay for prescription drugs and that the individual purchased the private plan directly from an insurance company, then the individual is coded as having Medigap coverage.

Towards the end of Section N, respondents who report taking prescription medications regularly are asked whether the costs of their prescription medications have been completely covered, mostly covered, only partially covered, or not covered at all by insurance. Sample members who are not covered under any of the aforementioned types of prescription drug insurance, but who report that their prescription drugs are at least partially covered are coded as having other drug

coverage. And finally, those individuals not reporting any of the aforementioned types of coverage are coded as having no coverage.

In the second part of the analysis, the two main outcome variables capture whether or not an individual regularly uses prescription drugs and the logarithm of monthly out-of-pocket expenses incurred in purchasing prescription drugs. This focus on utilization and (log) expenses, respectively, is consistent with prior studies on health service utilization that often employ a two-part model—one model to predict the probability or likelihood of any use, and a second model to predict the level of use (Diehr, 1999; also see Hurd & McGarry, 1997). In the sample, 90.9% report that they take prescription drugs regularly and 75.3% report that they incurred monthly out-of-pocket expenses for prescription drugs. Only those reporting out-of-pocket expenses (i.e., the 75.3%) are included in the final analysis of monthly out-of-pocket costs.

Another critical piece of the final analytical model is the measure of functional health status, i.e., the Katz ADL index, which reports the number of difficulties with six activities of daily living (e.g., bathing, eating, dressing, grooming, getting in and out of bed, and using the toilet). Based on this index, this research classifies sample members into three mutually exclusive and exhaustive groups: those with 0 ADL difficulties, those with 1 or 2 ADL difficulties, and those with 3 or more ADL difficulties. The use of the Katz index as a measure of health status is justified in the health and disability policy literature as being less susceptible to measurement and endogeneity problems (see Bound, Schoenbaum, Stinebrickner, & Waidmann, 1999) as well as for its clinical usefulness (see Katz et al., 1970).

This study also incorporates additional relevant factors regarding health needs, economic access, and predisposing characteristics that are aligned with Andersen's conceptual framework outlined above. Also subsumed under the category of health needs are a series of dummy variables indicating whether a doctor diagnosed the respondent as having a particular condition in the 2010 Wave. The eight included conditions are high blood pressure, diabetes, cancer, lung disease, heart disease, stroke, psychiatric issues, or arthritis in the current

wave. The economic access category includes information on family income (i.e., income less than or equal to 100% of the federal poverty line (FPL); income 101% to 200% of the FPL; and income greater than 200% of the FPL) and education (high school education or GED versus no high school education or GED). Finally, predisposing factors include dummy variables on gender (female versus not female), ethnicity (Hispanic versus not Hispanic), race (Black versus not Black), marital status (married or partnered versus not married or partnered), and a categorical age variable (65 to 74; 75 to 84; and 85 and older).

Using the key variables constructed and prepared for analysis along with the aforementioned health, economic access, and predisposing variables, the analysis begins with a logistic regression model of Medicare Part D enrollment, paying particular attention to the role of health needs. This first model only includes individuals who report no health insurance coverage in 2010, and is used to account for potential selection factors in the previously observed relationship between Medicare Part D coverage and prescription drug use. In the second part of the analysis, a logistic regression model is used to assess the determinants of prescription drug use while an ordinary least squares (OLS) regression is used to assess the determinants of monthly prescription drug expenses. In both the analysis of Medicare Part D enrollment and the analysis of prescription drug use and costs, the sample weights that are provided in the HRS tracker file are used to control for possible design effects.

While the research is fairly well established in asserting that Medicare Part D lowered out-of-pocket expenses and increased prescription drug use at least in the fledgling years of the program, what is less clear is whether the favorable effect of Medicare Part D coverage holds regardless of an individual's health status. Thus, this study uses interaction terms to investigate the possibility that the effect of Medicare prescription drug insurance may not be the same across different levels of functional health.

As such, the expectation is that Medicare Part D coverage should lower monthly out-of-pocket spending on prescription drugs and therefore increase prescription drug use, particularly among older adults with the poorest functional health.

Table 1. Logistic regression coefficients, standard errors, and exp(B) for Medicare Part D enrollment

	Medicare Part D Enrollment	
	B(SE)	Exp(B)
Health Needs		
Functional Limitations		
0 ADLs [Reference]	-	-
1 to 2 ADLs	1.228(.453)***	3.416
3 or more ADLs	-0.134(.891)	0.875
Diagnosed Conditions		
High blood pressure	0.192(.222)	1.211
Diabetes	-0.169(.435)	0.844
Cancer	-0.725(.575)	0.484
Lung disease	-0.080(.416)	0.923
Heart disease	0.647(.279)**	1.910
Stroke	0.117(.416)	1.124
Psychiatric	0.112(.348)	1.118
Arthritis	-0.501(.323)	0.606
Economic Access		
0% to 100% of FPL	0.956(.522)*	2.601
101% to 200% of FPL	-0.385(.452)	0.681
>200% of FPL [Reference]	-	-
High school education or GED	-0.569(.402)	0.566
Predisposing		
Female	0.209(.382)	1.232
Hispanic	0.055(.691)	1.056
Black	0.375(.499)	1.454
Married or partnered	0.307(.409)	1.359
Age		
65 to 74 years [Reference]	-	-
75 to 84 years	-0.049(.409)	0.953
85 years and over	-0.127(.560)	0.881
Constant	-2.131(.622)	0.119
Log Likelihood	-115.966	
Number of observations	367	

Notes: ***Significant at the .01 level; **Significant at the .05 level; *Significant at the .10 level

Conversely, older adults reporting no functional difficulties should have little need for prescription drugs, rendering the impact of Medicare Part D coverage minimal at best.

Results

Table 1 presents logit coefficients, standard errors, and the odds ($\exp(B)$) of Medicare Part D enrollment from a logistic regression model examining the determinants of the enrollment decision. Among the two sets of health-related measures, the model reveals that functional limitations and heart disease are significantly associated with the enrollment decision. More specifically, individuals with 1 to 2 ADL difficulties are more than three times as likely as those with 0 ADL difficulties to enroll in Medicare Part-D, while those with heart disease are nearly twice as likely to enroll in the program relative to those without heart disease, thus lending some credence to the notion that Medicare Part D enrollees may indeed be sicker than non-enrollees.

With respect to the economic access variables, the model reveals that family income as measured by an income-to-poverty ratio is significantly associated with Medicare Part D enrollment. Individuals with family income less than or equal to 100% of federal poverty are more than two and one-half times as likely to enroll in Part D relative to those with family income greater than 200% of poverty. Stated differently, it appears that Medicare Part D enrollees may not only be sicker but also poorer relative to non-enrollees. Meanwhile, none of the predisposing characteristics were found to be significantly associated with Medicare Part D enrollment.

Table 2 presents logit coefficients, standard errors, and the odds of prescription drug use, as well as ordinary least squares (OLS) estimates and standard errors of the logarithm of monthly out-of-pocket drug expenses. The models examine the extent to which the effect of Medicare prescription drug insurance coverage on prescription drug use and costs differs across functional health status, and finds that among individuals with 0 ADL difficulties, stand-alone Part D coverage is significantly associated with 4.29 times greater odds of prescription drug use. Among those with 1 to 2 ADL difficulties, stand-alone Part D coverage is significantly

associated with nearly 6 times greater odds of prescription drug use. Interestingly, stand-alone Part D coverage is not significantly associated with prescription drug use among those with 3 or more ADL difficulties. This may be due to the financing structure built into the Part D program, that is, the co-insurance payments and coverage gaps (i.e., the donut hole) that incentivize enrollees to either minimize annual drug costs or claim catastrophic needs.

Table 2a. Logistic and OLS Regression Coefficients and Standard Errors for Rx Drug Use and (log) Out-of-pocket Expenses

	Logistic Regression of Rx Drug Use		OLS Regression of (Log) Out-of-Pocket Expenses
	B(SE)	Exp(B)	B(SE)
<i>Health Needs</i>			
Functional Limitations and Prescription Drug Insurance			
0 ADLs Employer	1.289(.252)***	3.627	-0.015(.130)
0 ADLs Medicaid	1.098(.443)**	2.997	-0.674(.188)***
0 ADLs Stand-Alone Part D	1.456(.265)***	4.290	0.167(.132)
0 ADLs Medicare Adv/Medigap/Other	1.234(.247)***	3.437	-0.089(.130)
1 – 2 ADLs Employer	1.427(.518)***	4.166	0.139(.170)
1 – 2 ADLs Medicaid	1.437(.825)*	4.208	-0.479(.262)*
1 – 2 ADLs Stand-Alone Part D	1.779(.667)***	5.923	0.276(.176)
1 – 2 ADLs Medicare Adv/Medigap/Other	1.531(.460)***	4.621	0.202(.165)
≥ 3 ADLs Employer	1.585(1.015)	4.878	0.210(.251)
≥ 3 ADLs Medicaid	2.805(1.540)*	16.529	-0.387(.294)
≥ 3 ADLs Stand-Alone Part D	1.367(.998)	3.924	0.513(.267)*
≥ 3 ADLs Medicare Adv/Medigap/Other	2.808(1.179)**	16.576	0.456(.220)**
Diagnosed Conditions			
High blood pressure	1.831(.154)**	6.243	0.114(.040)***
Diabetes	1.418(.285)**	4.129	0.199(.042)***
Cancer	0.268(.168)	1.308	-0.043(.052)
Lung disease	0.391(.227)*	1.478	0.158(.053)***
Heart disease	1.385(.231)***	3.994	0.198(.039)***
Stroke	0.844(.429)**	2.325	0.167(.066)**
Psychiatric	0.479(.190)**	1.614	0.104(.041)**
Arthritis	0.060(.114)	1.062	0.060(.039)

Notes: ***Significant at the .01 level; **Significant at the .05 level; *Significant at the .10 level

Moreover, individuals diagnosed with high blood pressure, diabetes, heart disease, and stroke are more than twice as likely to use prescription drugs relative to those without these conditions. With respect to predisposing factors, females and married or partnered individuals are significantly more likely to use prescription drugs. Surprisingly, none of the economic access factors were found to be significantly associated with prescription drug use.

Table 2b. Logistic and OLS Regression Coefficients and Standard Errors for Rx Drug Use and (log) Out-of-pocket Expenses

	Logistic Regression of Rx Drug Use		OLS Regression of (Log) Out-of-Pocket Expenses
	B(SE)	Exp(B)	B(SE)
<i>Economic Access</i>			
Family Income			
0% to 100% of FPL	-0.166(.302)	.847	-0.167(.108)
101% to 200% of FPL	-0.006(.187)	.994	-0.044(.061)
>200% of FPL [Reference]	-	-	
High school education or GED	0.262(.198)	1.299	-0.009(.068)
<i>Predisposing</i>			
Female	0.375(.145)***	1.454	0.021(.050)
Hispanic	-0.086(.329)	.918	0.028(.116)
Black	-0.322(.284)	.725	0.101(.097)
Married or partnered	0.262(.154)*	1.300	0.133(.053)**
Age			
65 to 74 years [Reference]	-	-	
75 to 84 years	0.144(.158)	1.155	0.061(.052)
85 years and over	0.396(.272)	1.485	-0.038(.081)
Constant	-1.125(.329)	.325	3.247(.154)
Log Likelihood	-732.069		-
R Square	-		0.076
Number of observations	8456		6316

Notes: ***Significant at the .01 level; **Significant at the .05 level; *Significant at the .10 level

In the final OLS regression, the findings reveal that, surprisingly, Medicare prescription drug insurance coverage bears little relation to out-of-pocket spending on prescription drugs. While Medicaid coverage appears to be significantly associated with lower out-of-pocket spending for

individuals with either 0 or 1 to 2 ADL difficulties, stand-alone Part D coverage is found to be significantly associated with greater out-of-pocket spending on prescription drugs among individuals with 3 or more ADL difficulties. Thus, while prior studies have linked Medicare Part D coverage to lower prescription drug costs, and therefore, to increases in prescription drug use, these findings suggest a rather glaring disconnect in the effect of Medicare Part D coverage on prescription drug use and costs.

Moreover and as one might expect, individuals diagnosed with high blood pressure, diabetes, lung disease, heart disease, stroke, and psychiatric conditions incur greater monthly out-of-pocket expenses for prescription drugs relative to those without such conditions. More specifically, monthly out-of-pocket expenses are in the range of 10.4% to 19.9% greater for those with the aforementioned diagnosed conditions.

With respect to predisposing factors, out-of-pocket expenses are 13.3% higher for individuals who are married or partnered. And, as was the case for prescription drug use, none of the economic access factors were found to be significantly associated with the level of out-of-pocket spending.

Discussion

This research first examined the determinants of Medicare Part D enrollment with the expectation that Medicare Part D participants have poorer functional health relative to nonparticipants. The research then assessed whether and to what extent Medicare Part D coverage moderates the impact of functional health status on prescription drug use and costs. While prior studies have used quasi-experimental designs comparing Medicare eligible- to non-eligible (i.e., younger than age 65) individuals to assess the impact of Medicare Part D coverage on prescription drug use and costs, this research relied on multivariate regression analyses to assess the impact of Medicare Part D coverage within a sample of Part D eligible older adults and across varying levels of functional health.

As such, logistic regression analyses first revealed that Medicare Part D participants are systematically different from nonparticipants in a number of important ways. As prior studies have shown (Levy & Weir, 2010), individuals who enroll

in Medicare Part D indeed have poorer (functional) health relative to nonparticipants, and thus, have greater demand for prescription drugs. The analyses also revealed that Medicare Part D participants tend to have the lowest income levels according to federal poverty standards. That is, Medicare Part D participants likely use their Medicaid prescription drug insurance coverage to help pay for their Part D program benefits. In short, Medicare Part D participants are sicker and poorer relative to nonparticipants. Stated differently, health and income represent potentially powerful selection factors in any observed relationship between Medicare Part D coverage and prescription drug use which may remain unaccounted for in research designs that do not allow for random assignment into treatment and control conditions for practical or ethical reasons.

Taking into consideration these prominent selection factors and functional health status in particular, logistic and OLS regressions revealed that the effect of Medicare Part D coverage on prescription drug use and costs is not as unambiguous as previously believed. Clearly, Medicare Part D coverage is significantly associated with prescription drug use and costs, but in a manner that likely reflects the financing structure of the Medicare Part D program. For those with few health limitations, Medicare Part D coverage appears to have a negligible impact in lowering costs, and yet, enrollees are still more likely to use prescription drugs. For those with the most health limitations, Medicare Part D coverage is significantly associated with greater out-of-pocket spending on prescription drugs, and hence, such enrollees are not significantly more likely to use prescription drugs. Stated differently, while prior studies have compared Medicare eligible- to non-eligible individuals to find that Medicare Part D coverage significantly lowers out-of-pocket costs, and therefore, increases prescription drug use, this study compared Medicare Part D enrollees to age-eligible non-enrollees to generate findings that imply that the presumed effect of Medicare Part D coverage on prescription drug use may be spurious.

While the findings may seem somewhat counterintuitive, they are arguably consistent with the Medicare Part D financing structure and the coverage gaps that are inherent in the program. That is, individuals with the fewest health needs

may be incentivized to minimize their prescription drug use due to the deductibles and a significant coverage gap for annual prescription drug costs that reach moderate levels (i.e., the “doughnut hole”), while individuals with the most health needs may be incentivized to claim catastrophic benefits, particularly if their annual prescription drug costs fall within the doughnut hole.

Future research on prescription drug use among older adults might consider examining the impact of Medicare Part D coverage not only across varying levels of functional health but across varying levels of income. As shown above, Medicare Part D participants are not only sicker than nonparticipants but they also exhibit lower levels of income. Hence, it would be interesting to consider how selection factors other than health impact the use of prescription drugs and associated costs. Future research could also entertain the possibility of incorporating policy-relevant cutoffs in terms of annual (total) prescription drug costs if such data becomes available. This would be with an eye towards improving upon previously developed measures of the demand for prescription drugs (see Levy & Weir, 2009). In addition, with the implementation of the Affordable Care Act (ACA) provisions that gradually close the existing coverage gaps in prescription drug use and spending, it becomes almost imperative that this study is revisited after full implementation of ACA to see whether the differential impacts of Medicare Part D coverage across varying levels of functional health still hold.

While increasing access to prescription drug insurance coverage was not necessarily one of the prominent goals of the recent health care reform, implicit in the goal of expanding access to health insurance coverage more broadly among previously uninsured individuals is that this greater access to health insurance will necessarily lead to greater access to health service use in its various forms. Thus, the findings generated by this research provide evidence that while older adults across the health spectrum seem to be benefiting from greater access to prescription drugs, this greater access is probably not attributable to the lowering of prescription drug costs vis-à-vis the Medicare prescription drug benefit program, as prior research on prescription drug use has assumed to be the case. Hence, policy advocates who champion greater access to

health insurance and care should note that current advocacy efforts in this realm may be best directed at ensuring that the existing coverage gaps in government-sponsored prescription drug plans are indeed continually addressed.

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Appendix: Baseline Characteristics of Sample Members by Prescription Drug Insurance Coverage and Prescription Drug Use

Table A1 below describes the baseline characteristics of sample members by type of prescription drug insurance coverage in 2010. The columns represent five different prescription drug insurance options reported in the study. With respect to the number of functional limitations, sample members who report Stand-Alone Part D coverage are not different from those without prescription drug insurance coverage. While they appear to be no different in terms of their functional health, they are more likely to be diagnosed with high blood pressure (76% v. 60%), diabetes (28% v. 17%), cancer (21% v. 17%), lung disease (15% v. 10%), heart disease (36% v. 29%), psychiatric conditions (19% v. 15%), and arthritis (79% v. 65%) relative to those without coverage.

With respect to the economic access variables, sample members with Part D coverage are different from those without prescription drug insurance coverage both in terms of family income and educational attainment. They are less likely to be poor (7% vs. 10%) and more likely to have a high school education or GED (81% vs. 77%) relative to those without coverage.

As for predisposing characteristics, sample members with Part D coverage are less likely to be Hispanic and Black, and more likely to be female and married or partnered as compared to those without coverage. They are also generally younger relative to those without coverage.

Table A2 below describes the baseline characteristics of sample members by prescription drug use in 2012. Sample members who report regularly using prescription drugs are reported under one column, while those who report not using prescription drugs regularly are reported under a separate column. Among

sample members with 0 ADL difficulties, those who regularly use prescription drugs are more likely to be covered under stand-alone Part D relative to those who do not use prescription drugs (21% v. 18%). Among sample members with 1 to 2 ADL difficulties, only 3% of those who regularly use prescription drugs have stand-alone Part D coverage as compared to 1% for those who do not use prescription drugs. Among sample members with 3 or more ADL difficulties, there is no apparent difference in stand-alone Part D coverage between those who regularly use prescription drugs relative to those who do not use prescription drugs.

Moreover, sample members who regularly use prescription drugs are more likely to be diagnosed with high blood pressure (79% v. 25%), diabetes (31% v. 6%), cancer (21% v. 17%), lung disease (15% v. 7%), heart disease (38% v. 9%), stroke (11% v. 2%), psychiatric conditions (21% v. 8%), and arthritis (79% v. 64%) relative to those who do not use prescription drugs. They are also somewhat more likely to be female, Black, and married or partnered as compared to those who do not use prescription drugs.

Table A1. Sample Characteristics by Prescription Drug Insurance Coverage in 2010

	Prescription Drug Insurance Coverage					
	Employer	Medicaid	Stand-Alone Part D	Medicare Advantage/ Medigap/ Other	None	Total
<i>Health Needs</i>						
Functional Limitations						
0 ADLs	0.84	0.60	0.83	0.81	0.83	0.81
1 to 2 ADLs	0.12	0.23	0.12	0.14	0.13	0.14
3 or more ADLs	0.04	0.17	0.05	0.05	0.05	0.05
Diagnosed Conditions						
High blood pressure	0.73	0.87	0.76	0.72	0.60	0.74
Diabetes	0.28	0.42	0.28	0.27	0.17	0.29
Cancer	0.23	0.16	0.21	0.21	0.17	0.21
Lung disease	0.15	0.21	0.15	0.13	0.10	0.15
Heart disease	0.35	0.45	0.36	0.35	0.29	0.36
Stroke	0.11	0.17	0.10	0.09	0.09	0.10
Psychiatric	0.20	0.35	0.19	0.19	0.15	0.20
Arthritis	0.77	0.82	0.79	0.77	0.65	0.77
<i>Economic Access</i>						
Family Income						
0% to 100% of FPL	0.04	0.43	0.07	0.07	0.10	0.09
101% to 200% of FPL	0.15	0.35	0.25	0.26	0.29	0.23
>200% of FPL	0.81	0.22	0.68	0.67	0.60	0.68
High school education or GED	0.88	0.40	0.81	0.78	0.77	0.79
<i>Predisposing</i>						
Female	0.54	0.69	0.63	0.58	0.54	0.59
Hispanic	0.04	0.33	0.05	0.10	0.07	0.09
Black	0.12	0.33	0.10	0.12	0.13	0.13
Married or partnered	0.68	0.31	0.60	0.62	0.55	0.60
Age						
65 to 74 years	0.52	0.48	0.53	0.52	0.49	0.52
75 to 84 years	0.38	0.38	0.37	0.36	0.34	0.37
85 years and over	0.10	0.14	0.10	0.12	0.17	0.11
Number of observations	2581	652	2105	2751	367	8456

Table A2. Sample Characteristics by Prescription Drug Use in 2012

	Prescription Drug Use		
	Rx Drug Use	No Rx Drug Use	Total
<i>Health Needs</i>			
Functional Limitations & Prescription Drug Insurance			
0 ADLs Employer	0.26	0.25	0.26
0 ADLs Medicaid	0.05	0.04	0.05
0 ADLs Stand-Alone Part D	0.21	0.18	0.21
0 ADLs Medicare Adv/Medigap/Other	0.26	0.30	0.26
1 – 2 ADLs Employer	0.04	0.02	0.04
1 – 2 ADLs Medicaid	0.02	0.01	0.02
1 – 2 ADLs Stand-Alone Part D	0.03	0.01	0.03
1 – 2 ADLs Medicare Adv/Medigap/Other	0.05	0.03	0.05
≥ 3 ADLs Employer	0.01	0.01	0.01
≥ 3 ADLs Medicaid	0.01	0.00	0.01
≥ 3 ADLs Stand-Alone Part D	0.01	0.01	0.01
≥ 3 ADLs Medicare Adv/Medigap/Other	0.02	0.01	0.02
Diagnosed Conditions			
High blood pressure	0.79	0.25	0.74
Diabetes	0.31	0.06	0.29
Cancer	0.21	0.17	0.21
Lung disease	0.15	0.07	0.15
Heart disease	0.38	0.09	0.36
Stroke	0.11	0.02	0.10
Psychiatric	0.21	0.08	0.20
Arthritis	0.79	0.64	0.77
<i>Economic Access</i>			
Family Income			
0% to 100% of FPL	0.09	0.08	0.09
101% to 200% of FPL	0.23	0.21	0.23
>200% of FPL	0.68	0.70	0.68
High school education or GED	0.79	0.79	0.79
<i>Predisposing</i>			
Female	0.59	0.56	0.59
Hispanic	0.09	0.08	0.09
Black	0.13	0.11	0.13
Married or partnered	0.61	0.59	0.60
Age			
65 to 74 years	0.51	0.56	0.52
75 to 84 years	0.37	0.08	0.37
85 years and over	0.12	0.11	0.11
Number of observations	7750	706	8456

Book Reviews

James Midgley, *Social Development Theory & Practice*. Sage Publications, (2013), 296 pages, \$40.00 (paper), \$120.00 (hardcover.)

For more than 50 years, academics and practitioners have explored social development, and its theories and accomplishments have been the subject of extensive debate. This is a pivotal time for social development. The year 2015 marks the 20th anniversary of the 1995 World Summit for Social Development and its Copenhagen Declaration; it is the target date set for achievement of the Millennium Development Goals; and it will see the launch of the United Nations new Post-2015 Agenda for development and the environment. Thus, we can expect a reinvigorated interest in the debates surrounding development, including social development. The publication of *Social Development: Theory & Practice* by James Midgley is timely indeed.

In this new volume, James Midgley draws on his own extensive scholarship on development as well as the work of leading scholars from diverse disciplines to produce a summative work on social development. Reflecting on successes and disappointments of development efforts, he raises concerns about “distorted development” that has, in many cases, failed to improve the lives of those living in poverty.

The book synthesizes a great deal of information and diverse perspectives on social development. In selecting the topics of emphasis, Midgley lays out his definition of social development in depth. The book is logically organized into four sections. In the first section, he discusses definitions of social development, the history of social development, and its place within the overall framework of development. He begins with a broad definition of social development as “a process of planned social change designed to promote the well-being of the population as a whole within the context of a dynamic multifaceted development process” (p. 13). He then identifies

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a set of characteristics of social development including “productivist,” meaning that social development interventions contribute to economic development. This is not necessarily a part of all definitions of social development, but it explains the book’s heavy emphasis on interventions that have an economic component. This background is followed in Section II by two chapters summarizing theories and theoretical debates.

The main section of the book devotes a chapter to each of 7 intervention strategies for social development. These are: Investments in development of human capital; Development of social capital; Decent work and employment; Microfinance and microenterprise; Asset building as a social development strategy; Social protection; and Social planning. In each chapter, Midgley addresses the history of the intervention strategy, then presents features of the intervention, and assesses strengths and limitations of its contributions to social development. Community development is covered in the chapter on social capital, addressing efforts to build community, community action and economic development at the community level. Midgley pulls his arguments together in the final chapter in which he lays out his recommended approach to social development—institutional structuralism. Noting that this is best achieved within a “proactive, enabling state”(p. 214), he identifies the barriers and challenges ahead. A glossary of development terms and an extensive reference list complete the volume.

Social Development: Theory & Practice has many strengths. The book is thoroughly researched and brings together a vast literature in a coherent volume. It is global in scope, as the author draws on his experiences in diverse parts of the world. In most instances, readers will appreciate the scope of the work in providing careful historical perspective, a perspective often lacking in American scholarship. In the chapter on social protection, however, somewhat less emphasis might have been placed on the English Poor Laws and earlier interventions to provide more detail on the recent work by the International Labour Organization (ILO) and key social welfare advocacy groups to promote the Global Social Protection Floor Initiative. Inclusion of more data from the ILO on cost estimates for protection floors in poorer countries would have enriched the discussion.

Although the book is quite comprehensive, some of the more important recent developments could have been given more attention. Ironically, perhaps, the volume may over-emphasize economic productivity and put too little focus on the social and community aspects of development. Social integration, identified by the 1995 World Summit as one of the 3 pillars of social development, is largely ignored and does not even appear as a term in the index. There is also relatively little attention to environment and sustainability, a theme that will feature centrally in the United Nations Post-2015 agenda.

Overall, however, this is an important book that adds significantly to social development theory and practice. It provides excellent background for rethinking social development, the priority theme for the United Nations Commission for Social Development 2015-2016. James Midgley has once again enriched the social development knowledge base and produced a book that is a "must read" for scholars, students and practitioners in the field of development.

Lynne M. Healy, School of Social Work, University of Connecticut

James Midgley & David Piachaud (Eds.), *Social Protection, Economic Growth and Social Change: Goals, Issues and Trajectories in China, India, Brazil and South Africa*. Edward Elgar Publishing Ltd., (2013), 296 pages, \$120.60 (hardback).

Two decades ago a series of epochal events began to change the socio-political and economic landscape of the world. The fall of the Berlin Wall in 1989 coincided with the Tiananmen Square demonstrations in China, the return to democracy in Chile and the demise of the Soviet Union. Furthermore, economic liberalization in India in 1991 and the end of apartheid in April 1994 in South Africa marked the rise of civil society and democratic movements, as well as the emergence of a borderless one-globe market. In contemporary times, as vast power is concentrated in the hands of a few multinational corporations, the question remains about how individuals, families and communities can educate and organize themselves to protect their health needs, livelihoods, homes, neighborhoods and environment. Social protection policy has historically

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been accepted as important public policy to ensure the basic minimum quality of life for citizens and ideally contribute to achieving a more equitable resource and income distribution in society. Nation states in both the Global North and Global South have historically debated the human rights and liberatory function as opposed to the dependency and economically viable function of social protection policy. In the same breath, social workers have witnessed models of the welfare state shift and weaken as market forces are captured by consumerism, greed and business interests in both regions with implications for how to reform or construct social protection systems.

Midgley and Piachaud's book, based on a symposium held at the London School of Economics in 2012, offers scholars, students and social policy advocates an eminently readable, thought provoking overview of the historical development, current goals and future prospects of social protection policy in China, India, Brazil and South Africa. Piachaud and Midgely, two esteemed social policy analysts, set the introductory tone to this book and acknowledge that the challenges of rapid urbanization, fast economic growth and social change within each of these transitional nation states have implications for social protection policy forms; these challenges form the central premise of this book.

Parts two to five deliberate the historical developments of social protection policies, the current trends and approaches and the future prospects of social protection policy in China, India, Brazil and South Africa respectively. In addition to offering a comprehensive, engaging account, the chapter contributors share a conceptual synergy of their respective country's transition to a market economy which dramatically shifted the developments of social protection, the expansion of strategies and the *new* demands on the welfare system as well as *new* risks and vulnerability that have emerged. In particular, it was interesting to note the similar suggestions put forth by Zhu who writes on the context of China, Mutaatkar from India, Bastagli and Soares from Brazil as well as Kruger from South Africa that call on their respective governments to restore the rights-based approach to social protection and move beyond short-term and survival strategies for the poor to focus on long-term strategies that is required for a comprehensive social protection policy.

Another important but equally complex and interesting issue raised by Midgley (p. 17) is that “social policy scholars have not paid sufficient attention to social protection’s economic function.” This book no doubt makes an important contribution to comparative analysis in social work education, in particular courses on social policy and legislation and international social work. We live in complex times where citizens around the world have been seeking a new social protection and economic compact in which their individual and collective safety nets are not surrendered to the state’s power-politics or profit-driven markets. In the final chapter of the book, Piachaud and Midgely challenge us to pay attention to the emancipatory function of social protection that has largely been neglected by social policy makers; that is, “by enhancing human and social capital and by maintaining aggregate economic demand, social protection can promote economic growth.” As future social policy advocates, the question remains, will we rise to this challenge?

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Dawn Belkin Martinez & Ann Fleck-Henderson (Eds.), *Social Justice in Clinical Practice: A Liberation Health Framework for Social Work*. Routledge (2014), 218 pages, \$48.95 (paperback), \$155.00 (hardcover).

Social Justice in Clinical Practice includes 11 inspiring illustrations of liberation health practice in action and an introduction to the theory and practice of the liberation health model. Belkin Martinez describes the liberation health social work model as “a broader vision of what social work should be” and locates it as both an extension of “past radical traditions” and an attempt to “develop new paradigms for social work appropriate for our current crisis” (p. 4). Given the current social, economic and political crises that compromise health and well-being for much of the population, this edited book is both timely and necessary. It is a practical answer and challenge to the micro–macro divide, not only in social work, but also in sociology and related fields, bringing together a focus

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on the personal with the social and political. It actualizes a core principle of social work, that of social justice, and is replete with examples of clinical social workers' practicing elements of what is often referred to as "traditional social work" alongside what has been considered "radical social work."

The introduction addresses ways in which neoliberalism has contributed to the United States' current woes and has interfered with social work's carrying out its social justice mandate. It discusses three sources of liberation health theory: Paolo Freire and popular education; liberation psychology; and the history and legacy of radical social work and the U.S. rank and file movement. The chapter then presents principles of liberation health in clinical practice that build on and extend these traditions: understanding clients' problems in the context of social conditions; employing practice interventions that are both individual and social; expanding ways clients view problems by examining ideology; facilitating a process by which clients shift from object to subject in their own narratives; and social workers as partners and allies in the process. As part of setting the stage for the chapters focusing on specific populations and issues, the introduction also describes the problem analysis method used for this body of work—a method of worldview deconstruction that involves a visual triangle featuring personal, institutional and cultural factors. The process of developing and implementing an action plan is also highlighted.

The subsequent chapters build on and deepen the introductory material. Each chapter features content on the setting, population, and/or issue to be addressed, a literature review that discusses the principles above to varying degrees, as well as literature specific to the topic at hand, a case presentation with a visual triangle that represents the author's formulation and action steps taken, and reflections on the work presented. Kant discusses the transformative process he undertook in becoming a liberation health social worker. Osheroff focuses on child protective services and presents the work of a colleague who employed an agency-based intervention in response to victim blaming and experiences of burn out that were rampant in the agency. The remaining chapters address a client population and/or an issue, including LGBT people, African-Americans, Latinos, upper middle and privileged class families, serious

and persistent mental illness, domestic violence, substance abuse/addictive behavior, adolescent inpatient psychiatry and public housing. The intersection between forms of oppression is addressed throughout. Recurring themes include the insidious effects of dominant world view messaging, the damage caused by a culture of individualism over solidarity, the importance of rescuing the historical memory of change, and the shift from the object to subject subject to the object role as an integral part of both personal healing and societal change.

This book provides a clear and compelling vision of liberation health practice in social work. While not being prescriptive, it provides tools and a framework for analysis and action. The case presentations are highly effective at demonstrating the use of the triangle in a process of problem formulation that both includes and goes beyond traditional practice. These analyses and the plethora of interventions they inform will likely challenge all but the most cynical of practitioners, expanding readers' sense of what is possible. Several examples of challenges and conflicts experienced in practicing liberation health social work are provided and should prove valuable to the reader as well. While the decision to feature clinical situations that reflect success in applying the liberation health model in social work accomplished a great deal, it would have been good to include a chapter briefly discussing situations when clients did not find the work helpful.

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Naomi Nichols, *Youth Work: An Institutional Ethnography of Youth Homelessness*. University of Toronto Press, (2014). 158 pp., \$24.95, paperback.

Naomi Nichols undertook an ambitious ethnographic project with the aim of understanding efforts in Canada to serve homeless youth. For a year and a half, she placed herself at a youth homeless shelter, observing operations and interviewing homeless youth and some of the professionals and paraprofessionals that work with them. Nichols used her experience to illustrate how the Children's Aid Society (CAS) and other social service agencies function and how their discourse

and persistent mental illness, domestic violence, substance abuse/addictive behavior, adolescent inpatient psychiatry and public housing. The intersection between forms of oppression is addressed throughout. Recurring themes include the insidious effects of dominant world view messaging, the damage caused by a culture of individualism over solidarity, the importance of rescuing the historical memory of change, and the shift from the object to subject subject to the object role as an integral part of both personal healing and societal change.

This book provides a clear and compelling vision of liberation health practice in social work. While not being prescriptive, it provides tools and a framework for analysis and action. The case presentations are highly effective at demonstrating the use of the triangle in a process of problem formulation that both includes and goes beyond traditional practice. These analyses and the plethora of interventions they inform will likely challenge all but the most cynical of practitioners, expanding readers' sense of what is possible. Several examples of challenges and conflicts experienced in practicing liberation health social work are provided and should prove valuable to the reader as well. While the decision to feature clinical situations that reflect success in applying the liberation health model in social work accomplished a great deal, it would have been good to include a chapter briefly discussing situations when clients did not find the work helpful.

Nancy Feldman, Touro College Graduate School of Social Work

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frames the problems related to youth homelessness. Nichols discovered that rather than helping young people, accountability structures end up creating barriers.

In chapter 1, Nichols outlines her purpose and her approach for the reader, defining institutional ethnography and the textual analysis that she uses throughout the rest of the book, and shares an unexpected finding-- that the young people at the shelter did not consider themselves homeless. Although the literature in the field defines homelessness as "use of emergency shelter services," the young people with whom Nichols interacted saw the shelter as a temporary stopping place while they waited for other things in their lives to work themselves out. The language of homelessness was not meaningful for these young people and failed to describe their experience.

This disparity between institutional language and experience sets the stage for young peoples' attempts to navigate social aid systems. One issue is that the needs of homeless youth are not in line with the procedures set up by the social welfare system. For example, youth identify their first need as a safe place to sleep, yet there are several agencies and procedures to be navigated to meet that need: In order for the youth to be recognized by the system, the youth need to understand what to do, know where to ask for the assistance they need, and know to ask for what they need in the particular language of the agency. When a young person needs somewhere to sleep immediately, these processes, which may take days or even weeks to resolve, do not serve their needs.

In chapters 2 through 4, Nichols reports her interviews with young people who describe themselves as "falling through the cracks" in their attempts to receive services. Nichols uses their stories to show how seemingly simple and straightforward tasks become part of a "complex and disorienting institutional field." Tellingly, Nichols admits it took her a year to understand how to access the various services the youth needed. She states that the young people need effective advocates to educate them on how to successfully navigate the system. As it currently stands, the interactions between the homeless youth and the service agencies generally result in youth not getting their needs met and feeling like their attempts have been fruitless and frustrating.

Nichols illustrates how agency documentation and accountability requirements create barriers for both the homeless young people and the social service workers who are involved in their care. In Nichols' words, her work is an attempt to "draw attention to the processes whereby people's actual experiences are subsumed in discourse, objectified as abstract data, or transformed into the terms through which they become institutionally recognizable or actionable" (p. 25). This movement from experience to actionable data is what she argues produces the "gaps" through which young people find themselves falling. Governance and funding sources create accountability structures that drive agencies to serve bureaucratic needs instead of the needs of young homeless people.

As an example of institutional ethnography, this text would be great in the classroom. It is brief and is written for an academic audience. It shows clearly how the needs of clients and the needs of bureaucracy can have very little to do with one another. Finally, the author brings praxis into her final chapter, an important step in feminist scholarship. She examines ways to start to change the system, by making connections between those in need and those in positions of power to influence how need is provided.

For social workers in the field, this book will be an affirmation of what they have been struggling with for the past decade—an agency focus on accountability, paperwork, and bureaucratic requirements that take up much of the workers' time, leaving insufficient time to foster relationships with the people they want to help.

*Melinda McCormick, School of Social Work,
Western Michigan University*

Gary Cameron, Marshall Fine, Sarah Maiter, Karen Frensch, and Nancy Freymond (Eds.), *Creating Positive Systems of Child and Family Welfare: Congruence with the Everyday Lives of Children and Parents*. University of Toronto Press, (2013), 352 pages, \$56 cloth, \$27.96 paperback.

This is an unusual book, to its great credit. *Creating Positive Systems of Child and Family Welfare* provides an opportunity

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This is an unusual book, to its great credit. *Creating Positive Systems of Child and Family Welfare* provides an opportunity

for parents in the child welfare system to describe and assess their own lives and to reflect on their experiences in the child welfare system. It focuses on the critical, though often analytically neglected, interaction between clients and caseworkers. The book listens to and presents the voices of both parents and caseworkers to make the child welfare system "more welcoming and helpful for both families and service providers."

The chapters of the book are primarily based on research from the Partnership for Children and Families Project carried out in Ontario, Canada between 2000 and 2010, focusing on families with children who have been removed for fewer than four months. The chapters cover clients' and parents' perspectives on their interactions—18 life stories of fathers involved with the Children's Aid Society in southern Ontario, 16 mothers whose child welfare cases had been closed, parents' and service providers' perceptions of those 34 life stories, the experiences of 31 mothers whose children had been placed into foster care, an exploration of six "good worker-client relationships," a matched comparison of parents' and service providers' perceptions of their interactions, and so on. The book provides a unique body of information on the critical boundary where parents interact with caseworkers. The chapters report, again and again, that "service participants and service provider perceptions of what was important and what was helpful did not necessarily correspond to each other." The conclusions, again and again, are that child welfare practice would improve dramatically if the perceptions and needs of parents were a larger part of the child welfare decision-making process, and if supports for both families and caseworkers were more available.

Few studies focus on the perceptions and experiences of parents and caseworkers. This book begins to fill that gap, not only for social work students, who often have had little experience with the people and communities with whom they will be working in child welfare, but also for practicing professionals and administrators who will be enriched by learning more about the needs and life experiences of their clients. The book, however, fails to acknowledge other work that explores similar territory, such as the ground-breaking publication, *Rise Magazine* that presents the life stories and recommendations of parents whose children have been in the child welfare

system in the United States, primarily in New York City. Nora McCarthy, editor of *Rise*, who read the book at my request, found it to be “an important way to start a rich discussion. It focuses on parents without taking the workers out of focus.”

The chapters are all based on qualitative research called a “broken mirror design,” with “each fragment of the broken mirror...reflect[ing] something different...” At times samples are described as being randomly selected with no description of how random selection was carried out. Another oddity is calling impoverished, desperately struggling individuals, people with “lives of lesser privilege.” At times the chapters read like case notes rather than aggregated findings. But that is both the limitation of qualitative research as well as its power to illustrate through specific detail the generalizable experience of individuals.

The most important issue the book does not address is, how can the insights of the book be implemented? As noted in the conclusion by Gary Cameron,

The forces of inertia in a system as large and well-established as child welfare in Ontario are very powerful. Attempts at major reforms of Ontario's child welfare system over the past couple of decades, while they have had notable impacts, have left the core ideology, service delivery structures, and relationships with clientele largely unchanged.

The book concludes with useful recommendations including less paper work, fewer cases brought to court, local and team decision-making, service agreements with clients, and more quality daycare and other services. But the book is silent on what force will bring about a change in the core ideology, service delivery structures and relationships. The conclusion of one of the authors is to “recognize the power imbalance in the worker–client relationship and work at minimizing this by providing clear information...” But information alone will not change the balance of power in child welfare. There needs to be a countervailing force, as was used by child welfare parents who confronted similar problems in New York City. They organized and successfully pressured government and private

agencies to make the types of reforms this book seeks. Without an organized countervailing force for reform—parents, families, youth, or a class action lawsuit—the seminal findings of this book will remain marginalized.

David Tobis, Maestral International

Lauren Heidbrink, *Migrant Youth, Transnational Families, and the State*. University of Pennsylvania Press (2014), 208 pages \$49.95, cloth.

Visions of the Southwest border in the 1980s were revisited the summer of 2014 when thousands of youth fleeing organized crime and endemic poverty in Central America's northern triangle—Guatemala, El Salvador, Honduras—crossed into the U.S. seeking safety and economic stability. Customs and Border Protection officials apprehended more than 68,000 youth, about 23% of them from Mexico and the remainder from Central America, in FY 2014. After processing them at "holding facilities," they were transported without explanation to poorly equipped military bases in Oklahoma, Texas and California, and a FEMA-managed warehouse in Nogales, Arizona. Once transferred to the Department of Homeland Security's Office of Refugee Resettlement (ORR), the youth were locked up for indefinite periods in privately contracted Immigration and Customs Enforcement (ICE) youth detention shelters from California to Delaware. With minimal access to attorneys, family members, or even use of telephones, immigrant youth, far from feeling welcomed, found themselves in an incomprehensible maze of structures supposedly in place to protect them.

Though the United Nations recognized the majority of those fleeing northern triangle countries as refugees according to the 1951 UN Convention, the reasons for their desperate leave-taking were barely addressed by mainstream media. The youths' own voices and motives were utterly suppressed. By mid-November, a majority of U.S. voters endorsed the Congressional stalemate on immigration reform. Central American and Mexican children, despite U.S. and international laws in their favor, were on their own to defend their rights

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and struggle for their futures, losing their slim freedoms as international travelers in the process.

Enter anthropologist Lauren Heidbrink's *Migrant Youth, Transnational Families, and the State*, a courageous and timely analysis bringing out the testimonies of five unaccompanied migrant youth caught in immigration and child welfare snares. "This ethnography," Heidbrink states, "focuses on a largely invisible population of unauthorized migrant children in highly restrictive and largely inaccessible spaces, such as immigration detention, border stations, immigration and family courts, and underground communities." Their narratives reveal a string of restrictive and contradictory government structures pertaining to migrant youth that scatter their scanty dreams into a cosmic dust. Their reasons for fleeing their homes—to escape gang and cartel violence, to earn money to send to families left behind, and to join or rejoin family members in the U.S.—are ignored. Case managers, juvenile court judges and detention officials become their "new family." Heidbrink demonstrates how their personhood, sense of agency and rights as children dissolve in government paperwork and procedures they neither understand nor accept.

Heidbrink advises her readers that, like immigrant adults, immigrant youth are entitled to certain important immigration remedies and to legal counsel. Yet rarely, she notes, except for an initial rights orientation, do they have immigration attorneys to assemble their legal cases. Attorney access to youth detention shelters is severely limited. Rare, too, on the child welfare side, is the juvenile judge, protective services case manager or child welfare attorney who understands the options available to youth and can help navigate successful pursuit of these options. Indeed, all of Heidbrink's subjects are disrespected and disincentivized, often even punished, for attempting to exercise their rights or agency while in government custody. The reader learns that even close and trusted relatives, including parents, with whom a child has had previous contact, may be found unsuitable for placement or even for communication. Security concerns, such as inappropriate and threatening contacts with smugglers, drug or human traffickers, understandably play a role. But the youth, while able to navigate an arduous journey alone across foreign

lands, are not considered qualified to help determine who may contact them. As an example, the internet is considered off limits, even though for the majority of Latino and African youth, Facebook is the only free communication option available to families. When youth protest such deprivations, privileges may be withheld. Yet these youth, neither criminals nor delinquents, are only seeking to be united or reunited as expeditiously as possible with parents or kin.

Lauren Heidbrink skillfully critiques the shortcomings of intersecting systems that frequently collide and too often sideswipe best interests of children and families. Successful advocacy by community immigrant networks and by national child welfare and immigrant advocate organizations for immigration policy changes and for greater transparency, not mentioned in the book, are slowly turning around some of these egregious effects.

Laurie Melrood, *Immigrant Family Advocate, Tucson, AZ*

Laurence Tribe and Joshua Matz, *Uncertain Justice: The Roberts Court and the Constitution*. Henry Holt & Co. (2014), 416 pages, \$32.00 hardcover.

Most best selling books on the Supreme Court have been of the “inside story” variety, like Woodward and Armstrong’s *The Brethren*, or biographical portraits like Linda Greenhouse’s *Becoming Justice Blackmon*. Combining fine-tuned analysis of arcane doctrines—such as rules about standing, with interesting vignettes about life in the chambers and sweeping predictions about the distant impact of today’s high court decisions—is not a job for sissies, and the authors of *The Roberts Court* have broken the mold by producing a delightfully readable and erudite volume that both places complicated legal concepts within the easy reach of non-lawyers and synthesizes a broad swath of case law for the legally trained.

The central insight the authors seek to convey is two-pronged: the Court that began with the 2005 appointment of Chief Justice Roberts defies and perhaps does not deserve the hard, crass political descriptions commentators and humorists alike have applied (Steven Colbert’s spoof on the campaign

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finance case *Citizen's United* gets a good deal of ink in the book), and the decisions of the justices flow from fundamental beliefs about law, government, and American history rather than from antipathies towards particular kinds of litigants like consumers, marginalized minority groups, environmental advocates and criminal defendants. Roberts and his allied colleagues, on this reading, genuinely believe that, as a matter of constitutional design and original intent, the other two federal branches must be straightjacketed by the Court lest personal liberties disappear, that access to federal court should be restricted and closely monitored by the Supreme Court, and that the states are, in effect, the sovereign equals of the United States. In some places, the authors track centuries of jurisprudence to establish that these are arguments over core, if intellectually debatable, constitutional principles, seemingly to undermine the view of many court observers that these result-oriented jurists are, plain and simple, naked emperors.

While most students of the Constitution very much want to believe that a set of reasoned principles lie behind this Court's decisions, the authors' close examination of a wide range of issues suggests otherwise, and, hence, at the end of the day their premise, although generous and respectful, seems unsustainable. Thoroughly examining nine subject areas of the Court's work, the book surveys the constitutional history and enduring questions raised by each topic, probes the justices' thinking on well-known current cases, and dissects the ideological alignments that thread through these cases. Much of the material is journalistic in nature: Thomas's silence at oral argument, Scalia's penchant for scolding, Sotomayor's devotion to the Yankees. More valuable are simplifying and illuminating renderings of case law only lawyers need to know.

In that vein, a chapter on Access to Justice does a superb job of describing how procedural rulings about who can sue, when and for what claims have deeply diminished individual rights, fairness, and equal justice. The authors describe several cases decided by a five-to-four Court that have ravaged the class action lawsuit and endorsed the preference of businesses for private arbitration over public litigation. The criminal rulings on procedural issues are to the same effect: in one case, *Connick v. Thompson*, the Court allowed a New Orleans district

attorney whose line lawyers hid evidence from a defendant in order to win a capital conviction to escape civil litigation, thereby significantly diminishing the grounds for holding police departments accountable in federal court for civil rights violations.

The authors repeatedly claim that the complaints of critics that the court favors business over consumers and is hostile to civil rights and criminal defendants are only “partly right.” It is, they say, “not a neutrality v. activism story” but rather “competing beliefs about what law requires with fundamental disagreement about the role of courts and litigation in American life.” But time and again in the book, this plea for nuance and principle comes up short, which explains why normally hyper-professional jurists like Ruth Ginsburg—she is the real hero of this story—sometimes sound apoplectic. In the Court’s decision striking the individual mandate in the *Health Care Case*, Ginsburg labeled “specious,” illogical, and disingenuous Chief Justice Roberts’ claim that but for Court oversight Congress might require Americans to eat broccoli. The book makes clear that history will embrace Justice Ginsburg as one of the Court’s most effective voices, on a line with John Marshall, Robert Jackson, Earl Warren and William Brennan. Her prose is plain, her American history richly supported, and her legal argumentation always hits the mark.

For those who want both the play on the ground and the panoramic view, this book provides it. Taking us into corners of the Court’s work and thinking that only lawyers visit, it reflects the true costs of the rise of conservatism, and, despite the authors’ contention that the caselaw illuminates a complicated and diverse way of using constitutional principles, it suggests that Steven Colbert got it right. The Roberts Court mainly follows the money.

Margaret Burnham, Northeastern University School of Law

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INSTRUCTIONS FOR AUTHORS

(Revised July, 2013)

JSSW welcomes a broad range of articles which analyze social welfare institutions, policies, or problems from a social scientific perspective or otherwise attempt to bridge the gap between social science theory and social work practice.

Submission Process

Electronic submissions are welcome. Please send to Robert Leighninger at rleighn@berkeley.edu. If you have no access to the internet, submit three (3) hard copies of manuscripts to: Robert Leighninger, School of Social Welfare, University of California at Berkeley, 315 Haviland Hall, Berkeley, CA 94720-7400. Send with an abstract of approximately 100 words and key words. Submission certifies that it is an original article and that it has not been published nor is being considered for publication elsewhere. Electronic submissions will be acknowledged immediately and authors will receive an email when the manuscript goes out for review. Those with no email address will be notified by mail.

Progress reports can be obtained by e-mailing the editor at rleighn@berkeley.edu. Reviewing normally takes 120 days.

Preparation

Articles should be typed in a 12 point font, double-spaced (including the abstract, indented material, footnotes, and references), with one inch margins on all sides. Tables may be submitted single-spaced. Please provide a running head and keywords with manuscript. Include tables and figures in the same document as the narrative. Keep identifying information out of the narrative. Put identifying information in a separate document with full contact information and any acknowledgments. Aim for approximately 18 pages, not counting tables and references. Avoid footnotes and endnotes if possible. Overall style should conform to that found in the Publication Manual of the American Psychological Association, Sixth Edition, 2009.

Gender and Disability Stereotypes

Please use gender neutral phrasing. Use plural pronouns and truly generic nouns ("labor force" instead of "manpower"). When dealing with disabilities, avoid making people synonymous with the disability they have ("employees with visual impairments" rather than, "the blind"). Don't magnify the disabling condition ("wheelchair user" rather than "confined to a wheelchair"). For further suggestions see the Publication Manual of the American Psychological Association or Guide to Non-Sexist Language and Visuals, University of Wisconsin-Extension.

Book Reviews

Books for review should be sent to:

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