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Mission Statement

The School of Social Work at Loyola University Chicago created *Praxis: Where Reflection & Practice Meet* was created to give voice to the scholarly work of students and alumni. Our mission is to encourage and support the development of social work knowledge that will enhance the lives of the clients we serve, embody the humanistic values of our profession, and promote social justice and care for vulnerable populations. *Praxis* respects and welcomes all viewpoints.

Editorial Policy

Praxis is published by students in the School of Social Work at Loyola University Chicago. The editorial board is composed of masters and doctoral social work students. The board encourages students and alumni of the School of Social Work to submit papers that provide insight into clinical, policy, research, education and other areas relevant to social work practice. Submissions are accepted throughout the year and the priority deadline for the annual Fall publication is the last day of January. Submissions to the journal are reviewed anonymously by the the editorial board and edits accepted papers with permission from the authors. Papers should be no longer than 20 double-spaced pages and submitted as a Microsoft Word document file (.doc). All identifying information, including contact information, should be on a separate page. Responsibility for accuracy of information contained in written submissions rests solely with the authors. Opinions expressed in the journal are those of the authors and do not necessarily reflect the views of the School of Social Work or the Editorial Board.

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EDITORIAL

The Vocation of Social Work

“While both humanization and dehumanization are real alternatives, only the first is man’s vocation. This vocation is constantly negated, yet it is affirmed by the very negation. . . it is affirmed by the yearning of the oppressed for freedom and justice, and by their struggle to recover their lost humanity.”

~Paulo Freire, *Pedagogy of the Oppressed*, 1970, p. 28

Nearly five years ago, I was anxiously waiting to find out if my *Individuals and Families* paper would be accepted into *Praxis*. Luckily, my paper on case management was deemed “*Praxis*-worthy” and I had my first publication under my belt. Thereafter, my involvement with *Praxis* expanded as I applied to be on the editorial board and held that position for three years. Now, it feels surreal to be composing my first editorial as Editor-in-Chief. I would never have thought five years ago that one day I would be the one deeming papers “*Praxis*-worthy.” Putting together our seventh edition of *Praxis* has truly been an honor as well as a challenge, particularly considering the exceptional work of my predecessors, Marian Sharkey and Christie Mason. I hope to build on the excellent foundation that they set for me and take *Praxis* to a new level as we strive to ensure it garners the respect it deserves in the social work community.

Before looking ahead to the future of *Praxis*, I think it is important to first remember its foundation in order to guarantee this edition stays true to the roots of the journal. The obvious starting point would be to investigate the meaning of *praxis*. While in our first article, Brandy Maynard does a fine job of defining the origins of *praxis* and discussing its relevance to research in social work, I would like to focus on another utilization of *praxis* that certainly resonates with the mission of the profession of social work as well as this journal.

Paulo Freire (1970) attempted to address the divide between oppressors and the oppressed by defining a critical pedagogy. He argues that in order for the rampant dehumanization that exists among humans to be extinguished, a critical consciousness about the oppressive reality and deliberate action against that reality must be initiated. Freire (1970) writes:

The [oppressed], whose task it is to struggle for their liberation together with those who show true solidarity, must acquire a critical awareness of oppression through the *praxis* of this struggle. . . . To no longer be prey to its force, one must emerge from it and turn upon it. This can be done only by means of *praxis*: reflection and action upon the world in order to transform it. (p. 36)

He argues that through this constant interaction of increased awareness of reality and action upon that reality, people begin to shift from being either the oppressed or the oppressor to individuals who become in touch with their “ontological and historical vocation to be more fully human” (Freire, 1970, pp. 40-41). In the end, both the oppressed and oppressor are capable of experiencing a “permanent liberation” (p. 40) and “profound rebirth” (p. 47).

Certainly, the mission of social work includes ending social injustice, empowering the oppressed, and increasing awareness of the oppressors—all facets of Freire’s model against oppression. To achieve this mission, social workers must be proactive in our practice across all levels of intervention (micro-, mezzo-, and macro-) and reflective about that practice to achieve the fullest possible awareness of the reality that surrounds us. This intertwining of calls for action and reflective discussion embodies this volume of *Praxis*. I now turn to this volume’s articles, all of which contribute to this utilization of *praxis* by critically investigating issues dealing with a wide range of oppressed individuals and promoting action to alleviate existing dehumanization.

The first article, by Brandy Maynard, lays the groundwork for the subsequent articles by discussing the nature of knowledge in social work and how to effectively engage in best practices. Then, Mary Reynolds will certainly spark debates as she addresses issues in policy impacting drug-abusing mothers when fetuses are exposed to drugs. Christian Griffin exposes the institutionalization of individuals with mental illness in correctional settings and calls for immediate action.

Additionally, Deresha Gibson addresses the gaps in the health system that cause African-American children to be diagnosed with autism significantly later than White children. Priscila Freire offers a model of treatment designed to elicit Latino male batterers’ innate capacities for healthy human relatedness. Allison Lowe brings victims of human trafficking, an oppressed group frequently ignored, to the forefront of our attention. Finally, Anne Fleury writes an engaging article about a topic rarely addressed in the field—animal hoarding. A theme that flows through each of these articles is bringing rarely addressed, though extremely relevant, issues into the awareness of social workers in a reflective way. This is the first step of *praxis*; now we, as social work-

ers, must mobilize and take action to alleviate oppression and suffering.

In closing, I want to share the pride I take in introducing this volume of *Praxis*. I am proud of all the authors featured; they represent excellence in our profession and have contributed to our knowledge base, which is essential for our profession's longevity. I take pride in the editorial board for all of their talents, hard work and reliability; they have made this an amazing and rewarding experience for me. Finally, I look at the diversity in the articles presented in this edition and I take pride in our profession. What other profession advocates for drug-abusing mothers, tries to understand the phenomenon of animal hoarding, delves into the philosophical debates about research, critiques the disparity in the diagnosis of autism, intervenes in the dreadful act of human trafficking, seeks out ways to support and heal men who batter *and* investigates the institutionalization of the persons with mental illness in jails? That does not even cover the range of issues

addressed in the dissertation abstracts! It is truly amazing the number and diversity of people our profession impacts and the breadth of problems we address on a daily basis. With that in mind, I hope each reader leaves this journal with a new appreciation for our profession and a new inspiration to embrace this vocation of humanization.

Jeffrey Bulanda, LCSW
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Editor-in-Chief

Reference

Freire, P. (1970). *Pedagogy of the oppressed*.
(M.B. Ramos, Trans.). New York: The Seabury Press.

To EBP or Not To EBP?: Social Work's Dilemma with Evidence Based Practice

By Brandy R. Maynard

Abstract

Evidence-based practice (EBP) continues to be a widely debated and tentatively accepted movement in social work. Although there is a great deal of discussion of evidence-based practice within the professional literature, mainstream social work seems to be generally unaltered by this movement. This paper explores the history and evolution of social work knowledge development and the relationship between social work knowledge and practice in the context of the evidence-based practice movement. Evidence-based practice can be a useful framework to guide social work toward meeting the challenges of the profession, more effectively helping our clients and being better positioned to confront social problems. Adopting evidence-based practice will not be easy; there are a number of challenges, implications and choices that need to be considered. Critically considering evidence-based practice in the field of social work will put us in a better position to evaluate how we practice, and challenge us to do better.

Evidence-Based Practice in Social Work

Evidence-based practice (EBP) often elicits a range of reactions from social workers, including suspicion, criticism, apathy and enthusiasm. Evidence-based practice, which originated in medicine to address gaps between practice and research findings, has been widely adopted and advocated in medicine and nursing. EBP has also been more broadly adopted by human services professionals, including social workers in the United Kingdom and Australia, but remains in its infancy for social work in the United States (Gilgun, 2005; Rosen, 2003).

The social work literature reflects general support for embracing evidence-based practice; however, there are several authors and social workers who have expressed skepticism, rejection and caution of evidence based practice (Witkin, 1996; Witkin & Harrison, 2001; Blome & Steib, 2004; Gray & McDonald, 2006). It is becoming increasingly difficult to ignore the evidence-based practice movement as the President's New Freedom Commission report, the Council on Social Work Education (CSWE) and the National Association of Social Workers (NASW) have incorporated evidence-based language and are requiring social workers to use best evidence to guide practice (New Freedom Commission on Mental Health, 2003; NASW, 1999;

CSWE, 2004). There are also a number of entities with a certain amount of status, authority, and credibility that are promoting evidence-based practice, such as the Office of Juvenile Justice and Delinquency Prevention (OJJDP), Blueprints for Violence Prevention, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Department of Education and various state agencies across the U.S.

Even though there is agreement in the literature and by social work authorities (e.g., NASW and CSWE) on incorporating evidence-based practice into the social work profession, there are several issues that impact the ability for this to be broadly accepted by social work practitioners, educators and researchers. These issues relate to the definition of evidence-based practice, the nature of knowledge and how knowledge is used in social work practice, and the technical aspects and barriers to engaging in evidence-based practice (including the role of higher education, technology, dissemination, etc.).

What is Evidence-Based Practice?

Although there are a number of reasons for social work's ambivalence toward evidence-based practice, adding to the misunderstanding and confusion is the multitude of definitions of EBP found in the literature, a few are noted below:

Evidence-based practice...is the integration of best research evidence with clinical expertise and patient values (Crossing the Quality Chasm, 2001, as cited in Campaign for Mental Health Reform, 2003, p. 1)

EBP involves using the 'best available' evidence...about specific types of practices with particular problems. (Witkin & Harrison, 2001, p. 293)

Evidence-based practice is the conscientious, explicit, and judicious use of the current best evidence in making decisions about the care of clients. (Gibbs & Gambrill, 2002)

EBPSW [Evidence-based practice in social work] is defined as *the planned use of empirically supported assessment and intervention methods combined with the judicious use of monitoring and evaluation strategies for the purpose of improving the psychosocial well being of clients.* (O'Hare, 2005)

Evidence-based practice means basing intervention on proven effectiveness derived from empirical research. (Gray and McDonald, 2006)

The definition of evidence-based practice in social work has been, and continues to be, evolving; however, many authors continue to misrepresent evidence-based practice by defining it narrowly, neglecting many important characteristics of EBP as a philosophy of practice, selecting fragments of EBP, re-labeling old practice or practice as usual as EBP or ignoring it altogether (Gambrill, 2003). Evidence-based practice does not simply mean using research as the basis for making clinical decisions and selecting interventions nor does it simply refer to programs and interventions that have been deemed an "evidence-based practice" (e.g. Multisystemic Therapy [MST], Assertive Community Treatment [ACT], Integrated Dual Disorders Treatment [IDDT]) by various entities that are evaluating the efficacy of specific programs.

Eileen Gambrill (1999, 2003, 2006) has written extensively about evidence-based practice in social work and provides this description:

Evidence-based practice suggests a philosophy of practice as well as a unique series of steps and related technological innovations designed to help practitioners to integrate evidentiary, ethical and implementation concerns. (2003, p.19)

Most social workers do not argue with the need to provide effective and ethical services to clients, so why are social workers objecting to, misrepresenting, misunderstanding or ignoring evidence-based practice? To get a better understanding of evidence-based practice in relation to the social work profession, one must examine the historical, social and political context of the evolution of the social work profession, both in terms of knowledge and practice.

The Knowledge Base of Social Work

What do social workers know, what do social workers do and is there any connection between what social workers know and do? These are the age old questions that have plagued the social work profession since its inception. Social workers have long engaged in research and gathering evidence about interventions (Klein and Bloom, 1994; Tyson, 1995; Kirk & Reid, 2002), although the role and application of research and knowledge as it relates to practice have been elusive to the social work profession (Kirk & Reid, 2002; Tyson,

1995; Fischer, 1981; Fraser & Taylor, 1991).

Much of the U.S. health and human service system was developed out of organized religion. As churches and religion became more diverse and better organized, they began to develop more sophisticated networks of health and human services and demand was made for more professionally operated services and organizations using the latest information from the social sciences (Kirk & Reid, 2002). This occurred during the Progressive Era, a time in which greater emphasis was placed on technical expertise and empirical information.

In the 19th century, social workers advocated "scientific philanthropy," which was shaped by social, religious and moral views of the causes for social problems (Marx & Hopper, 2005; Fraser & Taylor, 1991). Also during this time, a movement toward professionalization began with the charity organization societies and the settlement house movement. These two groups, along with the psychiatric social work group, comprised three distinct kinds of social work research communities and developed distinct models and clinical practice in the early 20th century (Tyson, 1995). Tyson (1995) provides an in-depth discussion of research contributions from each of these communities as well as the diverse philosophical views they held about science and research. She described all three communities as having shared beliefs about scientific social work research. They all drew from pragmatism, rejected the positivist view of science and viewed the purpose of research as generating workable solutions for problems. Other social and behavioral scientists were being influenced by a positivist philosophy of research; however, logical positivism, the more stringent offshoot of positivism, was not adopted by social work researchers until the 1950s (Tyson, 1995).

Tyson (1995) identified three common beliefs about generating social work knowledge that the settlement houses, charity organization societies and the psychiatric social work group shared:

- 1) methodological pluralism....[using] diverse research designs without prescribing any one as inherently superior. . . .;
- 2) a non-restrictive approach to the variables that could be studied scientifically;
- 3) social work research actualizes value. . . about how the researcher should relate with clients and how to advance large-scale social reform (pp. 47, 49).

Social work pioneers, including Jane Addams, suggested that systematic data collection and information processing were critical aspects of effective individual-level interventions and community practice strategies

(Fischer, 1973). Fraser and Taylor (1991) also noted that early social workers viewed the profession as scientifically based, in that practice should be continually informed by scientific knowledge. Mary Richmond, exemplifying a largely positivist perspective in *Social Diagnosis* (1917), "chose to define social casework as a science and emphasized the collection of accurate information about families and individuals as the basis for rational decisions about service" (Fraser & Taylor, 1991, p. 7).

In 1915, Abraham Flexner, who had transformed the medical education and practice in ways that are still apparent today, concluded that social work was not a profession, with criticisms about social work's knowledge base being a significant factor (Flexner, 2001). Flexner's conclusions about social work were not based on the results of careful studies, interviews, or a systemic review of the literature, but rather were derived from his consideration of what criteria must be met for any occupation to be a profession in its own right, extracting the criteria he used by looking at those professions that were universally accepted as professions at the time: law, medicine and preaching (Kirk & Reid, 2002). This had a profound effect on the social work profession, providing an impetus for social workers to professionalize their occupation and, ultimately, bringing into focus the need to identify a body of scientific knowledge in social work (Kirk & Reid, 2002).

A New Paradigm: The Scientist-Practitioner

By the 1950s, little progress was made toward developing a body of knowledge based on research, despite the recommendations that Flexner had provided to advance social work as a profession forty years earlier. "The profession still had few, if any journals devoted to research, few research-oriented doctoral programs, and virtually no research establishment" (Kirk and Reid, 2002, p. 9). Questions continued to be raised about social work's status as a profession. Another set of criteria for social work's professional status was outlined by Ernest Greenwood, including 1) a systematic body of knowledge, 2) professional authority and credibility, 3) regulation and control of members, 4) a professional code of ethics, and 5) a culture of values, norms and symbols. Using these criteria, Greenwood concluded that social work did meet acceptance as a profession in the 1950s (Kirk & Reed, 2002). Despite Greenwood's assurances that social work was indeed a profession, there continued to be disputes whether social work had an identifiable knowledge base as well as epistemological concerns about whether the profession was using appropriate methods of scientific inquiry. A report of a conference published two years after Greenwood's pronouncement

opened with the following sentence: "Social work has not produced a systematic body of knowledge, although it exhibits many characteristics of a profession" (NASW, 1964, iii, as cited in Kirk & Reid, 2002, p. 11).

In addition to the efforts to construct social work's body of knowledge and the epistemological debates that were ongoing through the latter half of the twentieth century, there was also much criticism of the outcomes of social work practice. In the 1950's, "social work was largely conviction, tradition and untested practice theory" (Kirk & Reid, 2002, p. 9) and many questions were being raised to examine the effectiveness of social work. These factors led to yet another effort to construct a knowledge base, one that was built from scientific inquiry, rather than the traditional forms of knowledge based on conviction and values (Kirk & Reid, 2002).

In the first half of the twentieth century, there was very little in the way of empirically based intervention knowledge and, according to Kirk and Reid (2002), the early outcome studies that did exist were "rather crude efforts at determining effectiveness of social work" (p. 37). Due to judgments of effectiveness being made by those with interest in the program, with little attempt to determine measurement reliability and no controls to determine if the gains were due to the intervention or other factors, Richard C. Cabot, in 1931, called for social workers "to measure, evaluate, estimate, appraise your results" (cited in Kirk & Reid, p. 38). At this time, the profession "had a strong stake in determining if the methods used by practicing professionals and taught in schools of social work were indeed effective in alleviating client problems" (Kirk & Reid, 2002, p. 38).

"The social and political climate of the 1960's [also] created an interest in program evaluation and led to a questioning of social work's effectiveness" (Witkin, 1996, p. 69). By this time, controlled evaluations had accumulated and evidence began to emerge that social work services were not effective (Kirk and Reid, 2002; Fischer, 1973). Some concluded, as Fischer had, that the social casework interventions which were examined were deficient. Others, like Helen Perlman and Carol Meyer, concluded that it was the research methodology that was deficient, not the programs. Kirk and Reid concluded that both the programs and the research strategies were deficient (Kirk & Reid, 2002).

A shift to a logical positivist approach to social work research was also occurring in the mid-twentieth century. The logical positivist philosophy of science restricted social work research to that of "scientific" versus "non-scientific," a focus on theory verification rather than discovery, a prioritization of experimental design over other research designs and the belief that scientific research can and should be value-free. This, as Tyson

(1995) argues, was a diverging view of social work research which had been adopted by the early social work researchers. While the early social workers were engaged in practitioner-research, the new definition of valuable research led to the conclusion that "competence in research design calls for a degree of specialization which most practitioners cannot be expected to achieve" (Fletcher, 1955, p. 13, as cited in Tyson, 1995, p.76).

As a result, the gulf between practice and research widened in the 1950s and 60s. A new hierarchy was established in that the researcher was the expert and contributor to science and knowledge, while the social work practitioner was one who applied what was already known. Tyson acknowledges that the gulf between research and practice "reflected not only beliefs about social work knowledge but also differences between the authority and status of women and men in the social work profession. . . More women were in direct practice, whereas more men held management, research and faculty positions" (Tyson, 1995, p. 84).

These factors, as well as other social factors (see summaries in Tyson, 1995 and Witkin, 1996) led many schools of social work and the Council on Social Work Education to promote practice strategies that had a research base. The scientist-practitioner framework was promoted as a practice strategy to encourage social workers to rigorously evaluate the effects of intervention with clients by using research strategies associated with single subject design. "A testament to the importance relegated to this framework was the incorporation of the scientist-practitioner model into most schools of social work graduate programs in the 1980s" (Jenson, 2005, p. 131).

Although there was much effort to connect science with practice, the results proved largely unsuccessful and failed to contribute the kind of empirically tested intervention knowledge hoped for. Relatively few practitioners engaged in single subject design or systematic practice evaluation, and investigators found that "most practitioners did not consider empirical evidence when selecting interventions for clients" (Jenson, 2005, p. 131). Despite the lack of success of these efforts, a number of methodological lessons were learned which helped pave the way for new approaches (Kirk & Reid, 2002).

The "Social Work Revolution": Toward a Postpositivist Orientation

In 1981, Fischer described a "social work revolution," referring to the way that social workers viewed knowledge and practice and in the way social workers used that knowledge to conduct practice (Fischer, 1981). Also that same year, Heineman (1981) proposed an alternative, less restrictive approach for social work research,

heuristics, which provided the impetus for a shift in social worker's epistemological stance (Heineman, 1981; Tyson, 1995).

In 1989, Heineman Pieper put forward a post-positivist perspective, the heuristic paradigm, as an alternative paradigm of research to replace the "overly restrictive, outmoded logical positivist paradigm. *Heuristic* in this usage simply means any problem-solving strategy that appears likely to lead to relevant, reliable, and useful information" (As cited in Tyson, 1995, p. 207). Heineman Pieper argued that research studies based on the logical positivist paradigm, which placed artificial limits on treatment, manipulated variables for the sake of research design, and ignored the needs of practitioners and clients, resulted in research that appeared irrelevant to the practitioner and client, and was thus largely ignored. Heineman Pieper proposed that the use of the heuristic paradigm would decrease the tension and gap between researchers and practitioners by allowing research to be more collaborative and relevant, thus motivating practitioners to read and engage in research (Heineman Pieper, 1989 in Tyson, 1995, p. 211). Heineman Pieper (1989, in Tyson, 1995) notes that another important implication of the heuristic paradigm is:

no one category of facts is inherently better at telling us about reality than another category of facts. The heuristic researcher selects types of data and methods of data gathering for their appropriateness both to the theory chosen to guide the research and also to the problem under study (p. 211).

Heineman described a number of reasons for adopting a heuristic paradigm of research including contemporary philosophy having undercut logical positivism's claims, that the heuristic paradigm "welcomes the complex... problems that have been social work's focus," facilitates "cooperation between researcher and practitioner and between researchers in different fields" and it "makes research user-friendly by expanding...the operation of human judgment in the knowledge-building process" (Heineman, 1989 in Tyson, 1995, p. 219).

As represented by Heineman, the social work literature over the past twenty years, as well as the CSWE and schools of social work, appear to be reflecting a commitment to a postpositivist orientation (Fraser & Taylor, 1991).

"Postpositivism relies on 'critical multiplism,' or the use of multiple methods of inquiry and sources of information (for example, observation, self report, worker report, and management information system data)....

Ontologically, postpositivism acknowledges that the world is imperfectly known and measurable, but it subscribes to an objective reality (Fraser & Taylor, 1991, p.9).

Postpositivists acknowledge that objectivity may be elusive, but remains a goal toward which researchers strive, emerging from the process of replication (Fraser & Taylor, 1991).

The Current Status of Social Work Research

Over the past twenty years, social workers have taken positive and concrete steps toward connecting science with practice. The National Institute of Mental Health (NIMH) appointed a Task Force on Social Work Research in 1988. NIMH issued recommendations from that Task Force which contributed to a number of advances in social work research and subsequently funded seven Social Work Research Development Centers in schools of social work during the 1990's. This task force influenced important guidelines on research training in doctoral education and also made way for the creation of national organizations designed to promote social work research—Institute for the Advancement of Social Work Research (IASSWR) and the Society for Social Work Research (SSWR) (Jenson, 2005).

Although social work seems to be making great efforts in expanding the research and knowledge base, only about half of all articles published in journals for or by social workers were research based (Rosen, Proctor & Staudt, 1999; Fraser & Taylor, 1991). Two studies that reviewed social work literature within the past two decades revealed that 55.2% (published between 1985 and 1988) and 47% (published between 1993 and 1997) of articles were research based (Rosen, Proctor & Staudt, 1999; Fraser & Taylor, 1991). Fraser and Taylor (1991) noted that of those 55.2% of research-based articles, only 26.7% were written by social workers while the remainder was written by authors in other professions. The majority (70%) of articles that social workers wrote were composed of interpretation of theory, social comment, personal anecdote, and program advocacy (Fraser & Taylor, 1991). "A substantial portion of the research base of the [social work] profession appears to consist of contributions by authors with training in disciplines other than social work" (Fraser & Taylor, 1991).

In addition to a lack of research-based knowledge in social work literature, there is very little research on interventions (Rosen, Proctor & Staudt, 1999; Fraser, 2004; Kirk & Reid, 2003). Fraser (2004) argues that "in addition to explanatory research, intervention research is requisite for a profession because professions are com-

mitted to change...[and] the central most activity in social work is intervention and research on intervention is foundational to the profession" (p.210). Rosen, Proctor and Staudt (1999) reviewed 863 research articles published in 13 practice-oriented journals for or by social workers between January 1993 and July 1997. Only 15% of those research articles were focused on the effects of an intervention while 49% pursued knowledge for explanation and 36% were aimed at descriptive knowledge. Only "about a dozen research reports a year described an evaluated intervention in such detail that a practitioner might be able to replicate it [which] seems...a small number for a practice-oriented profession" (Fraser, 2004, p. 212).

Although social work is slowly developing a knowledge base, social work practitioners are not using this knowledge in practice (Jenson, 2005; Fraser, 2004; Nathan, 2004; Rosen, 2003). "Policy and practice are often not based on evidence but on ideology or politics, which may lead to an *ignoring* of the evidence" (Humphries, 2003, p. 82). Nathan (2004) notes that "despite the outpouring of research on counseling and psychotherapy over the past half century, the clinical activities of most counselors and psychotherapists remain largely untouched by it" (p. 949). Many gaps remain in our knowledge about "what works...that is, about the most effective...means of helping" (from Task Force on Social Work Research, 1991, p. 4, as cited in Rosen, 2003, p. 7).

Gambrill (1999) attributes the lack of the use of evidence in social work practice as social workers relying heavily on authority based criteria, "such as opinions of others, pronouncements of 'authorities,' unchecked intuition, anecdotal experience, and popularity (the authority of the crowd)" (p. 348). Based on the amount of literature that demonstrates a significant void of systematic research, a lack of research focused on interventions, few social workers reading research related materials, and evidence that social workers are not using research findings, research methods and methods of intervention based on practice research literature, it does appear that social work practice is based on authority rather than evidence (Fraser, 2004; Myers & Thyer, 1997; Rosen, 2003, Mullen & Bacon, 2004).

Clearly, social work is still struggling with many of the same questions our foremothers were struggling with in the early years of the social work profession: what do social workers do, how is knowledge used and are we effective in promoting change and solving the problems to which we set out?

So as we arrive at the present day, it is quite interesting, although not altogether surprising, that we are still not much further along than we were in the early

years of the profession in coming to an understanding of the roles research, knowledge and practice play in social work. Will evidence-based practice be the answer to this dilemma in social work? Before we try to answer this question, it is important that we look at the purpose and role of social work knowledge and practice.

The Purpose of Social Work Knowledge and Practice

Man must prove the truth, i.e. the reality and power, the this-sidedness of his thinking and practice...All social life is essentially practical. All mysteries which lead theory to mystics, find their rational solution in human practice and in comprehension of this practice...The philosophers have only interpreted the world, in various ways; the point is to change it. (Marx, 1845, as cited in Smith, 1999, p. 11)

Is social work a theoretical discipline, one in pursuit of the truth through contemplation, the attainment of knowledge for its own sake; one of production (*poietike*), making action from a guiding plan or idea as a skilled artisan; or one of practice (*praxis*), informed and committed action? Many readers may be inclined to say that social work is about *praxis*, to which I would agree as a premise, but we must further examine each to determine if that is what social work is, or what it should be (Smith, 1999).

According to Aristotle, contemplation was the form of thinking appropriate to theoretical activities (Smith, 1999). It involves mulling over facts and ideas that the person already possesses. For many in various disciplines, as it was for Aristotle, gaining knowledge for its own sake, and to reflect and contemplate on that knowledge, is the highest form of human activity (Smith, 1999). Although gaining knowledge for its own sake may be a relevant undertaking for some, it is not enough for a social worker. Fischer (1984) argues that "possessing a conceptual framework to help us understand or assess problems in practice does not lead automatically to knowing what to do or how to intervene with those problems. Understanding is not helping" (p.73).

The kind of knowledge involved in productive disciplines was a 'making' action (*poietike*) (Smith, 1999). This is most easily associated with craftspeople. Making action involves both skill (*techne*) and creativity in an artistic sense, but always begins with a plan or idea (*eidosis*) and ends with a thing or an object. Although the product can only come into being through the skill of the practitioner, it is the *eidosis* that prescribes the nature of the

product, not the practitioner's skill (Smith, 1999).

Praxis is the third form of reasoning as offered by Aristotle (Smith, 1999). *Praxis* is guided by a moral disposition to act truly and rightly and a concern to further human well-being. It begins with a question or situation which is considered in relation to what is thought to make for human flourishing, is then guided by a moral disposition to act truly and rightly which allows one to then engage with the situation or question as committed thinkers and actors. The outcome, then, is process. What this process involves is a round of interpretation, understanding and application (Smith, 1999).

Theory and practice are not completely separate entities. Practice cannot lack theory and theory is not usually devoid of reference to purposeful action. "Practice is soaked in theory" (Smith, 1999, p. 4); it is a constant process of theory making and theory testing. In *praxis*, there can be no prior knowledge of the right means by which we realize the end in a particular situation. For the end itself is only concretely specified in deliberating about the means appropriate to a particular situation. There is a continual interplay between ends and means as well as thought and action. *Praxis*, then, is not simply action based on reflection. It is action which embodies certain qualities, including a commitment to human well-being, the search for truth and respect for others (Smith, 1999).

Social work, then, seems to be a little of all of these. Social work has been a discipline often concerned with *poietike*, in that our "actions" have, at least some or most of the time, been dictated by a plan or design that was given to us (by the dominant culture or another discipline) and we simply were involved in "making action." As long as we understand practice to be merely application of theory, what is often believed to be 'real' knowledge, we will not be able to move past that of a "skilled artisan implementing the 'design' of others" (Smith, 1999). In this sense, the 'design' of others can be viewed as theories that we subscribe to, but do not critically evaluate, as well as in terms of aligning with the dominant culture and ignoring our social work mission.

Encompassing a truly practical discipline, *praxis*, one devoted to the act of doing in an informed and committed manner, involves a commitment to our mission: to "enhance human well-being and help meet the basic human needs of all people" (NASW, 1999, p. 1). *Praxis* would also involve asking questions relevant to a situation or person, to be guided by our ethics and values as well as "truth," or evidence, and engaging with the situation or person as committed thinkers and doers (Smith, 1999).

If we agree that the profession of social work is one of *praxis*, and that theory is an integral part of *praxis*, social work knowledge must then be comprised of both theoretical and practical knowledge, informed by ethics

and truth, guided by questions relevant to the situation or person and resulting in action. Social work literature has been comprised primarily of theoretical knowledge, but lacking in intervention knowledge, something that is required for the act of doing in an informed and committed manner.

Is Evidence-Based Practice the Answer?

There is clearly a need to have a framework or process to more effectively build a knowledge base that is meaningful and useful, to be good purveyors and consumers of research, to use evidence to guide practice decisions and interventions and to evaluate if what we are doing is effective and is achieving the intended impact. Can evidence-based practice be that framework? Jenson (2005) offers that “the recent interest in using principles of EBP to improve connection between research and practice offers a new sense of optimism in the movement to integrate science and intervention” (p. 132).

Indeed, evidence-based practice is a new way of doing things and involves a shift in paradigms (Gambrill, 2003, p. 13). EBP is not a different name for what has been proposed in the past (empirical clinical practice, empirically validated treatments). Although there have been many attempts to integrate knowledge and practice, EBP is quite different from what has been tried before. The unique process for drawing on external research findings and the greater attention given to ethical issues, such as informed consent and the importance of considering client values and expectations, the importance given to involving clients as active participants in the decision making process and the emphasis on the critical appraisal of practice and policy research set EBP apart (Gambrill, 2003). “Other differences include the greater emphasis in EBP on helping practitioners and clients to acquire critical appraisal skills, the promotion of transparency of what is done to what effect and focus on out-

comes *clients* [italics added] value” (Gambrill, 2003, P.13). Gambrill (2006) effectively summarizes EBP as

a guide for thinking about how decisions should be made....A systemic approach to integrating ethical, evidentiary, and application concerns that emphasize transparency regarding the uncertainties involved in helping clients....It describes a philosophy and process designed to forward effective use of professional judgment in integrating information regarding each client's unique characteristics, circumstances, preferences and actions and external research findings (p. 339).

Gilgun (2005) presents four cornerstones on which evidence-based practice in social work rests: (1) what we know from research and theory; (2) what we and other professionals have learned from our clients, or practice wisdom, which also includes professional values; (3) what we, as social workers, have learned from personal experience; and (4) what clients bring to practice situations. All four come into play and mutually affect each other as we go about our daily work with clients. “In sum, EBP promotes a high degree of practitioner reflection and mindfulness” (Gilgun, 2005, p. 52).

The facets of EBP are very much in line with Heineman's heuristic paradigm, a postpositivist philosophy of research and evaluation. Sackett et al. (as cited in Gambrill, 2006, p. 340) describes a five-step process in doing EBP to which I compare the heuristic paradigm to research and evaluation.

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Applying the Heuristic Paradigm to Evidence-Based Practice

EBP 5 step process	Gambrill's description (2006 p.340)	Heuristic counterparts (Heineman Pieper, 1985 and Tyson, 1995)
Defining the problem/ formulating the question	Converting information needs related to practice decisions into well-structured answerable questions.	Include the following considerations when generating the question/problem formulation (Tyson, p. 228): 1. What values underlie the problem formulation? 2. What possible solutions will the problem formulation lead? 3. Why is this problem formulation important? 4. Who is the client and how can the research be helpful to the client? 5. What are the ontological and epistemological assumptions that underlie the problem formulation? 6. What biases are evident? 7. How can biases be regulated?

To EBP or Not To EBP?: Social Work's Dilemma with Evidence Based Practice

EBP 5 step process	Gambrill's description (2006 p.340)	Heuristic counterparts (Heineman Pieper, 1985 and Tyson, 1995)
Discovering evidence	Tracking down, with maximum efficiency the best evidence with which to answer them	<p>All data and evidence available to the practioner are appropriate for use. The strategies for discovering evidence are heuristics that prioritize one form of accuracy at the expense of the others. (Tyson, p. 438)</p> <p>The evidence that the practitioner will seek is determined by the question/problem conceived in step one.</p> <p>Use the "sense" in operationalism to examine how the theoretical assumptions in the problem/question formulation lead to gather some forms of data and exclude other data.</p>
Appraising the evidence	Critically appraising that evidence for its validity, impact (size of effect) and applicability, (usefulness in practice).	The practitioner selects the level of analysis in relation to the problem to be addressed and recognizes the biases of those selections. Using multiple levels of analysis will mitigate the bias (Tyson, p. 439).
Applying to practice	Applying the results of this appraisal involves deciding whether the evidence found (if any) applies to the desision at hand and considering client values and preferences in making decisions.	Deciding whether the evidence found applies to the situation at hand. Evidence is not judged solely on the methodology used. No methodology is "better" than another except in terms of how it answers the question/problem formulated.
Evaluating	Evaluation our effectiveness and efficiency in carrying out steps 1 to 4 and seeking ways to improve them in the future	<p>The practitioner selects levels of analysis and recognizes the biases of those selections. Using multiple levels of analysis will mitigate the bias (Tyson, p. 439).</p> <p>Using change indices can help practitioners reflect on the changes they aim to accomplish and to determine whether those changes are taking place (Tyson, p. 440).</p>

Challenges

There are a number of barriers and challenges to implementing a philosophy of EBP, as well as future implications. One of the challenges to evidence-based practice is related to epistemological issues. Much of the literature criticizing EBP is often based on the presumption that evidence-based practice is a logical positivist construct. This is based mostly in reaction to the inclusion of "empirical" evidence as part of EBP. It is also, quite rightly so, in response to how some are defining and constructing EBP, using a narrow definition that ignores the ethical and application concerns and other important principles of EBP. The term "empirical" is often misused as Heineman (in Tyson, 1995, p. xxiii) describes: "The

terms *empirical* and *empiricist* traditionally refer to knowledge arising from experience that originates extracranially. The positivists fallaciously apply these terms only to data collected in a manner compatible with the positivistic paradigm." "*Empiricism* means that the method ultimately rests on experiential information derived through observation using the senses (sight, sound, touch, taste, or smell)" (Anastas, 1999, p. 11). Empirical in this sense takes a much more postpositivist philosophy of research, not specifying anything about the nature of the observations or defining one kind of observation as inherently superior (Anastas, 1999).

Not everyone agrees on the use of research for social work practice or on whether there is consensus about when an intervention has been demonstrated to be effective, relating to methodology, quality and validity of

the research. Some have argued that the lack of objectivity, lack of consistent criteria for determining the generalizability of a study and the lack of consistent and agreed upon criteria for determining the quality and validity of qualitative research as reasons for not using evidence-based practice (Kirk & Reid, 2002). In response, Kirk and Reid (2002) argue that "the research credentials of an intervention can be problematic yet still [demonstrate] enough evidence of effectiveness to warrant its use over options supported by less [or no] evidence" (p. 159).

The types of research that are funded and published will both be impacted by and have an impact on evidence-based practice. If the definition and operationalization of EBP is restricted to a positivist philosophy, then the types of research that will be funded and published will be primarily quantitative. This will further reinforce the belief that qualitative research is an inferior form of research and we will be leaving out the very important ways in which qualitative research can inform practice (Morse, 2006). If, however, we take a postpositivist philosophy of evidence-based practice, qualitative research will have an important role in contributing to and enriching the evidence of the effectiveness of social work practice.

Organizational barriers also exist as the real world and competing pressures challenge a new paradigm. Social workers often have high caseloads and productivity pressures with very little time to seek out, read and appraise research. Supervisors and administrators are often wedded to certain models or practices based on tradition, ideological preference or funding issues. Staff who are interested and motivated to do EBP may encounter resistance as they are questioning the practices of the organization.

Institutions of higher education will also encounter their own set of organizational challenges. As schools of social work wrestle with if, when and how to teach evidence-based practice, they will be confronted with both intra and extra-institutional forces. It would be hoped that schools of social work would be teaching practices and developing curricula that is at the forefront of knowledge and technology; however, this is too often not the case. Schools of social work are organizations, and organizations are often characterized as investing considerable effort in maintaining old organizational patterns and myths, often based on opinion or authority-based social work practice and teaching (Soydan, in press). In addressing this resistance to change, some external forces are starting to have an impact on schools of social work, including social work practice organizations demanding a workforce capable of implementing EBP, research and grant funding and insurance reimbursements that are requiring practitioners, researchers and organizations to demonstrate EBP and consumers

and consumer advocacy organizations demanding accountability of providers (Soydan, in press). As students in schools of social work begin to learn about evidence-based practice through their own personal experiences or reading, they will also begin to demand that their institutions incorporate EBP into the curricula and field placements.

Another challenge of adopting EBP is the technical aspects of doing it. There is much one needs to know in order to practice EBP that has not been traditionally taught in schools of social work, such as asking well-structured answerable questions, seeking out evidence and critically appraising research. Some schools of social work are starting to address this by adopting evidence-based practice as a new pedagogical paradigm (Howard, McMillen & Pollio, 2003). They are teaching students the value and components of EBP as well as ethical responsibilities to use effective interventions. They are also integrating into their curricula interventions that have empirical evidence of being effective and informing their students in practice courses "to the amount, type, and quality of evidence supporting major theories, policies and interventions in practice" (Howard, McMillan & Pollio, 2003, p.236). As the Council on Social Work Education accreditation guidelines now calls for learning skills essential to EBP in bachelor's and master's programs, teaching evidence-based practice will challenge, among other things, current curricula, faculty, and field placements. Much of the future of evidence-based practice lies in how social work education meets these challenges and to what level and scope they choose to integrate EBP into their professional education programs.

Gambrill (2006) attributes the preference for authority-based practice as the most challenging obstacle faced by EBP. The philosophy of EBP, as being a participatory, antiauthoritarian paradigm that encourages transparency and the questioning of what we know, challenges those who prefer not to be questioned or who feel they know better or have more experience. Many social workers have been trained in specific theories that may or may not have an evidence base, but are held onto because of ideological grounds and tradition.

Conclusion

Evidence-based practice involves a shift in paradigms and cultures, a new way of thinking about knowledge, practice, research and teaching social work practice and policy. There are a number of challenges, valid limitations and implications to adopting an evidence-based practice philosophy; however, the barriers and limitations are not valid reasons to disregard or dispense with EBP.

We can no longer continue to make practice

decisions based on tradition, good intentions, authority, intuition or personal preference as this is not in the best interest of the people that we are ethically bound to help. There is a growing body of knowledge and an availability of a variety of effective interventions which our clients have the right to receive and we have the ethical obligation to provide. The NASW Code of Ethics (1996), calls upon us "to help people in need and to address social problems" (p. 3), "to engage people as partners in the helping process" (p. 3), "to promote the well-being of clients" (p. 4), "to critically examine and keep current with emerging knowledge relevant to social work" (p. 13), and "to base practice on recognized knowledge, including empirically based knowledge, relevant to social work and social work ethics" (p. 13). As Howard, McMillan and Pollio (2003) affirm, "Failure to adopt more scientifically sound practice methods and evidence-based instructional approaches, in the face of burgeoning database of relevant empirical findings, might eventually marginalize social work itself, and relegate our service customers to substandard professional interventions" (p. 256).

Adopting evidence-based practice, teaching and policy will provide the framework, principles and guidelines to help us meet our ethical obligations, to further our

knowledge base and develop and use effective practices in ways that are aware of and sensitive to our clients' unique characteristics, values and circumstances. In short, EBP will allow us to more effectively help those who will benefit most from evidence-based practice: our clients.

At this crossroads of using EBP, there are a number of choices we must make and others we must be involved in influencing and directing. The question at this point is not whether social work should adopt an evidence-based practice philosophy, but how will social work define and use evidence-based practice? Will we maintain the broad philosophy and process that EBP was originally intended to be or will we continue to ignore, misrepresent and maintain business as usual and allow a narrow view of EBP to reign? The answers to the questions raised by evidence-based practice will not come easily, but the debates and critical evaluation of our research, practice and teaching that have resulted from the EBP movement will undoubtedly raise our awareness of what we are doing and how we are impacting our clients and the social problems with which we are faced. In that respect, evidence-based practice has already demonstrated a great deal of promise for our profession.

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References

- Anastas, J.W. (1999). *Research design for social work and the human services*. New York: Columbia University Press.
- Blome, W.W., Steib, S. (2004). Whatever the problem, the answer is "evidence-based practice"- or is it? *Child Welfare, 83*, 611-615.
- Campaign for Mental Health Reform. (2003). Evidence-based services and emerging best practices for treating mental disorders in adults and children. Retrieved on September 17, 2006 from <http://www.mhreform.org/policy/ebs.htm>
- Council on Social Work Education. (2004). *Educational policy and accreditation standards*. Retrieved November 12, 2006, from <http://www.cswe.org>
- Fischer, J. (1973). Is casework effective? A review. *Social Work, 18*, 5-15
- Fischer, J. (1981). The social work revolution. *Social Work, 26*, 199-207
- Fischer, J. (1984). Revolution, schmevolution: Is social work changing or not? *Social Work, 29*, 71.
- Flexner, A. (2001). Is social work a profession? *Research on Social Work Practice, 11*, 152-165.
- Fraser, M. & Taylor, M.J. (1991). Social work and science: Many ways of knowing? *Social Work Research and Abstracts, 27*, 5-16.

- Fraser, M.W. (2004). Intervention research in social work: Recent advances and continuing challenges. *Research on Social Work Practice, 14*, 210-222.
- Gambrill, E. (1999). Evidence-based practice: An alternative to authority based practice. *Families in Society, 80*, 341-350.
- Gambrill, E. (2003). Evidence-based practice: Sea change or the emperor's new clothes? *Journal of Social Work Education, 39*, 3-23.
- Gambrill, E. (2006). Evidence-based practice and policy: Choices ahead. *Research on Social Work Practice, 16*, 338-357.
- Gibbs, L. & Gambrill, E. (2002). Evidence-based practice: Counterarguments to objections. *Research on Social Work Practice, 12*, 452-476.
- Gilgun, J.F. (2005). The four cornerstones of evidence-based practice in social work. *Research on Social Work Practice, 15*, 52-61.
- Hayes, R.A. (2005). Introduction to evidence-based practices. In C. A. Stout & R. A. Hayes (Ed.), *The evidence-based practice: Methods, models and tools for mental health professionals* (pp. 1-10). New Jersey: Wiley.
- Heineman, M.B. (1981). The obsolete scientific imperative in social work research. *Social Service Review, 55*, 371-397.
- Howard, M.O., McMillan, C.J. & Pollio, D.E. (2003) Teaching evidence-based practice: Toward a new paradigm for social work education. *Research on Social Work Practice, 13*, 234-259.
- Humphries, B. (2003). What else counts as evidence in evidence-based social work? *Social Work Education, 22*, 81-91.
- Jenson, J.M. (2005). Connecting science to intervention: Advances, challenges and the promise of evidence based practice. *Social Work Research, 29*, 131-135.
- Kirk, S.A. & Reid, W.J. (2002). *Science and social work*. New York: Columbia University Press.
- Klein, W.C. & Bloom, M. (1994). Social work as applied social science: A historical analysis. *Social Work, 39*, 421-431.
- Marx, J.D. & Hopper, F. (2005). Faith-based versus fact-based social policy: The case of teenage pregnancy prevention. *Social Work, 50*, 280-282.
- Morse, J.M. (2006). The politics of evidence. *Qualitative Health Research, 16*, 395-404.
- Mullen, E.J. & Bacon, W. (2004) Implementation of practice guidelines and evidence-based treatment: A survey of psychiatrists, psychologists and social workers. In A. R. Roberts & K. R. Yeager (Ed.), *Evidence-based practice manual*. Oxford: Oxford University Press.
- Myers, L.L. & Thyer, B.A. (1997). Should social work clients have the right to effective treatment? *Social Work, 42*, 288-298.
- National Association of Social Workers. (1999). *Code of ethics of the National Association of Social Workers*. Retrieved September 13, 2006 from <http://www.socialworkers.org/pubs/code/code.asp?print=1>
- O'Hare, T. (2005). *Evidence-based practices for social workers*. Chicago: Lyceum Books.
- Rosen, A., Proctor, E.K., Staudt, M.M. (1999). Social work research and the quest for effective practice. *Social Work Research, 23*, 4-14.
- Rosen, A. (2003). Evidence-based social work practice: Challenges and promises. *Social Work Research, 27*, 197-208.
- Sackett, D.L., Rosenberg, W.M., Gray, M.J.A., Haynes, R.B., Richardson, W.S. (1996). Evidence based medicine: What it is and what it isn't. Retrieved on November 15, 2006 from <http://www.bmj.com/flagship.luc.edu/cgi/content/full/312/7023/71>
- Shek, D.T.L., Tank, V.M.Y., & Han, X.Y. (2005). Evaluation of evaluation studies using qualitative research methods in social work literature (1990-2003): Evidence that constitutes a wake-up call. *Research on Social Work Practice, 15*, 180-194.
- Smith, M. K. (1999). Praxis: An introduction to the idea. Retrieved from on November 15, 2006, from <http://www.infed.org/biblio/b-praxis.htm>
- Soydan, H. (in press). Improving the teaching of evidence-based practice- challenges and priorities. *Research on Social Work Practice*.
- Tyson, K. (1995). *New foundations for scientific social and behavioral research: The heuristic paradigm*. Boston: Allyn & Bacon.
- Witkin, S.L. (1996). If empirical practice is the answer, then what is the question? *Social Work Research, 20*, 69-75
- Witkin, S.L & Harrison, W.D. (2001). Whose evidence and for what purpose? *Social Work, 46*, 293-296.
- Gray, M. & McDonald, C. (2006). Pursuing good practice: The limits of evidence-based practice. *Journal of Social Work, 6*(1), 7-20.

The More Things Stay the Same: A Report on the Mental Health Problems of Inmates in America's Jails and Prisons

By: R. Christian Griffin

Abstract

Since the "incarceration revolution" of the 1980's, studies have consistently documented the disproportionately high rates of mental health problems found among jail and prison inmates in the United States. This paper presents in a summary manner the scope of the problem of mental illness among America's incarcerated population. Specific attention is given to historical precipitants of the problem as well as implications for social work practice.

Introduction

In recent years, a number of studies have documented the disproportionately high rates of mental health problems found among America's jail and prison inmates (Teplin, 1994; Ditton, 1999; James & Glaze, 2006). The incarceration of people with mental health problems has been precipitated in large part by the deinstitutionalization movement of the 1960's and the incarceration revolution of the late 20th century (Human Rights Watch, 2003; Harcourt, 2006). Though the courts have mandated treatment for mentally ill inmates (Teplin, 1994; White & Gillespie, 2005), the actual responsibility for identifying mentally ill offenders and implementing treatment programs has often been left to corrections officials who are not adequately trained to address the mental health needs of many incarcerated individuals (Teplin, 1990; White & Gillespie, 2005).

The purpose of this paper is to highlight the disturbingly high rates of mental illness that continue to plague so many jail and prison inmates. Specific attention is given to the need for social workers and mental health professionals to effect positive change through providing services to, conducting research on, and advocating policy improvements regarding inmates with mental health problems. It is hoped that by disseminating this information to professionals concerned with the dignity and worth of every individual (NASW Code of Ethics), social workers will demand the reduction of needless human suffering among mentally ill inmates and work to bring about more efficient correctional facilities and healthier, safer communities.

The New Asylums

By all accounts, detention facilities have become the United States' premier warehouses for people

suffering from mental illness. However, primary data on the prevalence of mental illness in America's jails and prisons have been obtained by very few studies. In fact, Human Rights Watch (2003) reports, "there are no national statistics on historical rates of mental illness among the prison population" (p. 19). Over the past decade, the few studies that have produced data on persons with mental illness in America's jails and prisons have generated much discussion about the disturbingly high rates of mental illness, including severe mental illness such as psychosis, found among inmates. The mental health crisis that exists behind the bars of this nation's correctional institutions is an alarming phenomenon for which the data currently available to the public essentially speak for themselves. This report will begin with a presentation of those data in their purest form, along with a few methodological caveats and comments on the data by corrections and mental health professionals.

The most recent and most cited statistics on the mental health problems present among those in America's jails and prisons come from a study conducted by James and Glaze with the federal Bureau of Justice Statistics (BJS) entitled, "Mental Health Problems of Prison and Jail Inmates." Published in September 2006, the report enumerates a number of troubling findings regarding the mental health problems of inmates. One of the most alarming findings contained in the report is that "[a]t midyear 2005 more than half of all prison and jail inmates had a mental health problem" (p. 1). This population comprises "56% of state prisoners, 45% of federal prisoners, and 64% of jail inmates" (p. 1).

Of course, rates of mental illness are largely a product of the way that mental illness is defined by researchers. In 1999, for example, Ditton found that only 16 percent of jail inmates and state prisoners were mentally ill. In her study, however, mental illness was assessed through the use of two rather narrow criteria: Inmates had to report either suffering from a mental or emotional condition at the time of the survey or previously being admitted overnight to a mental hospital or treatment program. As described in the Bureau of Justice Statistics' 2006 study, James and Glaze defined mental health problems by more capacious criteria than Ditton. In their study, a mental health problem was defined as "a recent history or symptoms of a mental health problem" (p. 1). A recent history of a mental health problem was operationalized as one's receiving a clinical diagnosis and/or treatment by a mental health professional within

twelve months of the study. Symptoms of a mental health problem were based on the diagnostic criteria of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Furthermore, only symptoms indicative of major depression, mania, and psychotic disorders were assessed. All information was obtained through detailed interviews with "systematically selected" inmates. The BJS reports that its inmate surveys, which are conducted every five to six years, "are the only national source of detailed information on criminal offenders, particularly special populations such as drug and alcohol users and offenders who have mental health problems" (p. 11).

Other notable findings from the Bureau of Justice Statistics' (BJS) 2006 report include the following: 43% of state prisoners and 54% of jail inmates "reported symptoms that met the criteria for mania. About 23% of state prisoners and 30% of jail inmates reported symptoms of major depression" (p. 1). Approximately "15% of state prisoners and 24% of jail inmates reported symptoms that met the criteria for a psychotic disorder" (p. 1). In terms of aggregated symptoms of the mental health disorders assessed by the BJS, "Jail inmates had the highest rate of symptoms of a mental health disorder (60%), followed by state (49%), and federal prisoners (40%)" (p. 3). Additionally, approximately 24% of state prisoners, 21% of jail inmates, and 14% of federal prisoners were found to have "a recent history of a mental health problem" as defined in the preceding paragraph (p. 2).

Subsequent to the publication of the Bureau of Justice Statistics' 2006 report, several journalists captured the reactions of mental health professionals to the ostensibly surprising findings contained in the report. Michael J. Fitzpatrick, the executive director of the National Alliance on Mental Illness, was quoted in the *Washington Post* as calling the report's findings "both a scandal and national tragedy" (Sniffen, 2006, para. 4). He also admitted, "The study reveals that the problem is two to three times greater than anyone imagined." The Bazelon Center for Mental Health Law told *The Nation's Health* that the report indicated the "numbers have increased significantly, with serious implications for taxpayers and public safety and for the lives of the individuals and their families" (Krisberg, 2006, p. 24). Yet, in the same article, Kim Krisberg observed, "While the [BJS'] report represents the first time in five years that such data has *[sic]* been available, the news that mental health problems abound inside the nation's correctional system is far from new" (p. 1).

Indeed, the Bureau of Justice Statistics' September 2006, report was definitely not the first study to find a disproportionately high rate of mental illness

among jail and prison inmates. In fact, over the past decade, researchers have consistently documented a harrowing percentage of mentally ill individuals among those detained in America's correctional facilities. By 1997, the National GAINS Center had concluded that prisoners suffer from serious mental illness at "three to five times the rate" of people in the community and are approximately four times more likely than the average person to have schizophrenia (National GAINS Center, 1997). In 1999, Pinta conducted a meta-analysis of eight studies that had been rigorously designed to assess prevalence rates of mental illness among prisoners. The study found "on average that 18 percent of inmates have serious disorders such as schizophrenia, bipolar disorder, or major depression at some point in their lives and 15 percent have current (within the past year) disorders" (Hills, Siegfried, & Ickowitz, 2004, p. 4). In 2003, Human Rights Watch concluded that the Los Angeles County and Cook County jails had become "two of the largest mental health providers in the country." Likewise, the Council of State Governments (2002) reported, "The Los Angeles County Jail, the Cook County Jail (Chicago) and Riker's Island (New York City) each hold *[sic]* more people with mental illness on any given day than any psychiatric facility in the United States" (Fact Sheet).

In 2006, the Commission on Safety and Abuse in America's Prisons included in its report, *Confronting Confinement*, that the "most conservative estimates of prevalence – 16 percent – means that there are at least 350,000 mentally ill people in jail and prison on any given day. . . Other estimates of prevalence have yielded much higher rates, even of 'serious' mental disorders – as high as 36.5 percent or 54 percent when anxiety disorders are included. . . These prevalence rates are two to four times higher than rates among the general public. . . They reflect what many witnesses told the Commission: *that prisons and jails have replaced state psychiatric hospitals as the institutions that house and care for persons with mental illness* (italics added)" (Commission on Safety and Abuse in America's Prisons, 2006, p. 43).

Similarly, White and Gillespie (2005) observed that "many experts argue that the criminal justice system is now the last resort provider for many hard-to-serve clients and is fast becoming the de facto mental health treatment resource for the nation's poor and disadvantaged" (p. 109). As one former corrections official succinctly stated the problem, "Detention facilities have, in

fact, become the new asylums" (Commission on Safety and Abuse in America's Prisons, 2006, p. 43).

One of the most glaring findings in the research mentioned above is the disheartening disparity in the prevalence of mental health problems among jail and prison inmates and the number of mentally ill inmates who have received treatment. In the study by James and Glaze (2006), for example, while approximately 60 percent of jail inmates and 50 percent of state prisoners reported "symptoms of a mental health disorder," only 21 percent of jail inmates and 24 percent of state prisoners indicated that they had a "recent history of a mental health problem," which would include contact with a mental health professional within the twelve months immediately preceding the study. These findings were consistent with a previous study conducted by the BJS which found that in 2000, only 10 percent of state inmates had received psychotropic medications and only 13 percent had attended some kind of mental health therapy or professional counseling (Beck & Maruschak, 2001). There is a clear need, then, for social workers to both provide direct services to inmates with mental health problems and advocate for improvements in the delivery of mental health treatment in America's jails and prisons.

From Institutionalization to Criminalization

Two major social movements have greatly contributed to the high rates of mental illness found among jail and prison inmates: the deinstitutionalization movement of the 1960's and the incarceration revolution of the late 20th century. The former included a drastic reduction of state psychiatric services as well as the failure of community mental health programs to effectively replace the psychiatric institutions that were being dismantled (Hills, Siegfried, & Ickowitz, 2004). Several factors precipitated the deinstitutionalization movement. Among them were the development of anti-psychotic medications, which introduced the prospect of successful psychiatric treatment taking place outside of mental hospitals, and increased litigation aimed at safeguarding the due process rights of persons involuntarily committed to mental hospitals (Human Rights Watch, 2003). Just before the deinstitutionalization movement began, approximately 339 out of every 100,000 Americans were institutionalized in a mental hospital. By 1998, the number had dropped to just 29 out of every 100,000 (Human Rights Watch, 2003). It would be a mistake, however, to assume that the abrupt decrease in the number of persons committed to mental hospitals represented a similarly abrupt drop in the overall number of institutionalized persons with mental illness.

As Harcourt (2007) observes, "Over the past 40 years, the United States dismantled a colossal mental health complex and rebuilt – bed by bed – an enormous prison. During the 20th century we exhibited a schizophrenic relationship to deviance" (A15). In other words, as Americans became increasingly "tough on crime," many individuals with severe mental health problems were shifted from state hospitals to jails and prisons. In 2006, Harcourt conducted a study that examined aggregate rates of institutionalization in the United States from 1928 to 2000. In it, he combined the number of people institutionalized in asylums and mental hospitals with the number of those incarcerated in state and federal prisons in order to posit a rate of aggregated institutionalization. The aggregated rate yields a more accurate representation of historical rates of institutionalization than examining either mental hospitalization or incarceration alone. Harcourt found that while an abrupt spike in incarceration has occurred since the "incarceration revolution of the late 20th century...the highest rate of aggregated institutionalization during the entire period [from 1928 to 2000] occurred in 1955 when almost 640 persons per 100,000 adults over age 15 were institutionalized in asylums, mental hospitals, and state and federal prisons" (Harcourt, 2006, p. 1751). Stated simply, although the incarceration revolution did yield a precipitous increase in the number of incarcerated Americans, resulting in the highest rate of incarceration in the world, by 2002, the aggregated rate of institutionalization had only risen to just below the aggregated rate for 1955. These figures suggest that "individuals who used to be tracked for mental health treatment are now getting a one-way ticket to jail" (Harcourt, 2007, p. A15).

Other researchers have similarly observed that mentally ill offenders are often arrested and detained because of behaviors caused by their mental disorders. Watson, Hanrahan, Luchins, and Lurigio (2001) observed that mentally ill individuals who interact with the police are more likely than other individuals to be arrested. Some police officers, often under pressure from local businesses, are even known to "clean the streets" of people who display certain undesirable behaviors (Treatment Advocacy Center, 2007). "Mercy bookings" are also somewhat commonly practiced by the police and are ostensibly done for the protection of severely mentally ill individuals (Treatment Advocacy Center, 2007).

Clearly, the deinstitutionalization movement and the incarceration revolution have led to the criminalization of many people suffering from severe mental health problems. This outcome is an unfortunate leap from the promises of those who advocated for and encouraged deinstitutionalization. Proponents of the deinstitutionalization movement envisioned a system of

community mental health programs as ensuring the successful transition of persons with mental illness from mental hospitals to their communities (Human Rights Watch, 2003). This vision, however, has never been fully realized. In fact, America's current mental health service and delivery system is notoriously fragmented and seemingly unable to address the needs of many of the most vulnerable Americans with mental illness. In its 2003 report to President George W. Bush, the New Freedom Commission on Mental Health stated, "...the mental health delivery system is fragmented and in disarray...lead[ing] to unnecessary and costly disability, homelessness, school failure and incarceration" (p. 3). Similarly, Michael J. Fitzpatrick of the National Alliance on Mental Illness laments, "The mental health system is failing long before people enter the criminal justice system and after they leave it" (Sniffen, 2006, para. 5).

The New Freedom Commission (2003) attributes the ineffectiveness of the current mental health delivery system to such problems as stigma surrounding mental illness, unnecessarily long periods of time between the discovery of effective forms of treatment and the implementation of the treatment into routine patient care, a lack of coordination between primary care physicians and mental health professionals, and high unemployment and other disabilities that often accompany the presence of a mental illness. These and other problems perpetuate the fragmentation of community mental health care systems, with the result that "all too many people who need publicly financed mental health services cannot obtain them until they are in an acute psychotic state and are deemed to be a danger to themselves or others" (Human Rights Watch, 2003, p. 21).

Human Rights Watch (2003) reports that "there is a direct link between inadequate community mental health services and the growing number of mentally ill who are incarcerated" (p. 23). People with mental illness are often left untreated and unhelped for so long that they experience severe mental deterioration and consequently become entangled in the criminal justice system (Human Rights Watch, 2003). Where criminal behavior is the result of mental illness, access to adequate community resources may act as a buffer between an individual with mental illness and the criminal justice system.

In recent years, economic factors have also contributed to the high levels of mental illness among jail and prison inmates. Restrictive insurance and managed care plans prevent some people from receiving needed mental health services (Hills, Siegfried, & Ickowitz, 2004). Furthermore, persons with severe mental disorders are over-represented in America's homeless population—approximately 20 to 33 percent of homeless people have a severe mental illness—and are thus too poor

to access even the most basic mental health services (Human Rights Watch, 2003). Additionally, many states may encounter economic incentives that encourage them to deal with severely mentally ill offenders through the correctional system rather than state hospitals (Human Rights Watch, 2003). Treating individuals in state hospitals is much more expensive than detaining them in prison. For some severely mentally ill people, prison may even provide an alternative to homelessness and a rare opportunity for mental health treatment.

The factors that have precipitated our nation's jails and prisons becoming the new asylums are complex and must be addressed through policies aimed exclusively at the hope of recovery for the severely mentally ill. As articulated in *Confronting Confinement* (2006), "Our jails and prisons should not have to function as mental institutions. As a society, we need to expand and improve community-based treatment for persons with mental illness" (p. 46). The following section will examine the reasons social workers and other mental health professionals should urge policy-makers to address the needs of incarcerated persons with mental illness. It will also review some recent actions taken to address the problem of severe mental illness among jail and prison inmates.

For Them and For Us: Why We Should Care about the Incarcerated Mentally Ill

In recent years, a number of diversion programs aimed at reducing the incarcerations of offenders with mental illness and/or substance abuse problems have burgeoned across the United States. These programs have been developed in large part because of the public's growing awareness of the expenses associated with the incarceration of non-violent offenders (Human Rights Watch, 2003). Drug courts, for example, have been established across the country to preclude the incarceration of low-level drug offenders and channel the offenders into substance abuse treatment programs. By 1997, there were more than 300 drug courts in 48 states, and the courts had produced promising results through the reduction of criminal behavior, drug use, and costs (Watson et al., 2001).

Subsequent to auspicious results produced by drug courts, several communities began to consider ways of diverting mentally ill offenders from jail and prison (Watson et al., 2001; Harvard Mental Health Letter, 2006). In 1997, Florida established the first mental health court, and currently, there are more than 100 mental health courts in the United States (Harvard Mental Health Letter, 2006). While mental health courts vary from state to state, they all share several basic features. As outlined by Watson and her colleagues (2001), all mental health courts:

handle only cases involving offenders with mental disorders. The judge, prosecutor, defense attorney, and other court staff often have special training in and are familiar with community mental health services. Court staff collaborate with community providers to implement a therapeutic intervention that may include medication management, substance abuse treatment, housing, job training, and psychosocial rehabilitation. Defendants can have their charges or jail sentences deferred if they agree to participate in services. The goal is to prevent criminalization and recidivism by providing critical mental health services (p. 477).

Evaluations of mental health courts have yet to produce conclusive results. While some studies of mental health courts have yielded promising findings, none have been controlled studies with random assignment (Harvard Mental Health Letter, 2006). As mental health courts continue to grow, there is much hope that they will be an effective tool in the diversion of low-level offenders with mental illness.

It is beyond the scope of this paper to further evaluate the varied attempts by policy-makers and legal and mental health professionals to prevent the incarceration of mentally ill offenders. Moreover, however successful they may be, diversion programs do not address the disproportionately high rate of mental health problems experienced by currently incarcerated jail and prison inmates. There are several reasons social workers, as well as the general public, should be concerned with the plight of the extant incarcerated mentally ill. These reasons can be divided into two groups—"for them" and "for us"—though there is clearly a good deal of overlap between the two.

For Us

Incarcerating people with mental illness is expensive. According to the Council of State Governments (2002), mentally ill offenders "stay in jail longer than other people do... [are] extremely expensive to keep [there] ... and after release they are likely to return to incarceration" (Fact Sheet). In Orange County, Florida, for example, the average inmate stays in jail for 26 days, but the average stay for an inmate with mental illness is 51 days (Council of State Governments [CSG] Fact Sheet, 2002). In Los Angeles County, 90 percent of mentally ill inmates are repeat offenders, and approximately 31 percent of mentally ill offenders "have been incarcerated 10 or more times" (CSG Fact Sheet, 2002).

Similarly, in 2006, James and Glaze found that state prisoners with mental health problems reported receiving sentences that were on average five months longer than state prisoners without mental health problems. They also reported that 25 percent of state prisoners with a mental health problem and 26 percent of jail inmates with a mental health problem "had served 3 or more prior incarcerations" (p. 8) compared with 19 and 20 percent of prison and jail inmates, respectively, without mental health problems. A fact sheet provided by the Treatment Advocacy Center (2007) corroborates the staggering expenses associated with the incarceration of persons with mental illness by pointing out that it costs approximately \$50,000 to incarcerate inmates identified as suffering from a psychiatric disorder. In contrast, the average cost of incarceration in the state of California is \$30,929 per inmate per year (Aker, 2006). In Pennsylvania, the daily cost of incarcerating an identified mentally ill inmate, including medications and mental health treatment, is almost double the daily cost of incarcerating an inmate without a mental illness (Human Rights Watch, 2003). Given the proclivity of inmates with mental illness to re-offend at higher rates than other inmates, and since incarcerating offenders with mental illness is disproportionately expensive, American taxpayers clearly have much to gain by providing mentally ill inmates with treatment options aimed at permanently ameliorating their mental health problems.

Another reason that Americans should be concerned about the mental health of jail and prison inmates is that the vast majority of them will return to their communities after completing their sentences. Hills, Siegfried, and Ickowitz (2004) state that 95 percent of all prisoners return to the community. The health and safety of America's communities, then, are linked to the rehabilitative options offered to inmates with mental illnesses. As described by the Council of State Governments (2002), "Screening inmates for mental illness, delivering effective services, providing appropriate housing, and developing a comprehensive treatment plan improve the likelihood that an inmate with mental illness will return to the community (and to his or her loved ones) healthy and safely" (p. 127). Ensuring that mentally ill offenders receive much-needed mental health services during their incarcerations helps to ensure the eventual safety and health of the communities to which those inmates will return.

For Them

Inmates with mental illness face a disproportionately high number of obstacles in jails and prisons. These obstacles interfere with both the inmates' person-

al lives and the ability of corrections officials to operate detention facilities well. Addressing the unique problems encountered by inmates with mental illness, then, affords Americans the opportunity to reduce needless human suffering and increase the capacity of corrections officials to meet the goals of incarceration—ensuring security and safety.

James and Glaze (2006) report that inmates with a mental illness are more likely than inmates without to be charged with rule violations and injured in fights. For example, 19 percent of jail inmates with a mental health problem, compared with 9 percent of those without, reported having been charged with violating a facility rule. Since their admissions, 9 percent of jail inmates with a mental health problem, compared to 3 percent of jail inmates without a mental health problem, “had been injured in a fight” (p. 10).

Similarly, in 2003, Human Rights Watch found that mentally ill prisoners are often vulnerable to abuse by other prisoners. They also note that “male and female mentally disordered prisoners are disproportionately represented among the victims of rape” (p. 57). In its report, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness*, Human Rights Watch concluded that the mental illnesses of many prisoners cause their behavior to be interpreted as incomplicant and/or defiant by corrections officials. “Prisoners with mental illness may find it difficult, if not impossible, to comply consistently with prison rules. Some exhibit their illness through disruptive behavior, belligerence, aggression, and violence” (p. 59). Inmates with a severe mental illness such as schizophrenia often “display predictable deficits in behavioral and emotional control” (p. 59). However, “such rule violations, even if the result of mental illness, are routinely punished...Numerous studies report that the mentally ill have higher than average disciplinary rates” (p. 59).

Inmates with mental illness may also present a heightened risk of suicide (Commission on Safety and Abuse in America's Prisons, 2006; White & Gillespie, 2005). As observed by the Commission on Safety and Abuse in America's Prisons (2006), mentally ill prisoners frequently display behaviors construed by corrections officials as necessitating segregation from the general inmate population. Segregation, however, is particularly difficult for inmates with severe mental illnesses to cope with. “In fact, many completed suicides occur in segregation and are committed by offenders with mental illness” (White & Gillespie, 2005, p. 109). A national study of U.S. jails in 1986 found that two-thirds of suicides in the jails examined were committed by inmates detained in a control unit (Commission on Safety and Abuse in America's Prisons, 2006).

The above-mentioned findings all underscore

the significant personal difficulties encountered by detainees with mental health problems. They also depict a correctional environment in which the dignity and worth of mentally ill offenders are severely compromised. For social workers, whose code of ethics specifically recognizes the “dignity and worth of the person,” (NASW Code of Ethics, p. 1) the personal effects of detention facilities on detainees with mental health problems present a salient impetus to work for change. While conceding that some offenders deserve to be incarcerated and in fact must be held in detention facilities in order to protect the public, social workers must also responsibly stand for the dignity and worth of every mentally ill offender and demand that attention be given to the reduction of needless human suffering.

Social Work Implications

With respect to professional obligations, the implications of social workers' concern for the dignity and worth of inmates with mental health problems spans all levels of practice. Perennial threats to funding for mental health treatment in jails and prisons, for example, provide opportunities for social workers to advocate for inmates at the macro-level. Since policy-makers regularly review and occasionally bolster extant treatment programs, social workers must intervene at the policy level to demand the proper treatment of mentally ill detainees. Organizations committed to human rights, such as Human Rights Watch, often act as media for the entrance of social workers into the world of policy-making. At the mezzo-level, social workers may address the problem of mental illness among inmates by becoming involved in programs that currently exist to meet the needs of detainees. Extant treatment programs in jails and prisons are chronically under-staffed, leaving an unfortunate dearth of competent, caring mental health professionals. Given their comparatively broad training, social workers are well situated to “fill the gaps” that often plague treatment programs in correctional facilities.

The problems faced by inmates with mental illness should not only cause concern for social workers, however; they should concern Americans from every community and profession. As mentioned above, the mental health of those detained in America's jails and prisons is inextricably tied to the values of all Americans and the safety of their communities. Yet despite all of the obvious reasons to provide adequate mental health treatment in America's jails and prisons, only 34 percent, 24 percent, and 17 percent, respectively, of state prisoners, federal prisoners, and jail inmates with a mental health problem report receiving any kind of mental health treatment since their admissions to correctional facilities

(James & Glaze, 2006). Of those who do receive treatment, the most common form of treatment is taking a prescribed medication (James & Glaze, 2006). Sadly, only 22.6% of state prisoners and 7.3% of jail inmates reported receiving some kind of professional mental health therapy since being admitted to the facilities where the surveys were conducted (James & Glaze, 2006).

The Council of State Governments (2002) has enumerated several recommendations for improving the mental health treatment of inmates with mental illness. These recommendations include improving screening for mental illness upon admission, bolstering individualized treatment plans, and periodically evaluating inmates for signs of mental health problems. These recommendations provide a good framework for the implementation of more effective mental health treatment programs in jails and prisons.

Specialized mental health units such as intermediate care programs within jails and prisons also provide policy-makers and corrections officials with a way to address the mental health problems of inmates (Hills, Siegfried & Ickowitz, 2004). These therapeutic communities allow mentally ill inmates to be sheltered from harmful conditions of confinement while receiving intensive mental health services. Research on specialized

mental health units has yielded promising results regarding their effectiveness in reducing institutional problems and improving the lives of mentally ill inmates.

Conclusion

In conclusion, research on the mental health problems of America's jail and prison inmates over the last couple of decades has made one thing very clear: The more things stay the same, the more social workers must demand change! For social workers, addressing the mental health problems of America's detainees presents a unique opportunity to work for change at all levels – micro, mezzo, and macro – of practice. For all of the reasons given above, there is much at stake in this work. Like all epic struggles, the perennial foes (e.g., bureaucracies, financial restraints) are ever present in this battle. Also present, however, are those ideals that have guided social workers since the inception of their profession, including our belief in the dignity and worth of every human being. From providing direct clinical service to conducting rigorous research evaluating treatment programs, social workers must spearhead the call for policy-makers and corrections officials to implement practices that fully embrace the dignity and worth of America's detainees with mental health problems.

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References

- Aker, E. (2006, July 5). The Business of Punishment. *Policy Today*. Retrieved on April 23, 2007, from www.policytoday.com/index.php?option=com_content&task=view&id=79&Itemid=40
- Beck, A.J., & Maruschak, L.M. (2001). *Mental health treatment in state prisons, 2000*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.
- Commission on Safety and Abuse in America's Prisons. (2006). *Confronting confinement*. Washington, DC: Vera Institute of Justice. Retrieved on February 3, 2007, from www.prisoncommission.org/pdfs/Confronting_Confinement.pdf
- Council of State Governments. (2002). *Criminal justice/Mental health consensus project*. Retrieved on February 17, 2007, from http://consensusproject.org/topics/the_report
- Council of State Governments. (2002). *Fact Sheet: Mental Illness and Jails*. Retrieved on February 17, 2007, from http://consensusproject.org/downloads/facts_jails.pdf
- Ditton, P.M. (1999). *Mental health and treatment of inmates and probationers*. Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics.

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- Harcourt, B.E. (2006). From the asylum to the prison: Rethinking the incarceration revolution. *Texas Law Review*, 84, 1751-1786.
- Harcourt, B.E. (2007, January 15). The mentally ill, behind bars. *New York Times*, p. A15.
- Harvard Mental Health Letter. (2006). *Mental health courts*. Boston, MA: Harvard Health Publications.
- Hills, H., Siegfried, C., & Ickowitz, A. (2004). *Effective prison mental health services: Guidelines to expand and improve treatment*. Washington, D.C.: U.S. Department of Justice, National Institute of Corrections.
- Human Rights Watch. (2003). *Ill-Equipped: U.S. prisons and offenders with mental illness*. New York: Human Rights Watch.
- James, D. J., & Glaze, L.E. (2006). *Mental health problems of prison and jail inmates*. Washington, D.C.: U.S. Department of Justice, Bureau of Justice Statistics.
- Krisberg, K. (2006). Serious mental health problems prevalent among U.S. inmates. *The Nation's Health*, 36(9), 1-24.
- National GAINS Center. (1997). *The prevalence of co-occurring mental and substance abuse disorders in the criminal justice system*. Just the Facts Series. Delmar, N.Y.: National GAINS Center.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America. Final report*. Rockville, MD: Department of Health and Human Services Pub. No. SMA-03-3832. Retrieved on April 2, 2007, from <http://www.mentalhealthcommission.gov/reports/reports.htm>
- Sniffen, M.J. (2006, September 6). Prisons lacking mental health treatment. *Washington Post*. Retrieved March 14, 2007, from <http://www.washingtonpost.com/wp-dyn/content/article/2006/09/06/AR2006090601629.html>
- Teplin, L. (1990). Detecting disorder: The treatment of mental illness among jail detainees. *Journal of Consulting and Clinical Psychology*, 58(2), 233-236.
- Teplin, L. (1994). Psychiatric and substance abuse disorder among male urban jail detainees. *American Journal of Public Health*, 84(2), 290-293.
- Treatment Advocacy Center. (2007). *Fact sheet: Criminalization of Americans with severe mental illnesses*. Retrieved on April 5, 2007, from <http://www.psychlaws.org/GeneralResources/fact3.pdf>
- Watson, A., Hanrahan, P., Luchins, D., & Lurigio, A. (2001). Mental health courts and the complex issue of mentally ill offenders. *Psychiatric Services*, 52(4), 477-481.
- White, T.W., & Gillespie, E. (2005). Mental health programs: Addressing the unfunded mandate. *Corrections Today*, 67(6), 108-115.

Racial Disparities in the Age of Diagnosis of Autism Spectrum Disorder: Examining Factors That May Contribute to Delayed Diagnosis in African-American Children

By Deresha D. Gibson

Abstract

Autism is a neurobiological disorder that affects approximately 1 child in 150 and occurs equally across demographic groups. While there is a similar rate of occurrence among African-American children and Caucasian children, there is a disparity in the age of diagnosis between the two groups. African-American children are likely to be diagnosed 1.5 years later than Caucasian children. Because it is critical to the long-term outcomes of children with autism to be diagnosed as early as possible and to participate in interventions, it is imperative that the reasons for this later diagnosis of African-American children be understood and action be taken to eliminate this disparity. This paper will identify possible factors that may contribute to the disparity in age of diagnosis between African-American and Caucasian children, make recommendations for intervention and policy, and discuss implications for social workers.

Introduction

A recent study released by the Centers for Disease Control and Prevention calls Autism Spectrum Disorder (ASD) a continuing public health concern (Centers for Disease Control and Prevention, 2007a). Autism, a neurobiological disorder of development, has been described as a “national crisis” and is the fastest growing disability in the United States, with approximately one child diagnosed with autism every twenty minutes (Autism Speaks, 2007). Rates of autism have increased from 1 child in every 166 to 1 child in every 150 as reported in January 2004 (Centers for Disease Control and Prevention, 2007b).

Although autism has a similar prevalence rate for African-American and Caucasian children, a disparity in the age of diagnosis has been identified for these two populations (Mandell, Listerud, Levy, & Pinto-Martin, 2002). It is important that the reasons for this disparity are identified so children can begin necessary interventions as soon as possible. This paper will examine factors that may contribute to late diagnosis in African-American children, make recommendations for intervention and policy, and discuss implications for social workers.

Prevalence and Diagnosis of Autism

Autism falls under the umbrella of Pervasive

Developmental Disorders (PDD) which includes conditions such as Rett’s Disorder, Childhood Disintegrative Disorder, and Asperger’s Disorder. Pervasive Developmental Disorders share the characteristics of a delay in the development of social skills, language and communication, and behavioral repertoire. According to the American Psychiatric Association (2000), autism is the most well known of the PDD’s and is characterized by sustained impairment in comprehending and responding to social cues, aberrant language development and usage, and restricted, stereotypical behavioral patterns. The American Academy of Pediatrics (2001) writes:

Children with autism demonstrate behaviors and skills that span a broad continuum extending from very mild peculiarities to severe developmental challenges. It is now known to be a very heterogeneous disorder, with milder forms being more common than the classic form. Although clinical patterns vary depending on severity, all children with autism demonstrate some degree of qualitative impairment in reciprocal social interaction, qualitative impairment of communication, and restricted, repetitive, and stereotypic patterns of behaviors, interests, and activities. Because of qualitative and quantitative variations in symptoms, autism is often referred to as autistic spectrum disorder (ASD) (p. 1221).

Autism knows no racial, ethnic, or social boundaries. “Family income, lifestyle, and educational levels do not affect the chance of autism’s occurrence” (Dyches, Wilder, Sudweeks, Obiakor, & Algozzine, 2004, p. 212); however, a difference in the occurrence of autism between genders has been found, with autism affecting one girl for every four boys. A study on the prevalence of autism found that prevalence rates were remarkably similar when examined by race, but a predominance of males was found in each racial category (Yeargin-Allsop et al., 2003). Because of the racial homogeneity of the children included in published studies, little has been done to specifically examine the prevalence of autism by race. In one study of 987 Caucasian and African-American children, it was found that the prevalence of autism did not vary by race, even within race and sex subgroups (Yeargin-Allsopp, Rice, Karapurkar, Doernberg, Boyle &

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Murphy, 2003).

Autism is believed to have a genetic component as the underlying cause of the disorder with possible environmental triggers, but its exact etiology is not known. Collins, Ma, Whitehead, Martin, Wright, Abramson, et al. (2006) found that the malfunctioning of two receptor genes, GABRB1 and GABRA4, contribute to autism susceptibility among African-Americans and Caucasians. Although the susceptibility is the same, evidence suggests that some autistic characteristics, such as “indicators of language development, may be more severe in African-Americans, compared to non-Hispanic Caucasians” (Collins et al., 2006, p. 168). Researchers have also looked at possible neurological, environmental, and immunization links, but nothing conclusive has been found to cause autism (American Academy of Pediatrics, 2001).

Although much is still unknown about the cause(s) of autism, a body of knowledge has been accumulating on the diagnosis and treatment of autism. Autism can be diagnosed as early as 18 months of age. A child may exhibit autistic behaviors in infancy or develop normally for a year or more and then begin to exhibit autistic behaviors. Autism typically comes to the attention of a pediatrician from parents sharing their concerns and/or observing delays in the child meeting developmental milestones. A screening tool may be used and further testing can be done if autism is suspected. The process of diagnosing ASD entails a comprehensive evaluation by a medical team, including a psychologist, neurologist, psychiatrist, and speech, developmental, and occupational therapists. The process of identifying and diagnosing children early is critical as “early diagnosis resulting in early, appropriate, and consistent intervention has . . . been shown to be associated with improved long-term outcomes” (American Academy of Pediatrics, 2001, p. 1223).

Once children have been appropriately diagnosed with ASD, they and their families can have access to and receive appropriate services and interventions to improve outcomes for children and to help families cope with the disabling effects of autism, which can be a constant source of stress on a family system (Mandell et al., 2002; Higgins, Bailey, & Pearce, 2005). Beginning at the age of three, children diagnosed with ASD are covered under the Individuals with Disabilities Education Act (IDEA) and are eligible to receive services through the public education system for special education and related services (Mandell et al., 2002). Children under the age of three are eligible for the Early Intervention Program, which identifies children with developmental delays and works with them to improve their skills in the areas where they are deficient. Other interventions may be in the areas

of speech, communication, or sensory processing. Services received in Early Intervention can be continued in the public school system.

Despite the increasing ability to identify the early signs of ASD, knowledge of the benefits of identifying and treating children with ASD early, and the general growing awareness of this set of disorders, children with ASD often do not receive a diagnosis until they enter elementary school (Mandell, Novak, & Zubritsky, 2005). Although no significant difference in prevalence of autism among African-Americans and Caucasian children has been found, a study of 406 Medicaid-eligible children found that African-American children with ASD received a diagnosis an average of 1.5 years later than Caucasian children did (Mandell et al., 2002). In this study, Caucasian children received a diagnosis at an average of 6.3 years of age and African-American children at an average of 7.9 years of age (Mandell et al., 2002). Although there may be several reasons for the delay in diagnosis of ASD in children in the general population, the disparity in the age of diagnosis between African-American and Caucasian children is disturbing and necessitates further examination.

Factors Contributing to the Disparity in Age of Diagnosis

There are a number of factors that may contribute to African-American children being diagnosed with ASD 1.5 years later than Caucasian children. Misdiagnosis, pediatrician-parent relationships, access to health care, and biases of healthcare providers have been studied and discussed in the literature as factors contributing to the delay in diagnosis of African-American children.

The misdiagnosis of autism seems to be a factor contributing to a delay in the diagnosis of ASD in general, but particularly to the later diagnosis of ASD in African-American children. Symptoms common to autism, such as delayed speech, poor response to others, and behavioral difficulties, can lead to a misdiagnosis of language impairment or Attention Deficit/Hyperactivity Disorder (ADHD). In older children, repetitive behavior may steer clinicians toward a diagnosis of Obsessive-Compulsive Disorder and non-compliance related to resistance to change may lead clinicians to diagnose Oppositional Defiant Disorder (Mandell, Ittenbach, Levy, & Pinto-Martin, 2006). Mandell et al. (2006) examined the disparities in the diagnosis of children with autism using insurance claims of 406 Medicaid-eligible children, including 242 African-American, 118 Caucasian, 33 Latino, and 13 children falling into other categories. They found that African-American children were three times more likely than Caucasian children to receive another

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diagnosis first and were 2.6 times less likely than Caucasian children to receive an autism diagnosis on their first specialty care visit (Mandell et al., 2006). Once African-American children entered treatment, they required three times the number of visits over a period three times as long as Caucasian children before receiving an autistic disorder diagnosis (Mandell et al., 2006).

African-American children were also 5.1 times more likely than Caucasian children to receive a diagnosis of Adjustment Disorder than of ADHD, and 2.4 times more likely to receive a diagnosis of Conduct Disorder than of ADHD (Mandell et al., 2006). Diagnosing children with Adjustment Disorder may allow clinicians more time to evaluate a child, enable reimbursement for services and the opportunity to see the child again. Clinicians may diagnose Conduct Disorder when they interpret the child's behavior as disruptive or aggressive or see other characteristics associated with Conduct Disorder manifested in the child's behavior (Mandell et al., 2006). Mandell et al. (2006) state,

...the more frequent diagnosis of Conduct Disorder among African-Americans may be associated with clinicians' erroneous beliefs regarding the higher prevalence of Conduct Disorder among African-American children, while the more frequent diagnosing of Adjustment Disorder among all groups other than Caucasian children may be the result of clinicians' misinterpretations of parental concerns (p. 1483).

The quality and continuity of pediatrician-parent relationships is another factor contributing to the disparity in age of diagnosis between African-American and Caucasian children. "Early diagnosis of ASD is challenging in the context of primary care visits, because there is no . . . laboratory test to detect it" (American Academy of Pediatrics, 2001, p. 1221). If a pediatrician consistently sees the same child and has a relationship with the parents, identifying atypical behavior may be easier. Mandell et al. (2005) found that children who had four or more primary care physicians before diagnosis received a diagnosis an average of 0.5 years later than children who had one primary care physician. "Children who were referred to a specialist in response to parental concerns received a diagnosis an average of 0.3 years earlier than other children" (Mandell et al., 2005, p. 1483). Having many primary care physicians may be related to poor access to healthcare that results in discontinuity of care and misdiagnosis. As reported by Weinick and Krauss (2000),

studies have shown that Black and Hispanic children are more likely to lack a usual

source of care and less likely to have an office-based source of care than are White children . . . Black and Hispanic children are more likely than White children to be uninsured . . . Children without health insurance are more likely to lack a usual source of care, a regular clinician, and access to after-hours medical care than those with coverage (p. 1771).

Because children with autism manifest a complex array of deficits in communication and social interaction skills as well as behavior patterns, obtaining an accurate diagnosis is often the culmination of a long and protracted evaluation period, including the efforts of multiple professionals from a variety of disciplines (Seltzer, Krauss, Orsmond, & Vestal, 2000). If African-American children are more likely to not have access to healthcare, experience greater discontinuity in healthcare, and/or are more likely to see multiple primary care physicians, the opportunity for a provider to make an accurate and timely diagnosis is greatly jeopardized.

Physician bias is another possible factor contributing to the disparity of diagnosing ASD in African-American children. Since cultural factors are intertwined with thoughts and behaviors and can contribute to bias, culture may assume a major role in the way physicians see and respond to deviations in their patients' development and may influence the extent to which they subscribe to assessment, diagnosis and intervention strategies (Mandell & Novak, 2005). A family's culture and a physician's lack of knowledge about that culture could contribute to a child being misdiagnosed.

Clinicians may be influenced in their decision to screen for ASD in African-American children due to having different expectations about treatment and service needs by ethnicity and may therefore not screen for ASD as quickly as they would among Caucasian children (Mandell & Novak, 2005). "Physicians may also more quickly discount the concerns of African-American parents than they do the concerns of white parents related to their children's developmental delays, or not elicit those concerns in the first place" (Mandell & Novak, 2005, p. 112). Cooper-Patrick et al. (1999) found, in 32 primary care practices, that African-Americans rated their visits as significantly less participatory than Caucasians did. This could be due to racial and ethnic differences between physicians and their patients (Cooper-Partrick et al, 1999).

There may also be a bias on the part of the professional related to the notion of socioeconomic status (SES) as a relevant etiologic consideration for autism. Although it is clear that SES is not a determinant as to whether a child has autism, it may play a factor in

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whether a physician screens for ASD. Cuccaro et al. (1996) writes,

An alternative hypothesis involves the ambiguity of low SES and how clinicians factor in the contributions of disadvantage. In a low SES context, there may be a preponderance of biopsychosocial factors which could explain observed behaviors. In a high SES context, the number of possibilities is diminished as children born in “advantaged” settings are more likely to have had adequate environmental supports (p. 468).

This bias may determine how a physician reacts to parents’ concerns about their child’s development. Sociodemographic factors might also influence who gets evaluated for developmental concerns, how these concerns are documented, how soon a child is referred for specialty services, and who participates in studies (Mandell et al., 2002).

Implications for Social Workers

Due to the rise in the number of cases of autism and the importance of early diagnosis and treatment, it is crucial that social workers become more knowledgeable about ASD and be aware of the disparity in age of diagnosis of African-American children and the factors that contribute to this disparity. Social workers are often in positions to identify and screen children for ASD, educate other professionals, advocate on behalf of children and families, and influence and develop policies to ensure appropriate and timely diagnosis and treatment of ASD and equitable care for African-American children. Because of social workers’ training and sensitivity to racial and socioeconomic factors, they are well positioned to respond to the disparity in age of diagnosis of African-American children and take steps to close the gap. Social workers are also well positioned, once children have received a diagnosis, to be culturally sensitive when intervening with children who have been diagnosed with ASD. It is also essential that social workers help families understand the life-long impact of autism and ensure that children and families are receiving culturally appropriate care, and that all available services and social supports are being used to help families cope (Newsome, 2000). “Intervention in the form of information at the family level may be an appropriate policy response, par-

ticularly among harder-to-reach subpopulations, such as those with lower incomes or lower literacy” (Porterfield & McBride, 2007, p. 328).

Social workers can also contribute to the understanding of both the disparity in the age of diagnosis of African-American children as well as the experiences of African-American families and children who have been diagnosed with ASD by conducting research targeted specifically to African-Americans and other communities of color. Despite autism being recognized as a disorder that knows no racial, ethnic, or social boundaries, the majority of research has ignored or minimized race, and autism studies that specifically target African-Americans are rare (Dyches et al., 2004; Collins et al., 2006). Few studies look at the impact autism has on African-American families and, although it is clear there is a disparity in the age of diagnosis, there is only speculation as to why. It seems researchers have attempted to generalize their findings to a population that deserves to be studied independently. Social workers can contribute to the body of knowledge on ASD by conducting research that is specific to the experiences of African-American children and families, further helping us understand the disparities in the age of diagnosis and developing specific interventions and policy recommendations from the research findings.

Conclusion

Although we know disparities in the age of diagnosis of African-American children exist, it is unclear if the misdiagnosis of children, physician-parent relationships, access to health care, physician bias, or another factor yet to be identified is most responsible. It is likely a combination of all these that factor into African-American children being diagnosed an average of 1.5 years later than Caucasian children. Although we do have some information on the reasons for the disparity, there clearly needs to be further research to examine the various factors that contribute to the later age of diagnosis in African-American children. Because early diagnosis and treatment of ASD is so important to the long-term outcomes of children with ASD, it is crucial that we understand the factors that contribute to later diagnosis in African-American children and take steps to close the gap. Social workers are uniquely positioned to make an impact on this problem and help children and families who have been affected by ASD through clinical work with children and families, advocacy, teaching, policy development, and research.

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References

- American Academy of Pediatrics, Committee on Children with Disabilities. (2001). The pediatrician's role in the diagnosis and management of autistic spectrum disorder in children [Electronic version]. *Pediatrics*, 107(5), 1221-1226.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (Revised, 4th ed.). Washington, DC: Author.
- Autism Speaks Inc. (2007). *Facts About Autism*. Retrieved February 25, 2007 from <http://www.autismspeaks.org/whatisit/facts.php>
- Centers for Disease Control and Prevention. (2007a). Prevalence of autism spectrum disorders—autism and developmental disabilities monitoring network, six sites, United States, 2000. *Morbidity and Mortality Weekly Report Surveillance Summaries*, 56(SS-1), 1-11. Retrieved February 25, 2007 from <http://www.cdc.gov/mmwr/PDF/ss/ss5601.pdf>
- Centers for Disease Control and Prevention. (2007b). Prevalence of autism spectrum disorders—autism and developmental disabilities monitoring network, 14 Sites, United States, 2002. *Morbidity and Mortality Weekly Report Surveillance Summaries*, 56(SS-1), 12-28. Retrieved March 1, 2007 from <http://www.cdc.gov/mmwr/PDF/ss/ss5601.pdf>
- Collins, A., Ma, D., Whitehead, P., Martin, E., Wright, H., Abramson, R., et al. (2006). Investigation of autism and GABA receptor subunit genes in multiple ethnic groups [Electronic version]. *Neurogenetics*, 7(3), 167-174.
- Cooper-Patrick, L., Gallo, J., Gonzales, J., Vu, H. T., Powe, N., Nelson, C., et al. (1999). Race, gender, and partnership in the patient-physician relationship [Electronic version]. *JAMA*, 282(6), 583-589.
- Cuccaro, M., Wright, H., Rownd, C., Abramson, R., Waller, J., & Fender, D. (1996). Brief report: professional perceptions of children with developmental difficulties: The influence of race and socioeconomic status [Electronic version]. *Journal of Autism and Developmental Disorders*. 26(4), 461-469.
- Dyches, T., Wilder, L., Sudweeks, R., Obiakor, F., & Algozzine, B. (2004). Multicultural issues in autism [Electronic version]. *Journal of Autism and Developmental Disorders*, 34(2), 211-222.
- Higgins, D., Bailey, S., & Pearce, J. (2005). Factors associated with functioning style and coping strategies of families with a child with an autism spectrum disorder [Electronic version]. *Autism*, 9(2), 125-137.
- Mandell, D. S., Ittenbach, R. F., Levy, S. E., Pinto-Martin, J. A. (2006). Disparities in diagnosis received prior to a diagnosis of autism spectrum disorder. *Journal of Autism and Developmental Disorders*, [E-published ahead of print, December 8, 2006].
- Mandell, D. S., Listerud, J., Levy, S., & Pinto-Martin, J.A. (2002). Race differences in the age of diagnosis among medicaid-eligible children with autism [Electronic version]. *Journal of the American Academy of Child & Adolescent Psychiatry*, 41(12), 1447-1453.
- Mandell, D. S., Novak, M. (2005). The roles of culture in families' treatment decisions for children with autism spectrum disorders [Electronic version]. *Mental Retardation And Developmental Disabilities Research Reviews*, 11(2), 110-115.
- Mandell, D. S., Novak, M. M., & Zubritsky, C. D. (2005). Factors associated with age of diagnosis among children with autism spectrum disorders [Electronic version]. *Pediatrics*, 116(6), 1480-1486.
- Newsome, W. (2000). Parental perceptions during periods of transition: Implications for social workers serving families coping with autism [Electronic version]. *Journal of Family Social Work*, 5(2), 17-31.
- Porterfield, S., & McBride, T. (2007). The effect of poverty and caregiver education on perceived need and access to health services among children with special health care needs [Electronic version]. *American Journal of Public Health*, 97(2), 323-329.
- Seltzer, M. M., Krauss, M. W., Orsmond, G., & Vestal, C. (2000). Families of adolescents and adults with autism: Uncharted territory [Electronic version]. In L. Glidden (Ed.) *International Review Of Research In Mental Retardation: Autism 23*, 267-294. San Diego: Academic Press.
- Weinick, R., & Krauss, N. (2000). Racial/ethnic differences in children's access to care [Electronic version]. *American Journal of Public Health*, 90(11), 1771-1774.
- Yeargin-Allsopp, M., Rice, C., Karapurkar, T., Doernberg, N., Boyle, C., & Murphy, C. (2003). Prevalence of autism in a US metropolitan area [Electronic version]. *Journal of American Medical Association*, 289(1), 49-54.

OBJECT RELATIONS AS A THEORETICAL MODEL IN THE WORK WITH LOW ACCULTURATED LATINO MEN WHO BATTER

By Priscila R. Freire

Abstract

The notion of applying psychological theories to the issue of domestic violence is controversial. The field of domestic violence has struggled to hold societal beliefs and structures accountable for individual behaviors that are abusive. However, it is equally important for mental health professionals who work with the Latino man who batters to have a theoretical basis for practice that considers the psychological contributions that influence their behavior. This paper explores the application of object relations theory to Latino men who batter. A case example using the group modality is presented to apply object relations theory to work with this population.

Introduction

As the field of domestic violence continues to evolve, so does the need to continue expanding theory in order to provide a better understanding of abusive behavior with all its complexities. There has been some resistance to utilizing psychological theory as a source of direction for professionals who work with men who batter due to the political origins. A complicating factor is the perception that by focusing on psychological theories, we are in some way viewing abusive behavior as a mental health issue, when advocates believe it is a learned behavior maintained by societal attitudes and institutions (Almeida & Durkin, 1999; Almeida & Bograd, 1991; Berry, 1996; Pence, & Paymar, 1993; Schechter, 1983).

While the social components of violence against women cannot be ignored, it is also critical to examine how societal factors impacts people differently at a psychological level. In order to continue addressing the latter, clinicians must consider ways to augment theory in order to have a better understanding of effective interventions. A limited review of the literature on heterosexual groups for men who batter revealed that the focus is on either discussing the advantages of a certain theory or approach (Russell, 1995; Edleson & Tolman, 1992; Pence & Paymar, 1993; Kesner, Julian, & McKenry, 1998; Sonkin, 1988; Trimble, 1997; Foster & Gondolf, 1989; Kivel, 1992; Murphy & Baxter, 1997; Schechter, 1983) or discussions on whether or not programs for men who batter are effective (Edleson, 1990; Tolman & Edleson, 1995; Bennett & Vincent, 2001; Brandl, 1990; Gondolf, 1997; Shepard, 1992). A common problem in evaluating programs for men who batter has been how to define success (Bennett & Vincent, 2001; Bennett &

Williams, 2001; Edleson, 1995; Edleson, 1990; Gondolf, 2004; Gondolf, 1997; Robertson, 1999). A criticism has been that studies that see ending physical violence as the criteria for success (Neidig, 1986) do not measure whether there have been changes in emotional abuse and power and control issues (Brandl, 1990; Gondolf, 1987; Hendricks, Werner, Shipway, & Turinetti, 2006; Tolman & Edleson, 1995). Other critiques relate to using outcomes in reductions of recidivism, drop out rates and re-arrest rates, which do not capture an aggressor's ability to switch to other forms of abuse, and the use of measures such as the Conflict Tactics Scale, which is not meant to measure before and after changes (Bennett, Call, Flett, & Stoops, 2005; Brandl, 1990; Edleson, 1995; Gondolf, 1987; Jackson, Forde, Davis, Maxwell, & Taylor, 2003; Straus, Hamby, Boney-McCoy, & Sugarman, 1996).

As societal beliefs about domestic violence have been changing, so have the ways this issue has been approached therapeutically. There have been a number of approaches used that reflected the process of understanding the dynamics of domestic violence in the clinical field itself. From behavioral interventions to confrontation, there still is widespread debate about the best way to approach men who batter. Central to the educational process with men who batter is the challenge of long-held beliefs as being neither truth nor right but a culturally constructed justification to exploit others (Pence & Paymar, 1993). In other words, the therapeutic interventions with men who batter have been changing from the prevailing male deficit model to a focus on belief systems. This means that the emphasis in treatment has changed from concentrating on negative sanctions to the belief systems that maintain men's abusive behaviors (Pence & Paymar, 1993; Russell, 1995) and the systems that sustain them (Edleson & Tolman, 1992).

In the field of domestic violence, research on treatment methods using various modalities has increased. Despite this, or perhaps because of the history of certain modalities with increasing victim risk, groups have been the preferred method of education/treatment for men who batter. An important distinction, though, is that this modality is preferred among programs that tend to serve mandated clients, which includes men who have been arrested for domestic violence. There remains a considerable gap of information related to men who have battered and not been arrested (often referred to as "voluntary clients") and preferred methods of treatment with them.

There is a dearth of studies that focus on the

Latino man who batters using attachment theories as their theoretical orientation. The few writings that relate attachment theories to the man who batters use an individual approach (Worley, Walsh, & Lewis, 2004; Sonkin & Dutton, 2003; Kesner, Julian, & McKenry, 1998) or have related attachment styles to partner violence (Bartholomew, Henderson, & Dutton, 2001; Dutton, Saunders, Starzomski, & Bartholomew, 1994). This information, paired with information that addresses attachment theories as a way to look at relationship issues, (Bartholomew, 1994; Sperling & Berman, 1994; Bartholomew & Horowitz, 1991; Bartholomew, 1990) can be useful. Part of the concern from advocates has been that by using this type of orientation one might possibly attribute domestic violence to a mental health issue, reducing partner violence to pathology, and ignoring societal influences on promoting and sustaining certain behaviors, particularly in the context of relationships. Yet as the knowledge of interventions for men who batter continues to evolve, it will be helpful to look at how both internal psychological dynamics and external social influences (including cultural variables such as class, race, gender socialization, and sexual orientation) result in partner violence. Toward this aim, it seems appropriate from a clinical perspective to look at all of this information and then consider its cross-cultural applicability to the Latino man who batters.

As one can appreciate from the foregoing discussion, there is considerable controversy about batterer intervention. The political implications of batterer intervention have influenced the field to consider abusive behaviors as a result of social beliefs or cognitions that have been supported by a society that has traditionally oppressed certain groups, including women. Nonetheless, while these are aspects of domestic violence that still continue to merit advocacy and political involvement, there is also still the need to address the issue of domestic violence from a theoretical perspective that can explain and address abusive behaviors from a psychological viewpoint. Many of the theories currently being used are more cognitive-behavioral, perhaps because these are theories that lend themselves more easily to concrete ways of proving change of behavior.

The focus of this article is the use of object-relation theories with a population of heterosexual Latino men with low acculturation who batter. Object relations theories are those which examine the search for relationship as the primary motivator of human behavior and from the nature of those relationships the creator of personality structure. First, a review of the contributions of object relations theory is explored and related to group psychotherapy. The particular issues that need to be taken into consideration when using the group modality with

Latino men with low acculturation are also identified. A case example using the group modality is provided to demonstrate an application of object relation theory to this population. Finally, recommendations for further inquiry are made to add to the limited body of clinical knowledge on group interventions with Latino men who batter.

Review of object relations theories

Object relations theories can be discussed as if on a continuum, where on one end of the continuum some of the theorists examine relationships and personality structure emerging out of the sexual and aggressive drives, while on the other end of the continuum theorists argue that the search for relationships is the primary motivator of human behavior and the nature of those relationships create personality structure. Object relations theorists observe that people live simultaneously in an external and internal world and that the relationship between the two ranges from the most fluid intermingling to the most rigid separation. Thus, these theories explore the relationship between the real, external people, the internal images and residues of relations with them, as well as the possible significance of these residues for psychic functioning (Ganzarain, 1989).

Freud (1905) initiated the notion of object relations when he stated that there was a "reciprocal relationship between the ego and the object as processes whereby the ego modifies the object through identification and introjection and in turn is modified in its dynamics and structure" (Ashbach & Schermer, 1987, p. 36). According to Rice (1992), Freud also hypothesized that through identification with parents, the child internalizes them within the superego subsystem, which then is the carrier of social values and proscriptions. By cathecting the mental representations and the objects themselves, the emphasis had moved from external to internal object relations, which later laid the foundation for future interest in inner object relations (Rice, 1992).

Klein (1935) enlarged on Freud's drive theory and incorporated the object within the drive. She stressed the importance of very early internalized object relations, and their influence on intrapsychic conflicts and personality structure (Kibel, 1992). As infants interact with the environment, they attempt to match their outer object relations with their existing inner object relations through the processes of projection, identification, and introjection. While the infant projects aggression to the mother, the mother's nurturing responses can then be identified with and then internalized or introjected. In normal development this process of integration is called projective identification (Rice, 1992). However, this interaction

does not reflect the ways the mother may behave nor focused on the mother as a person who also brings her own character structure. For Klein, the earliest developmental stage or position of the ego is called the “paranoid-schizoid” position, where initially the infant relates to the mother in a state of hallucinatory fusion, which is the schizoid side of the position, and then as they separate, they view the world in terms of bad and good, or loved and hated, which is the paranoid side of the position (Rice, 1992). The concepts of splitting, and its relationship to projection are important in the paranoid-schizoid position. When the integration of the good and bad objects does not occur, it is due to splitting and part-object relations. While one may observe these behaviors in clients with schizophrenia and paranoid psychosis, Kibel (1992) states that this position can also be applied to social situations that are conflict-laden, such as in the group setting. The second position in Klein’s theory was the depressive position, in which good and bad objects are integrated and people are perceived as whole and not part objects.

Fairbairn (1952) developed his theory incorporating ideas from Freud and Klein. He believed that the expression of the drives was not the goal, but that the drives were a means toward the goal of establishing relationships. Fairbairn believed that at birth a “pristine whole ego existed...and that it was object-seeking, as opposed to satisfaction-seeking” (Kibel, 1992, p. 142). He claimed that inner objects were derived from external relationships and that the infants themselves had no hostile, aggressive impulses, because the interaction with the mother elicited those responses. In his model the inner objects are used as substitutes for satisfactory interpersonal relationships (Rice, 1992). Development in Fairbairn’s view is achieved through two stages: infantile dependency and mature dependency. Infantile dependency, characterized by primary identification, does not acknowledge a separate self from the other and experiences the other as unconditional and absolute. Mature dependency, on the other hand, is the ability to establish interdependent relationships with the other, which can occur when the self is differentiated from the object (Rubens, 1994). “This process of development is characterized (a) by the gradual abandonment of an original object-relationship based upon identification, and (b) by the gradual adoption of an object-relationship based upon differentiation of the object.” (Fairbairn, 1952, p. 34)

Winnicott (1960) followed Fairbairn’s interpersonal views but then focused more on the mother/infant interaction and the process the infant goes through in order to develop from that relationship. The notion of synchrony was important to Winnicott’s theory. Based on this view, infants could develop normally insofar as the

mother related in a synchronous manner to the child’s developmental needs, while she provided a “holding environment” that is conducive to such growth. As the mother became preoccupied with other concerns, the child learned to separate and in this maturational process used a “transitional object.” Through the use of this object, the child can separate and learn to distinguish between the objective and subjective worlds. A significant contribution by Winnicott is the distinction of infant development in terms of “good enough maternal care” and “maternal care that is not good enough” (Winnicott, 1960, p. 252) and he calls attention to how this experience can play out in the transference within the therapeutic relationship.

Bowlby (1969) contributed to object relations theory with his writing and research on attachment and loss. However, Bowlby did not focus on the subjective experience and instead, concentrated on “actual experiences, not fantasized ones, on parental losses and not on parental attitudes or projections” (Rice, 1992, p. 35). He believed that loss and grief could result in scars that could cause difficulty later in life.

Viewing object relations theory from a social context, one must take into consideration the historical circumstances in which it developed, and that its proponents were largely white, Jewish or Christian, middle- to upper-class clinicians who treated clients mostly from their same socio-economic backgrounds (Melano-Flanagan, 1996). Hence, one limitation of this theory is that they were not conceived in the work with the poor, disadvantaged, or with ethnic or racial minorities, or non-Western cultures, which has implications for clinicians who work with these populations. One has to consider these limitations when attempting to explain behavior from other groups that occur within a social or cultural environment.

Finally, applying these theoretical views at a macrolevel, it is relevant to think in transcultural terms about the social and cultural determinants of psychopathology. For example, one can view racism as a social issue embedded in economic oppression and imperialism, which become expressed in behaviors both at the social organizational and individual levels (Frosh, 1987, as cited by Innis, 1998), or as an alienated or unacceptable aspect of the self that is projected onto others (Fanon, 1952, as cited by Innis, 1998). When one reflects on the self structure in terms of internalized experiences of relationship, it makes sense to include a context in which these relationships are formed and shaped in order to link the impact of external factors with the internal processes of a person. The latter seems particularly significant when the understanding sought relates to disenfranchised and oppressed populations.

Object relation applied in group psychotherapy

Bion (1961) was the creative mind who began applying object relations theory to groups. He incorporated concepts from other theorists, including Klein and Winnicott. From Klein he used the concepts of the paranoid-schizoid and depressive positions and projective identification, drawing parallels between her descriptions of these stages and the processes in the group. From Winnicott he used the notions of “transitional object” and “holding environment.”

Bion drew an analogy between the relationship between the mother and her child, and the relationship between the group and the group leader. He “...used the concept of projective identification in his description of unacceptable impulses or wishes being disowned and poured into the therapist or group, like the infant pours unwanted feelings into the mother” (Klein, 1992, p. 91). It was Bion’s belief that groups were part of being human and for this reason a person could not help but interact. He called this quality “valency,” which in turn activates primitive defense mechanisms in group members that seem to mimic the interactions that occur in early ego development (Kibel, 1992). Moreover, Bion (1961) stated there were two levels that developed in the group process: the work group and the basic assumption. The work group refers to the group process that concentrates on the primary tasks, such as keeping the group focus, leadership, and staying reality- and goal-directed. The basic assumption is that the emotional aspects of groups that are unconscious and collective are the factors which usually hinder productive group process. Bion believed that the basic assumptions reflected,

primitive object relations, [that] originate within the individual as powerful emotions associated with a specific cluster of ideas that compel the individual to react in particular ways in groups and also to be attracted to individuals imbued with similar or complementary attitudes” (Sutherland, 1985, cited in Kibel, 1992, p. 144).

In Bion’s integration of object relations principles he viewed the group as a place where the interaction of part-objects can occur. These part-objects are reenacted because of splitting, projective identification, and playing out roles that contribute to complement their inner needs. Through valency, the members set in motion dynamic processes where they can reenact transference patterns that are based on their mutual identifications with each other, the attachment to the leader, and even a

shared identification with the group. Transference in the group can occur between and among members, but the group as a whole is also a transference object (Rice, 1992). The group can represent a mother or even a family-of-origin and then elicit responses that repeat those interactions. Group members in subgroups can also become transference objects, and of course, the group leader can become a transference object as well.

Object relations from a relational perspective would regard the leader as an active participant in the interaction, versus a passive recipient of the transference of the group. For this reason, group leaders would consider their own countertransference issues in their relationship with the group and its members. The leader’s countertransference can be a source of much understanding about the group that can result in interventions that are attuned, or using Winnicott’s term, “synchronous” to the needs of the group. Collusion with the group can result if the projections are not contained, which can be detrimental to the group process.

In short, change in the group from an object relations perspective would occur because new self representations would be incorporated through interactions in the group. As the group progresses, new introjects of the self are internalized and become new identifications that influence each member’s behavior. As behavior is reinforced by the group and outside the group, there are internal and external motivators that promote the maintenance of change (Kibel, 1992). Therefore, feedback by the group members and the leader can have a constructive, growth-promoting effect.

Using the group modality with Latino men who batter

As with any diverse group, when speaking about general characteristics or traits one has to take into consideration that generalizations allow for a presentation of information, while it also tends to exclude individual differences. Some elements are racism, segregation, unequal opportunities for education, unequal accessibility to health and social services, unfair employment (or unemployment) practices, and political disenfranchisement (Casas & Vasquez, 1989). Finally, socioeconomic status, religion, country of origin, level of acculturation, and immigration status add to the body of important information about an individual’s particular experience. Differences of education, socioeconomic status, religion, country of origin, and level of acculturation may also apply if a Latino(a) worker is providing the services. For this reason, clinicians should keep in mind that to “start where the client is” may mean a general understanding of the dynamics that impinge upon a Latino family, but it is

best not to have a preconceived notion of what a particular Latino family is like before they share their own view of their problem.

Perhaps the single most important factor to keep in mind as a discussion on the particularities of Latino men who batter unfolds is that there is as much diversity within the Latino culture as there is in the general population of the United States. While Spanish is the prevalent language, there are still many native languages used by a number of groups throughout Latin America. These groups are cultures within larger cultures that maintain their traditions and worldview. In terms of religion, there is also a variety of belief systems influenced by Christian worldviews which resulted in syncretism, as native cultures during the Spanish conquest incorporated other beliefs into their own. This can be important as practices related to spirituality and religion will reflect belief systems that are deeply cultural and can manifest themselves in particular indigenous healing customs. Considering these practices when working with communities of color can assist in promoting psychological, physical, and spiritual well-being (Constantine, Myers, Kindaichi, & Moore, 2004). Because Latinos are not a homogenous group, even though they may share a broad set of cultural expectations, as they are brought together in the context of a group one has to consider the factors listed above and even differences in language.

Acculturation is not unidirectional; for example, a person can act "Americanized" in one setting, while maintaining traditional Latino values at home. Three major dimensions reflect acculturation: (1) language proficiency, preference, and use; (2) socioeconomic status; and (3) culture specific attitudes and value orientations (Casas & Vasquez, 1989). The issue of acculturation is extremely important in addressing Latino issues because the differences in acculturation account for another source of diversity within the group.

It is the author's experience that male Latinos, particularly those who have low levels of acculturation, tend to be more reserved and formal in dealing with authority figures, and be very aware of the differences in hierarchy between people who are in their closer circle and those who are not. It is expected that one should be polite and usually defer to authority. A traditional Latino person would not generally be confrontational and blunt, as it may be considered impolite to do so. Instead, comments might be made indirectly, or in a "half-jest, half-serious" way. As one can see, in general, a traditional Latino man would have respect for authority, formal and often indirect communication, be defensive about his family, particularly his role as its leader, but also tend to conform to the group. Due to feelings of suspicion of outside influence into what is their realm, Latino men may

seem to accommodate to what is asked of them rather than challenge or question.

Arcaya (1996) contributed many helpful observations about the Latino man. While some have been incorporated in the discussion thus far, others are particular to the therapeutic encounter. In his writings Arcaya (1996) states that the Latino man is "deeply private" and for this reason it is difficult to engage him in the group. For this reason, Arcaya continues, the Latino man must be emotionally invested in his treatment by realizing that he is who determines the therapeutic agenda in order for the intervention to be transformative. By the process of appealing to his pride and sense of honor and duty, one can discuss the notion of choices and thus, the fact that he is an active participant in the consequences of his decisions. It can also be helpful to recognize the burdens and unrealistic expectations that come from society's definitions of what it means to be a man. As Arcaya (1996) so eloquently expresses it:

Nevertheless, however true the Hispanic male's shortcomings may be, interventions highlighting only negative characteristics are, in the bulk of effect, would likely make these individuals more proud and rigid than might otherwise be the case. Instead of encouraging openness about their role confusion or difficulties adapting to the norms of the new culture, this type of commentary would serve only to close them down further. The Hispanic male is more likely to reorganize his thinking around culturally relevant lines if he is coaxed into awareness about the social contradictions in which he finds himself, thereby giving him an opportunity to integrate old ideals with new realities of U.S. society. (p. 160)

Case example

Mr. M is a married Latino in his early thirties. He has three children from his ten-year-old marriage. He was convicted of domestic battery after an incident with his wife that resulted in his arrest. The courts mandated him to a program for men who batter. He chose a program where group services were offered in his native language, Spanish. After an orientation session, the two hour open groups run weekly for 26 weeks. They are composed of 10-15 Latino men from a variety of different backgrounds, ages and generations, although they are predominantly from Mexico with low acculturation, low literacy, and low socioeconomic status.

When Mr. M first came to the batterer group he

appeared angry, defiant, and “cocky.” He sat rigidly and held a “tough” stance by speaking with a firm tone, lifting his head sustaining a hard gaze, and looking around to other group members as if for support for his views. At one point he addressed the female co-facilitator in an abrupt, aggressive manner, questioning her abilities and possible motivation for being in the group. The facilitator tried to not react defensively and get into a power struggle. She attempted to address and validate the apparent underlying concerns in Mr. M’s behavior and encouraged him to bring up again any other thoughts that she may be able to clarify.

The way Mr. M often interacted with the group seemed immature. He would at times giggle with the member next to him, make jokes related to the discussion, and in general have a bravado attitude. However, Mr. M could also appear engaged, invested in group discussion, mature, and attentive. His interaction with other group members was respectful, however. He seemed to know how far to go with his jokes or comments.

One group session focused on the family dynamics that often occur in both violent and alcoholic families. The group was asked to divide into smaller groups in order to role-play vignettes. After, the smaller groups reported to the larger group what it was like for each person and the larger group also made observations about the “family.” After Mr. M’s group finished their role-play, he seemed to become thoughtful and withdrawn. With some hesitation, Mr. M disclosed how the role-play had reminded him of his childhood. He described his father’s general tyrannical attitude, his alcoholic behavior and how he and his family feared him. He shared how he had often had to intervene when his father physically abused his mother. He disclosed how difficult it was for him to receive the loving attention that he needed as there was constant tension in the household. He often felt alone, afraid, and unwanted. Mr. M’s body language and affect changed. He seemed exposed and fragile. His head hung low as his voice cracked.

The group became silent. The female co-facilitator felt touched by the man’s apparent display of emotion and vulnerability. She softened the tone of her voice and approached Mr. M in a nurturing manner, stating that it must have been painful for him to be in that situation. She further added that children in those situations act as protectors but are also caught in a loyalty conflict. Mr. M seemed to be filled with emotion as if reliving a moment. The group seemed attentive and interested in the interaction. Mr. M expressed discomfort about the disclosure. The facilitator invited the group to provide support for Mr. M. The group responded immediately, validating his feelings. Some could appreciate the difficulty of disclosing such an event. Another member disclosed his experi-

ence as a child who witnessed violence between his parents. Mr. M’s body straightened up, he lifted his face, and seemed to listen attentively.

Mr. M’s demeanor changed in subsequent group sessions. While he still appeared immature in his behavior at times, more often than not he made valuable contributions to the group discussion. His body language appeared less tense and less defiant. On the contrary, it appeared relaxed and his gaze softened. On one occasion he stayed until the end of the group session and assisted the facilitators on cleaning up the room after the group ended. His experience of feeling a wider range of emotions with the group would be repeated with increased intensity in several sessions that followed and became extremely beneficial to the group process.

In the above case example it seemed Mr. M had introjected a negative object, as a result of witnessing violence as a child and the experience of neglect, which he then projected in his relationships with others. Eventually we learned that he engaged in violent behavior often, getting into fights with both family members and others. He reenacted this behavior within the group, projecting his feelings. However, due to the boundaries and the “containment” (using Klein’s term) offered by the group, as well as an awareness of this dynamic by the facilitator, new introjects of the self developed as he experienced different relationships within the group. It is possible that in the instances with the female co-facilitator described above the client engaged in projective identification where he used splitting to ward off his aggressive feelings toward the female leader. In other words, it is possible that Mr. M’s negative introjections from living in a household full of fear and chaos were projected onto the female worker. In such a household it is likely that his emotional needs could not be met and that the anxiety he felt as a child resulted in splitting in order to cope. The group process seemed to elicit unwanted feelings that Mr. M projected onto the worker and then treated the worker as if she had those feelings. It was difficult at times for the female facilitator not to act on the projections that made her feel angry and defiant. By interpreting his behavior and providing feedback Mr. M could own split-off aspects of himself in a safe, accepting, or “holding” environment. When the group provided support and nurturing, the object relations aspects were enhanced because it created additional interactions that were more complex, which helped him incorporate both negative and positive parts of his self. He gradually became ready to experience problematic parts of his self without having to take psychological distance. Mr. M eventually became more integrated experiencing his sense of self with a fuller range of emotions. This became evident in the changes in his behavior. He showed more mature and thoughtful interac-

tions within the group and with the group facilitators, while also making relevant contributions to group process.

When using object relation theories, the role of the worker is to create the conditions for safety in the group so that exploration and play can occur. The following are some areas that should be taken into consideration when working in groups with heterosexual Latino men who batter with low acculturation:

Mandated or voluntary status: This is important because the source of motivation toward change will be different although in general he can appear compliant and cooperative, particularly if he is undocumented. On the other hand, one cannot assume that the person is not receptive to change because they are mandated. However, the mandated Latino man might be more receptive to feedback individually due to the shame they usually feel.

Level of education. The ability to understand more abstract language and level of literacy will impact how interventions are chosen. For example, many Latino men cannot read or write in neither English nor Spanish. Their low level of education often makes understanding abstract concepts difficult. Using homework, role plays and audiovisuals in creative ways can assist in making abstract concepts more concrete.

Gender of the facilitator. Gender relations can be complicated with many groups that are not Latino. With Latino men who feel threatened by the process of receiving services that by definition challenge aspects of their gender identity, having a woman facilitator presents different challenges than for a male facilitator. Often women who facilitate these groups must avoid personalizing attacks based on gender, while male facilitators must be aware of the potential for gender effects on collusion.

Leadership style. A style that is more relaxed and has flexible boundaries works best. Fostering cohesiveness can occur by pointing out common group concerns or resistances (Kibel, 1992). As the clients act out their ways of relating, the practitioner facilitates the "holding environment" to which Winnicott refers. It is also important to be self-aware of one's own assumptions and biases in terms of the intersections between acculturation, experiences with immigration, the fluidity of culture, socio-economic status, and education, to name a few.

The need for a flexible structure in which there is room for exploration of feelings, memories, etc., while at the same time there is a focus and direction. By providing feedback on the mental representations they have and their impact on behavior, they can increase awareness on their patterned forms of relating.

Using group dynamics to point out resistance, or allowing group participants to do so with each other since in general the group process helps participants work

through resistance very effectively. Here we must include the use of values that guide the worldviews of participants. Making them aware of how their values might be in conflict or challenging interpretations of values that perpetuate violence can be helpful in establishing a validating therapeutic relationship that works toward synchrony between beliefs and behaviors. A more concrete example is that to many Latino men who batter the notion of equity makes more sense than the idea of equality. One reason may be because it is less threatening to his sense of manhood, but also because in translation equality gains a meaning of "sameness" that is not culturally sound, since men and women "are not the same."

Awareness of the politics of oppression and marginalization of groups, which often are unquestioned and play out in the ways psychosocial processes are interpreted and explained. This includes how information is sought and gathered about groups and using the perspectives of those who are in power. Said differently, the mental health professional can become "an alternative solution to social conflicts: it tries [*sic*] to change the individual while preserving the social order, or, in the best of cases, generating the illusion that, perhaps, as the individual changes, so will the social order—as if society were a summation of individuals" (Deleule, 1972, cited by Martin-Baró, 1994, p.37).

Conclusion

In exploring theoretical orientations in the service provision to men who batter in the field of domestic violence, there is paucity in the body of clinical knowledge that can guide clinicians in their work with men who batter. There is even more of a lack of clinical information on working with Latino men who batter. Even though there may be some similarities in how the services are implemented, there are also clear differences.

While a number of studies have explored abuser intervention in groups from a cognitive-behavioral perspective, there is no information about using object relations theory in groups for Latino men who batter. Much of the data using this theory has focused on groups other than men who batter. For this reason, it is important to consider how the contributions that object relations theory can be useful in working with men who batter who are Latino.

It is relevant to turn to the particular issues of Latino men within groups, as it is at this time the preferred modality of treatment. Cultural issues need to be considered as Latinos engage with the group before they are able to explore changing their behavior. Some of the issues are the pride and sense of duty these men feel in protecting their private affairs and their role as providers.

Their external locus of control and their need to “save face” to preserve the appearance of harmony are critical factors in understanding behaviors that may be perceived as resistant, although these behaviors could also be interpreted as the beliefs about inequality and power of high power distances cultures, which have a worldview where everyone has his place and inequality is accepted (Hofstede, 1980). Also, because there is much diversity within Latino communities, when one is working with immigrant populations with low acculturation one cannot disregard the impact of environmental factors such as immigration, racism, and the process of acculturation with individuals and families who are adapting to the value systems of American society, but also of the Latino workers themselves. On the other hand, Latino families who have lived in the U.S. for generations, who may have higher acculturation will present with unique factors of their own to consider; for example, feeling identified with the values and practices of familial and group ancestry at the same time they participate with the values and practices of their country of birth.

There are still many areas of inquiry that need to be researched further in working with Latino men who batter. Areas for further research include: what are the differences between ethnic/racial groups in terms of how abuser services are delivered? By observing and talking with other clinicians we may be able to articulate into theoretical terms what is helpful. Can we integrate theories that have a different value orientation with the values of a particular cultural group? As we learn more about what is helpful and with whom, it will be more possible to expand theory based on practice. A complicating issue is that programs often are not viewed as being helpful because they have a therapeutic/educational role but also are viewed as extensions of the criminal justice system because client progress, including disclosures of re-offenses, is reported back to the courts. The dual roles of therapists and reporters to the courts that facilitators of men who batter groups have present an added challenge in the process of engagement. What are helpful strategies to keep in mind? Furthermore, there is a need for more research on the female/male co-facilitation team that works with groups for men who batter. Are there gender differences in terms of how each facilitator experiences the group process? When the workers are Latino, does their own level of acculturation impact their interactions with the group? What are the countertransference issues that commonly arise in Latina co-facilitators? How can female co-facilitators be additionally supported in their function as role models for how the men who batter can experience a male/female relationship? Independent observations could be made in order to document further the way men who batter and the co-facilitation team

interact with each other. All of these questions could assist in expanding our understanding of how object relations theory can be utilized with this population. Outcome studies that measure the effectiveness of different theories on particular issues and populations also continues to be an important area for research that should be pursued.

Finally, are there other ways to gain new perspectives about interventions with Latino men who batter which incorporate their views? In other words, what does mental health look like from the perspective of marginalized populations? Should we be using definitions that reflect the realities of oppressed communities? Or as Martin-Baró (1994) reflects, is it time to “involve ourselves in a new praxis, an activity of transforming reality that will let us know not only about what is but also about what is not, and by which we may try to orient ourselves toward what ought to be” (p.29), through participatory research? As researchers we must also feel the responsibility to include the impact from the political, social, historical, economic, and religious domains in our understanding of human behavior (Perilla, 1999).

Even though the domestic violence field began as a grassroots movement, there seems to be a variety of levels of intervention in order to address this issue. Hence, there is still a need to continue working together, each advocate making contributions that can augment an understanding that reflects the complexity of the dynamics of domestic violence. From a clinical standpoint, there is still a lot to be done to learn what is effective and with whom. As the attitudes and beliefs of society continue to evolve, we must expand theories that can be useful in our interventions with men who batter. Theories and what they look like in practice may vary depending on the population being served. As the case example demonstrates, some theoretical concepts may need to be reframed, such as the notion of equity, in order to make interventions more culturally sound while not losing focus of behavior change.

Our charge as clinicians and advocates for a domestic violence-free society is to provide the information to support our principles so we can continue advocating at the therapeutic level by using contextual frameworks. Or as Martin-Baró (1994) puts it, recalling one of his professors from the University of Chicago, “the healing power of any psychotherapeutic method depends on the dosage of break with the dominant culture” (p. 120). In this spirit it is our collective responsibility as a society to recognize and be aware of the attitudes, beliefs, and social structures that create the conditions in which partner violence is maintained, justified, and kept silent.

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References

- Almeida, R.V., & Bograd, M. (1991). Sponsorship: Men holding men accountable for domestic violence. In M. Bograd (Ed.), *Feminist approaches for men in family therapy* (pp. 243-259). Binghamton, NY: Haworth Press.
- Almeida, R.V., & Durkin, T. (1999). The cultural context model: Therapy for couples with domestic violence. *Journal of Marital and Family Therapy*, 25(3), 313-324.
- Arcaya, J. M. (1996). The Hispanic male in group psychotherapy. In Andronico, M.P. (Ed.). *Men in groups. Insights, interventions, and psychoeducational work* (pp. 151-163). Washington, D.C.: American Psychological Association.
- Ashbach, C., & Schermer, V.L.O. (1987). *Object relations, the self, and the group*. London: Routledge & Kegan Paul.
- Bartholomew, K., Henderson, A., & Dutton, D.G. (2001). Insecure attachment and abusive intimate relationships. In C. Clulow (Ed.), *Adult attachment and couple psychotherapy* (pp. 43-61). Taylor & Francis: Philadelphia.
- Bartholomew, K. (1994). Assessment of individual differences in adult attachment. *Psychological Inquiry*, 5(1), 23-28.
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four category model. *Journal of Personality and Social Psychology*, 61(2), 226 – 244.
- Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. *Journal of Social and Personal Relationships*, 7, 147-158.
- Bennett, L.W., Call, C., Flett, H., & Stoops, C. (2005). *Program completion, behavioral change, and re-arrest for the batterer intervention system of Cook county Illinois. Final report to the Illinois Criminal Justice Information Authority*. Retrieved June 28, 2007 from <http://tiger.uic.edu/~lwbenn/DVPEP/cjia.pdf>
- Bennett, L., & Vincent, N. (2001). Standards for batterer programs: A formative evaluation of the Illinois protocol. *Journal of Aggression, Maltreatment & Trauma*, 5(2), 181-197.
- Bennett, L., & Williams, O. (2001). Controversies and recent studies of batterer intervention program effectiveness. *Applied Research Forum. National Electronic Network on Violence Against Women*. Retrieved January 17, 2006 from http://www.vawnet.org/DomesticViolence/Research/VAWnetDocs/AR_bip.pdf
- Berry, D.B. (1996). *Domestic violence sourcebook. Everything you need to know*. Los Angeles, CA: Lowell House.
- Bion, W.R. (1961). *Experiences in groups, and other papers*. New York: Basic Books.
- Bowlby, J. (1969). *Attachment and loss. Vol. 1: Attachment*. New York: Basic Books, Inc.
- Brandl, B. (1990). *Programs for batterers: A discussion paper*. Wisconsin: Department of Health and Social Services.

- Casas, J.M., & Vasquez, M.J.T. (1989). Counseling the Hispanic client: a theoretical and applied perspective. In Pedersen, P.B. & Draguns, J.G. & Lonner, W.J. & Trimble, J.E. (Eds.). *Counseling across cultures*. (3rd Ed.), (pp. 153-175). Honolulu: University of Hawaii Press.
- Constantine, M.G., Myers, L.J., Kindaichi, M., & Moore III, J.L. (2004). Exploring indigenous mental health practices: The roles of healers and helpers in promoting well-being in People of Color. *Counseling and Values*, 48(2), 110-125.
- Dutton, D.G., Saunders, K., Starzomski, A., & Bartholomew, K. (1994). Intimacy-anger and in secure attachment as precursors of abuse in intimate relationships. *Journal of Applied Social Psychology*, 24(15), 1367-1386.
- Edleson, J.L. (1995). *Do batterers' programs work?* Retrieved February 24, 2006 from Minnesota Center Against Violence and Abuse Electronic Clearinghouse: <http://www.mincava.umn.edu/documents/battererprogram/battererprogram.html>
- Edleson, J.L., & Tolman, R.M. (1992). *Intervention for men who batter. An ecological approach*. Newbury Park, CA: Sage Publications.
- Edleson, J.L. (1990). Judging the success of interventions with men who batter. In D.J. Besharov, *Family violence: Research and public policy issues* (pp. 130-145). Washington, D.C.: The AEI Press.
- Fairbairn, W. D. (1952). *Psychoanalytic studies of the personality*. New York: Routledge.
- Foster, R., & Gondolf, E.W. (1989). From social work to batterer counseling: One man's personal journey. *Response*, 12(3), 3-5.
- Freud, S. (1905). Three essays on the theory of sexuality: I: The Sexual Aberrations. In Buckley, P. (Ed.). *Essential papers on object relations* (pp. 5-39). New York: New York University Press.
- Ganzarain, R. (1989). *Object relations group psychotherapy. The group as an object, a tool, and a training base*. Madison, CT: International Universities Press.
- Gondolf, E.W. (2004). Evaluating batterer counseling programs: A difficult task showing some effects and implications. *Aggression and Violent Behavior*, 9, 605-631.
- Gondolf, E.W. (1997). Batterer programs. What we know and need to know. *Journal of Interpersonal Violence*, 12(1), 83-98.
- Gondolf, E. (1987) Seeing through smoke and mirrors: A guide to batterer program evaluation. *Response*, 10(3), 16-19.
- Hendricks, B., Werner, T., Shipway, L., & Turinetti, G.L. (2006). Recidivism among spousal abusers. Predictions and program evaluation. *Journal of Interpersonal Violence*, 21(6), 703-716.
- Hofstede, G. H. (1980). *Culture's consequences, international differences in work-related values*. Beverly Hills: Sage Publications.
- Innis, B. (1998). Experiences in difference. *Psychodynamic Counselling*, 4(2), 171-189.
- Jackson, S., Forde, D.R., Davis, R.C., Maxwell, C.D., & Taylor, B.G. (2003). *Batterer intervention programs. Where do we go from here?* Retrieved June 28, 2007 from <http://www.ncjrs.gov/pdffiles1/nij/195079.pdf>
- Kesner, J.E., Julian, T., & McKenry, P.C. (1998). Application of attachment theory to male violence toward female intimates. *Journal of Family Violence*, 12(2), 211-228.
- Kibel, H.D. (1992). The clinical application of object relations theory. In Klein, R.H.; Bernard, H.S.; Singer, D.L.(Eds.). *Handbook of contemporary group psychotherapy: Contributions from object relations, self psychology and social systems theories* (pp. 141-176). Madison, CT: International Universities Press, Inc.
- Kivel, P. (1992). *Men's work: How to stop the violence that tears our lives apart*. Center City, MN: Hazelden.
- Klein, E.B. (1992). Contributions from social systems theory. In Klein, R.H.; Bernard, H.S.; Singer, D.L. (Eds.). *Handbook of contemporary group psychotherapy: Contributions from object relations, self psychology and social systems theories* (pp. 87-123). Madison, CT: International Universities Press, Inc.
- Klein, M. (1935). A contribution to the psychogenesis of manic-depressive states. *Contributions to Psycho-Analysis, 1921-1945*. New York: McGraw-Hill Book Company.
- Martin-Baró, I. (1994). *Writings for a liberation psychology*. Cambridge, MA: Harvard University Press.
- Melano-Flanagan, L. (1996). Object relations theory. In Berzoff, J., Flanagan, L.M. & Hertz, P. (Eds.). *Inside out and outside in: Psychodynamic clinical theory and practice in contemporary multicultural contexts* (pp. 127-171). Northvale, N.J.: Jason Aronson, Inc.
- Murphy, C.M., & Baxter, V.A. (1997). Motivating batterers to change in the treatment context. *Journal of Interpersonal Violence*, 12(4), 608-613.
- Neidig, P.H. (1986). The development and evaluation of a spouse abuse treatment program in a military setting. *Evaluation and Program Planning*, 9, 275-280.
- Pence, E., & Paymar, M. (1993). *Education groups for*

- men who batter*. New York: Springer Publishing Company.
- Perilla J.L. (1999). Domestic Violence as a human rights issue: The case of immigrant Latinos. *Hispanic Journal of Behavioral Sciences*, 21(2), 107-133.
- Rice, C. A. (1992). Contributions from object relations theory. In Klein, R.H.; Bernard, H.S.; Singer, D.L. (Eds.). *Handbook of contemporary group psychotherapy: Contributions from object relations, self psychology and social systems theories* (pp. 27-54). Madison, CT: International Universities Press, Inc.
- Robertson, N. (1999). Stopping violence programmes: Enhancing the safety of battered women or producing better-educated batterers? [Electronic Version]. *New Zealand Journal of Psychology*, 28(2), 68-78.
- Rubens, R. L. (1994). Fairbairn's structural theory. In J. S. Grotstein & D. B. Rinsley (Eds.), *Fairbairn and the origins of object relations*. New York: Guilford Press. Retrieved April 6th, 2007, from <http://www.columbia.edu/~rr322/FAIR-BAIRN.html>
- Russell, M.N. (1995). *Confronting abusive beliefs: Group treatment for abusive men. Interpersonal Violence: The Practice Series*. Thousand Oaks: Sage Publications.
- Schechter, S. (1983). *Women and male violence: The visions and struggles of the Battered Women's Movement*. Cambridge, MA: South End Press.
- Shepard, M. (1992). Predicting batterer recidivism five years after community Intervention. *Journal of Family Violence*, 7(3), 167-178.
- Sonkin, D. J., & Dutton, D. (2003). Treating assaultive men from an attachment perspective. *Journal of Aggression, Maltreatment, and Trauma*, 7(1/2), 105-133.
- Sonkin, D. J. (1988). The male batterer: clinical and research issues. *Violence and Victims*, 3(1), 65-79.
- Straus, M.A., Hamby, S.L., Boney-McCoy, S., & Sugarman, D.B. (1996). The revised conflict tactics scales (CTS2). *Journal of Family Issues*, 17(3), 283-316.
- Tolman, R.M., & Edleson, J.L. (1995). Intervention for men who batter: A review of the research. In S.R. Smith & M.A. Straus (Eds.), *Understanding partner violence: Prevalence, causes, consequences and solutions* (pp. 262-273). Minneapolis, MN: National Council on Family Relations.
- Trimble, D. (1997). Confronting responsibility: Men who batter their wives. In Steinberg, D.M., *The Mutual-Aid Approach to working with groups: Helping people help each other* (pp. 257-271). Northvale, NJ: Jason Aronson.
- Winnicott, D. W. (1960). The theory of the parent-infant relationship. In P. Buckley (Ed.), *Essential papers on object relations* (pp. 233-253). New York: New York University Press.
- Worley, K., Walsh, S., & Lewis, K. (2004). An examination of parenting practices in male perpetrators of domestic violence: A qualitative study. *Psychology & Psychotherapy: Theory, Research & Practice*, 77(1), 35-54.

Human Trafficking: A Global Problem with Solutions that Begin at Home

By Allison H. Lowe

Abstract

Human trafficking has become a global problem that can no longer be ignored. It has always existed, as evidenced by slavery throughout history, but often times, people did not see it as a problem. After drug trafficking, human trafficking is now tied with the illegal arms industry as the most profitable component of organized crime. It is also the fastest growing. Human trafficking encompasses enforced labor, enforced sex work, and even organ harvesting. This paper examines human trafficking at various levels. First, it reviews the history of the issue, and current legislation. Next, the paper outlines the types of problems facing advocates, specifically social workers, and finally, it offers ideas regarding what needs to be done to eradicate this problem.

Introduction

Human trafficking is an international problem that requires immediate attention from the field of social work. The 2000 UN Convention Against Transnational Organized Crime provided the first international agreement defining trafficking:

trafficking in persons shall mean the recruitment, transportation, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (Trafficking Protocol, Article 3a). (quoted in Phinney, 2001, ¶ 2)

Despite the prevalence of human trafficking, most of the general public is unaware that it even exists; even those who do hear of this problem distance themselves from it by thinking that it happens in a faraway country. In reality, human trafficking exists in every country in the world. Here is one story.

V, a ten-year-old girl from Africa, was brought to Chicago by a family friend who promised V's mother she would go to school and have a better life in the United States. For the next four years, V was forced to cook,

clean, and take care of three small children. She slept next to the washing machine and was only allowed to eat when the family was done with their meals. V was not allowed to go to school, leave the home, or talk to anyone. She did not have access to her identification documents, which were kept by her 'employer.' She was told if she went outside, the police would 'catch her' and beat her. V was verbally, physically and sexually abused in this home. V tried to run away but was kidnapped twice by men who raped her and prostituted her out to other men. (Heartland Alliance for Human Needs and Human Rights [Heartland Alliance], n.d., p. 1).

V's story is just one example of the millions of people who are forced into modern-day slavery.

Human trafficking affects all of us by changing migration patterns, spreading diseases, increasing substance abuse and increasing the profits earned by organized crime. It affects many different systems from health-care to criminal justice to the business market. It seeps into every corner of our world so that no one can truly say they are untouched or unaffected by human trafficking: the charcoal in U.S. grocery stores may have been harvested by slaves in Brazil, the money exchanged at a bar or strip club may have been earned by a young girl who sexually serviced 25-30 men against her will the night before, an illegal substance moving into the U.S. may have originally been transported from Burma into China by an indigenous child forced to serve as a drug mule, or the patients treated in hospitals may have sexually transmitted diseases (STDs) or psychological trauma they received from being a victim of human trafficking.

We in the social work community have an even greater responsibility to educate ourselves about this problem and to reach out to victims; it is our job, our livelihood, and our passion to help the disadvantaged and mistreated. Human trafficking takes away people's basic human rights, which goes against everything for which social workers stand. However, because human trafficking is only now garnering attention among social workers, there is very little literature on this issue. Most of the literature deals with describing the problem and the legislation.

Further work is needed on the development of appropriate means of treating victims of this particular form of trauma. Education is the key to beginning the

fight against human trafficking, and to be effective, social workers need to have access to information, literature, and research about this growing problem.

Description of the Problem

“The U.S. government estimates that 600,000 to 800,00 persons are trafficked across international borders annually; however such estimates of global human trafficking are questionable” (United States Government Accountability Office [GAO], 2006, p. 2). Phinney (2001) writes that

relatively little is known about traffickers’ routes, networks, and associations with organized crime . . . [and] international and domestic laws are lacking or insufficient; where laws do exist, sentencing guidelines do not provide a deterrent. (Conceptual Framework, ¶ 6)

Permeable borders and advanced communication technologies have also aided the industry. Experts claim many reasons for the spread and growth of trafficking, including, easy profits made from exploitation, growing poverty in many areas of the world, discrimination against women, restrictive migration laws, a lack of information about trafficking, and insufficient penalties against traffickers. Some claim that trafficking is exacerbated by governments in countries that allow “‘zones of tolerance,’ tourist areas, ports, areas along international trucking routes, . . . and gambling establishments” (Torrey, 2003, p. ix).

The distinction between human trafficking and human smuggling is important, because the two are often taken to mean the same thing. Fassmann, Kohlbacher, Reeger, and Sievers (2005) state that “Human smuggling means assisting in an illegal border crossing and in illegal entry and, therefore, always has a transnational element” (p. 48). The smugglers’ involvement ends once the person has been smuggled into another country. Victims of trafficking, on the other hand, are controlled at every point in the process from countries of origin, through countries of transit, and into countries of destination, which raises questions of human rights. Julia O’Connell Davidson (2005) argues that “the greater the individual’s dependence on middle agents and employers who are effectively unaccountable and unregulated, the more that these third parties enjoy the godlike power to choose between harming or helping” (p. 76), which blurs the distinction between smuggling and trafficking. The situation may be further complicated if a person willingly agrees to travel to another country for work that is promised by a third

party. However, this situation becomes trafficking if the third party fails to live up to their promises or if force, fraud, or coercion are used to lure and/or enslave people.

There are many views and opinions as to how we should define and fight trafficking, but the two most outspoken groups disagree about prostitution and trafficking. The abolitionists, such as the Coalition Against Trafficking in Women (CATW), equate prostitution with both trafficking and violence against women. Saunders (2005) indicates that the nonabolitionists, such as the Global Alliance Against Trafficking in Women (GAATW), “oppose abuses of sex workers under the rubric of forced prostitution while in general supporting sex work as a form of labor” (p. 347). In some countries, prostitution is a legal labor choice, but in many places there is little or no way to distinguish between those who choose to go into sex work and those who have been forced into it by trafficking. Some believe that legalization of sex work would help reduce trafficking; however, there has been only a small amount of research in this area to date.

Like any type of market, human trafficking is driven by supply and demand. It is a booming economy populated with disposable products, which makes it different from the primarily racial, systemic slavery of centuries past. One argument is that the demand for sex work drives human trafficking. Phinney’s (2001) summary of the limited research on this topic indicates,

that men’s reasons for buying sex include a desire for sex without commitment or emotional involvement; the perception that they can ask a prostitute to ‘do anything,’ including acts they would hesitate to request from a regular partner; the belief, particularly among men without (or separated from) regular partners, that sex is necessary to their well-being—a basic need; and the feeling of power experienced in sexual encounters with prostitutes. (Conceptual Framework, Para 3)

People who support this argument, like the CATW, say that the best solution is to arrest people, commonly referred to as “johns,” who patronize sex workers.

Those opposing CATW’s position believe that “demand for sex work is not a predominant driving factor for trafficking; instead, it is driven by poverty, race, and gender inequalities” (Sex Workers Project at the Urban Justice Center, Network of Sex Projects & Prostitutes of New York, 2005, ¶1). Opponents also believe that defining sex work by its demand leads to an “anti-sex work, anti-male and homophobic mindset which, under the guise of protecting sex workers, is another way of under-

mining sex workers' autonomy and causing more harm to them" (§ 2). Groups who believe in this argument, such as the GAATW, believe in acceptance of sex work as a legal labor choice and argue for more regulation in this industry, as in other industries, to stop violence and trafficking.

Trafficking is not limited to sex work; therefore, we must also consider the demand of any employer looking for cheap labor and the supply of men, women, and children for this form, which has been abundant. "In areas where poverty has already limited people's choices, discrimination against women in education, employment and wages can leave them with very few options for supporting themselves and their families" (Phinney, 2001, Conceptual Framework, § 4). Legal migration may not be possible for many, and they may fall prey to traffickers' false promises. People who have fled areas of violence and corruption and people who have been sold to pay off a debt are also susceptible to traffickers who promise a better life. Suppliers, who are driven by the vast profits gained by selling humans, often target the most vulnerable members of society, which enables them to control their victims through violence, denying health care, denying education, denying contraceptives, psychological abuse, taking away documentation, and threatening family members. The problem with human trafficking is exacerbated because humans can be sold repeatedly, creating greater profits for the suppliers.

Legislation against Human Trafficking

The first major step in human trafficking legislation was the 1949 UN Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others (United Nations Office of the High Commissioner for Human Rights, 1949). This law strictly equated trafficking with prostitution and assumed all victims were either women or children, while neglecting the forced labor trade. General consensus is that the 1949 Convention was not successful because of weak enforcement methods. It was adopted by only 69 countries and was not re-ratified by subsequent UN Conventions (Phinney, 2001, Legal Context, § 1).

The 2000 UN Convention Against Transnational Organized Crime and its Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children is currently the most widely accepted statute worldwide and is used as a ruler for international laws against trafficking. Also known as the Palermo Convention, this protocol "specifies criminalization, stronger border controls, and increased security and control of documents as preventive mechanisms" (Phinney, 2001, Legal Context, § 1). It calls for more international cooperation and for the first time, focuses on the victims

of trafficking by addressing their needs for assistance and protection. By May 2001, the protocol had been signed by 85 countries and only needs 35 more signatures to become an instrument of international law.

In the United States, Section 1584 of Volume 18 of the U.S. Code makes it a crime to force a person to work against his will, and Section 1581 makes it illegal to force a person to work through debt servitude (U.S. Department of Justice, Civil Rights Division, n.d., §§ 3, 5). Some child victims may be covered by child abuse and neglect laws as every state in the U.S. requires "law enforcement officers, health care workers, social workers, mental health professionals, and school personnel" to report suspected cases of parental or caregiver abuse and/or neglect. In addition, some states require "commercial film or photograph processors" to report suspected cases of abuse, violence, and/or neglect (Hughes, 2003, Who Should Report Suspected Cases of Trafficking § 1).

The first piece of modern, comprehensive federal legislation concerning human trafficking is the Trafficking Victims Protection Act (TVPA) of 2000. The goals of the TVPA are to prevent trafficking overseas, protect victims, and prosecute traffickers. The TVPA concerns "severe forms of trafficking in persons," which is defined as follows:

- (a) sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person is induced to perform such an act has not attained 18 years of age; or
- (b) the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage or slavery. (U.S. Department of State, 2007, p. 18)

The TVPA classifies what constitutes trafficking and sets criteria for the minimum standards for a country to be considered as combating trafficking. A government is considered to have made serious and sustained efforts to combat trafficking if it investigates and prosecutes and if it contributes data regarding investigations, prosecutions, convictions, and sentences of trafficking cases to the U.S. Department of State. A government must also protect the victims of trafficking and ensure that they will not be jailed and/or penalized themselves. They must institute public awareness and education programs, cooperate with other governments in investigations and prosecutions of traffickers, and extradite persons charged with acts of severe forms of trafficking. Monitoring of immi-

gration and emigration patterns is also considered imperative. Finally, a government must achieve noticeable progress in fighting trafficking from previous years. All governments' efforts are monitored in the State Department's annual Trafficking in Persons (TIP) Report. The report ranks every country in the world according to its risk of being a country of origin, transport, or destination for victims of trafficking and also ranks it according to its efforts to fight trafficking.

Prevention efforts in the U.S. involve conducting educational and public awareness programs. In 2004, the Department of Health and Human Services organized *Rescue & Restore Victims of Human Trafficking*, a public awareness campaign to educate intermediaries, such as law enforcement, social service providers, and faith-based organization workers who may come into contact with victims of human trafficking (U.S. Department of Health and Human Services, Administration for Children & Families [U.S. DHHS, ACF], n.d.a).

The TVPA was reauthorized in 2003 and again in 2005 as a means of renewing the United States' commitment to combat trafficking. The 2003 reauthorization introduced one important new point: victims of trafficking may bring federal civil suits against traffickers for actual and punitive damages (U.S. DHHS, ACF, Office of Refugee Resettlement, 2003). It also includes sex trafficking and forced labor as offenses under the Racketeering Influenced and Corrupt Organization statute.

In order to protect victims of trafficking, the U.S. is providing social service programs for the victims that include making housing, education, health care, childcare, transportation, and job training readily available, which makes it more victim-centered than any previous legislation. The law established the T visa, which allows victims to become temporary residents of the U.S. A quota of 5,000 victims of trafficking per year may receive permanent residence status after 3 years from issuance of the temporary visas (U.S. DHHS, ACF, n.d.b, p. 1). Trafficking victims become eligible for federal or state benefits and services once they become certified by the Department of Health and Human Services. After they are certified, they may apply for the same benefits available to refugees, such as refugee cash, medical assistance, and social services. Victims under the age of 18 do not need to obtain certification; they are automatically issued letters of eligibility by the department.

To ensure prosecution of traffickers, the TVPA has created new law enforcement tools, such as lengthening sentences for traffickers, specialized training for law enforcement officers to recognize victims of trafficking, sending more law enforcement officials undercover, and conducting research to execute well-planned raids. The

training of law enforcement officials is beneficial for the victims, because in the past they were simply arrested as illegal immigrants or prostitutes and deported to their countries of origin. Traffickers may be sentenced to life in prison if the crime results in death or includes kidnapping, sexual abuse, an attempt to kill, or if the victim is under the age of 14. The minimum sentence for a trafficker is 20 years in prison, and it is always considered a trafficking crime if the victim is under the age of eighteen in the sex trade whether or not force, fraud, or coercion were used.

Ambassador Mark P. Lagon (2007), Senior Advisor on Trafficking in Persons, stated that President Bush has allotted more than \$448 million since fiscal year 2001 to combat trafficking, and that this money is used both to implement numerous programs in the U.S. and sent to other countries to assist in funding programs of their own or to investigate international cases of trafficking. In fiscal year 2006, 28% of funding was committed to domestic programs within the U.S., while the other 72% funded international programs. The majority of domestic funding went to organizations such as the Salvation Army, Safe Horizon, the U.S. Conference of Catholic Bishops, and programs in Texas along the U.S. Mexico border. The countries with the highest number of projects (excluding the U.S.) were India, Russia, and Mexico; however, there is at least some funding going to almost every country or region in the world (U.S. Department of State, Under Secretary for Democracy & Global Affairs, Office to Monitor and Combat Trafficking in Persons, 2007). The U.S. government collaborates with many non-governmental organizations (NGOs) to institute the programs that aid the victims of trafficking. The local nongovernmental organizations, law enforcement offices, social service agencies, and religious institutions are often the first to come into contact with victims of trafficking and traffickers; therefore, they are integral in implementing the policies and goals of the TVPA.

Problems with Current Legislation

With all of the benefits described so far of the TVPA and the international laws against trafficking, there is still much to be accomplished in order to fight the trafficking in persons. Much of the U.S. public is only recently becoming aware of this problem. Some who are aware usually consider it an international problem that does not occur within our borders; however, we cannot ignore that it does happen here at home. The TVPA does not monitor the trafficking of victims within the U.S., so we have no idea how big a problem it is within our national borders. The majority of the programs financed by the TVPA are international. Many states, including Illinois with House

Bill 1469, have passed or are working to pass legislation that penalizes traffickers, which is an important beginning. However, there should be equal focus on domestic trafficking within national borders and not just across international borders.

Most of the victims identified by the U.S. government within our borders are citizens of other nations; however, U.S. citizens may also be subjected to trafficking. Victimization can occur in many ways; for instance, both citizens and non-citizens (with or without legal documentation) are trafficked into the U.S. from other countries. Victims may be trafficked from one location to another within the US, often multiple times. In fact, trafficking may not involve travel as some people are enslaved within their own hometown. There is consensus in the field that human trafficking is less about the movement of a person than the exploitation of a person through the use of force, fraud, or coercion.

The GAO states that “the quality of existing country level data varies due to limited availability, reliability, and comparability” and that there is a “considerable discrepancy between the numbers of observed and estimated victims of trafficking” (2006, p. 2). The different definitions of trafficking among countries and the relationships between countries may also make it more difficult to fight trafficking. In some countries, prostitution is legal and therefore, laws against trafficking may be different from prostitution laws in more conservative countries. Every year the U.S. Department of State ranks countries with regard to human trafficking (GAO, 2006, p. 1), but the GAO warns that economic, political, or social ties to other countries may influence our government’s ranking process (p. 33).

Immigration laws in the U.S. can have an effect on trafficking since smuggling and trafficking are often confused. After the September 11th attacks, work-site inspections by U.S. immigration officials fell because they were focusing on larger national security cases (Watson & Rodriguez, 2006, p. 9), causing a cutback in illegal immigration cases. However, immigration, both legal and illegal, has now become a primary focus because of the recent proposals for revised immigration laws. More focus on the illegal immigration industry is likely to have a negative effect on victims of trafficking, since most are seen first as illegal immigrants.

Peter Laufer, in his book *Wetback Nation* (2004), argues that the current situation with the Mexican/U.S. border is offering ample opportunities for human trafficking: drug smugglers are now moving into human trafficking since people-smuggling usually results in a less severe jail sentence; rival *coyoteros* (smugglers) kidnap and sell families who are trying to cross into the U.S., and some employers in the U.S. are actively recruit-

ing people in Mexico, hiring them illegally, and then treating them inhumanely. Each case of illegal immigration does not necessarily constitute human trafficking, but some cases do begin or end as human trafficking and we must investigate each case on its own merits without identifying the immigrant as a criminal. The debate on illegal immigration and the United States’s view of illegal immigrants affects and changes how we see victims of human trafficking.

Action Needed

The United States, as well as the world, needs to focus on obtaining more reliable data on victims of trafficking. Because the TVPA is such a new policy, its success has yet to be determined. The TVPA does fund research projects every year; however, the methods for uncovering data and studying instances of human trafficking are not yet fully formed or understood. There is little comprehensive data about human trafficking or about the success of the TVPA and more is needed. Of course, this is extremely difficult since most victims are considered “the invisibles.” The very nature of human trafficking is that marginalized populations are targeted and are therefore overlooked to begin with, much less after they have been trafficked. They are either prevented from seeking help by their traffickers or are too frightened to report them. We as fellow humans should reach out to these marginalized populations and refuse to overlook them. If the general public, the police forces, and national governments are educated, the world will be more aware of this issue and will recognize victims more easily. Research, education, and prevention are the keys to combating this problem.

As social workers, we are some of the first to come into contact with the victims, especially those of us who work with immigrants, refugees, and disadvantaged populations within and outside our own country. The social work community should train the people in our field to learn how to identify victims and help them. Social workers should be taught to listen closely to stories about how immigrants and refugees came to this country and how they were treated here. We should ask questions about the migration patterns of our clients if they have moved from place to place frequently with no apparent reason. We should look for clues of people who have little or no control over their own schedule, are isolated culturally or physically, or show signs of abuse. We should identify symptoms of complex post traumatic stress disorder (PTSD) that often accompanies a crisis such as sexual abuse or violence, and we should find ways to get victims medical treatment, psychological treatment, and financial and legal support.

There are many ways to educate the general public about this issue and to reach out to potential victims. I accompanied a delegation of social work graduate and law students to a student-to-student conference in Guayaquil, Ecuador, which was cosponsored by the American Bar Association Human Trafficking Project and the *Proyecto Contra la Trata de Personas Ecuador*. It was an opportunity to exchange ideas with Ecuadorian university students about what our countries are doing to fight trafficking. In Ecuador, the *Instituto Nacional de la Niñez y la Familia* (INNFA) has partnered with other NGOs and private organizations to create an advertising campaign to promote awareness of human trafficking. The commercials shown on national television feature such celebrities as Ricky Martin and aim to educate children to stay away from *coyoteros*, inform the public about the dangers of human trafficking, and provide information on how to identify victims of trafficking. The INNFA has also been integral in instituting a national hotline, much like 911 or 411, where people may call in specifically to report traffickers or notify that they may have identified a victim.

Some organizations in the United States are already utilizing the ideas communicated at the conference in Ecuador. In Illinois, the Rescue and Restore Campaign organizes an Outreach Day each year. At the second annual Outreach Day on May 5, 2007, hundreds of volunteers across the state hung thousands of posters displaying the phone number for the National Human Trafficking Resource Center, also known as the U.S. Victim Hotline, (1-888-373-7888). As a volunteer on this day, I was not surprised to find that most of the people I talked to had no idea that trafficking existed. The Illinois Rescue and Restore Campaign hopes to eventually expand Outreach Day to include public service announcements on television and to include more states. Public awareness was raised on that day, but more advertising of the hotline number is needed, so that suspected cases can be reported and victims can reach out for help.

Another way to fight human trafficking is to reach out and educate young people. One example of such an initiative was the Ecuadorian conference I attended in which high school students representative of those most likely to fall victim due to underprivileged backgrounds, were invited to learn about trafficking and discuss how they felt about it. The students I observed appeared deeply moved by what they heard and spoke out about it vehemently. Many of them left the conference eager to spread the word and help put a stop to trafficking. As an intern with the Illinois Rescue and Restore Campaign, I have also had the opportunity to speak at a local high school to more than 600 students about human trafficking. High school students are a target audience in

discussions of trafficking, not only because they are the future policy-makers and social workers of our country, but also because runaways and street children are highly susceptible to being ensnared by traffickers and pimps. More opportunities for education about human trafficking should be available throughout all parts of the world and in the United States, especially targeting groups that are disadvantaged or at risk and are more likely to become victims.

More discussion about the spread of HIV/AIDS and its tie to trafficking must also happen. Most of the world's trafficking industry occurs in Asia, where discussions of sex and promiscuity are still considered taboo and are only now receiving some attention. Many of the victims of trafficking in this area, and throughout the world, are prevented from protecting themselves against STDs as they are denied the use of condoms. As difficult as discussions of rape and sexual abuse are, especially when it happens to children and minors, we must talk about ways to increase safe-sex practices. The current conservative climate in the U.S. also makes it difficult to educate our children about the use of condoms, but it is an imperative point when discussing human trafficking for sex work.

The TVPA establishes adequate guidelines for finding legal support and basic services for victims of trafficking; however, more attention should be given to finding therapeutic treatments for the psychological trauma and abuse victims suffer. Many experts agree that victims of human trafficking require much longer treatment than victims of similar crimes, such as domestic abuse or childhood sexual abuse. While the atrocity of these crimes should not be downplayed and existing treatments should be used as a starting point, social workers and therapists should be aware of the ways human trafficking is similar and different from these crimes. Victims of human trafficking are brainwashed to be distrustful of authorities, to sometimes become attached to their captors, and to feel shame and self-blame. When faced with freedom and free choice, many victims become frightened and overwhelmed after so many years of psychological abuse. Social workers should be aware of these possibilities in order to treat their clients more fully if they do come across a victim.

Finally, more information and support is needed for all victims of trafficking, not just victims of sex work. Sex work is most often what the public hears about in the popular media because of its shock value and it is easily sensationalized. Since traffickers often prey on the most vulnerable members of society and since those members are most often women and children, unfortunately most victims of trafficking are women and children in the sex industry. However, we must not forget the men who are

forced into sex work; the people who are forced into labor; the children who are forced to beg on the streets far from home; the children who are forced to become soldiers in guerrilla warfare; and the prisoners who sometimes live and sometimes die after they are forced to give up an organ.

Conclusion

V, the victim mentioned previously, was eventually rescued. She managed to escape her third captor when she ran away to a nearby convenience store. The employee contacted a Chicago social service provider, who referred her case to a local program serving victims of human trafficking. The social workers at this agency helped V obtain public benefits, including placement in federal foster care, therapy and counseling, and are helping her apply for a T visa (Heartland Alliance, n.d., p. 1). V's rescue story is encouraging, but there are millions in the world who are still enslaved. Only about 1,000 victims have been identified by the U.S. government since 2000. Just because so few victims have been identified and found does not mean that millions more do not exist.

Great strides have been made in the fight against human trafficking, but complacency must not accompany the progress. Our global society must continue to make gains in the fight by researching the problem, educating the public, empowering the victims, and punishing the

criminals. We must realize that trafficking affects all of us, even if peripherally, by changing migration patterns, increasing the spread of STDs, such as HIV/AIDS, increasing substance abuse, increasing the revenue earned by members of organized crime, and also by taking the time of our law enforcement and by clogging our court systems. Continued profit in this industry will have a ripple effect on our society at large and will change the face of our world. This change will not be for the better if we continue to profit in the selling of our own kind.

Kevin Bales, the President of Free the Slaves and an expert on human trafficking issues, says that

If there is one basic truth that virtually every human being can agree on, it is that slavery must end. What good is our economic and political power, if we can't use it to free slaves? If we can't choose to stop slavery, how can we say that we are free? (2004, p. 262)

Social workers can be at the forefront of this fight, from education and prevention to outreach, protection, and treatment of victims. Every life has value and each person deserves the basic human right of freedom of choice. The more people are aware of this issue, the better equipped they are to reach out to victims and to eradicate this problem.

Allison Lowe is currently in her 2nd year in the MSW program at Loyola. She is interning with the Rescue and Restore Victims of Human Trafficking Campaign at the Illinois Department of Human Services. She also works at the Carole Robertson Center for Learning and plans to continue working in human trafficking advocacy and outreach following graduation.

References

- Bales, K. (2004). *Disposable people: New slavery in the global economy*. Berkeley: University of California Press.
- Davidson, J. O'C. (2005). *Children in the global sex trade*. Cambridge, UK: Polity Press.
- Fassman, H., Kollbacher, J., Reeger, U., & Sievers, W. (2005). *International migration and its regulation: State of the art report Cluster A1*. (International Migration, Integration, & Social Cohesion Rep. No. WP-2). Retrieved June 23, 2007 from http://www.imiscoe.org/publications/workingpapers/documents/international_migration.pdf
- Heartland Alliance for Human Needs & Human Rights. (n.d.). "V" Africa. *Heartland Alliance Counter-Trafficking Program training efforts* [Handout]. Chicago: Author.
- Hughes, D. M. (2003). *Hiding in plain sight: A practical guide to identifying victims of trafficking in the U.S.* Retrieved November 24, 2006 from http://www.acf.hhs.gov/trafficking/resources/plain_site.html
- Lagon, M. P. (2007, June 12). *Release of the Seventh Annual Trafficking in Persons Report* [Briefing]. Retrieved June 30, 2007, from <http://217.160.247.250:8000/cgi-bin/nph-proxy2.cgi/010110A/http/www.state.gov/g/tip/rls/rm/07/86306.htm>

Human Trafficking: A Global Problem with Solutions that Begin at Home

- Laufer, P. (2004). *Wetback nation: The case for opening the Mexican-American border*. Chicago: Ivan R. Dee.
- Phinney, A. (2001). Trafficking of women and children for sexual exploitation in the Americas: An introduction to trafficking in the Americas. Retrieved November 24, 2006, from the Organization of American States Web site: <http://www.oas.org/cim/english/proj.traf.alisonpa-per.htm>
- Saunders, P. (2005). Traffic violations: Determining the meaning of violence in sexual trafficking versus sex work. *Journal of Interpersonal Violence*, 20, 343-360.
- Sex Workers Project at the Urban Justice Center, Network of Sex Work Projects, & Prostitutes of New York. (2005, March 1). What is "demand" in the context of trafficking in persons? Retrieved November 24, 2006 from the Sex Workers Project Web site: <http://www.sexworkersproject.org>
- Torrey, M. (2003). Preface. In M. Torrey (Gen. Ed.) & S. Dublin (Stud. Rep. Ed.), *Demand dynamics: The forces of demand in global sex trafficking: conference report, conference held October 17 and 18, 2003, Chicago, Illinois, USA* (pp. vii-ix). Retrieved April 17, 2006, from http://www.law.depaul.edu/institutes_centers/ihrli_downloads/demand_dynamics.pdf
- Trafficking Victims Protection Act, Div. A of Pub. L. No. 106-386 § 108, as amended (2000).
- United Nations Office of the High Commissioner for Human Rights. (1949) *Convention for the suppression of the traffic in persons and of the exploitation of the prostitution of others*. Retrieved November 24, 2006, from <http://www.unhchr.ch/html/menu3/b/33.htm>
- U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.a). *Federal government efforts to combat human trafficking*. Retrieved June 27, 2007, from the Campaign to Rescue & Restore Victims of human Trafficking. <http://www.acf.hhs.gov/trafficking/>
- U.S. Department of Health and Human Services, Administration for Children and Families. (n.d.b). *Trafficking Victims Protection Act of 2000 Fact Sheet*. Retrieved November 24, 2006 from http://www.acf.hhs.gov/trafficking/about/TVPA_2000.pdf
- U.S. Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement. (2003, December 22). *Statement by Tommy G. Thompson* [Press release]. Retrieved June 28, 2007, from http://72.14.205.104/search?q=cache:yUSovJ5sWpgJ:www.acf.hhs.gov/programs/orr/programs/state-ment_by_tommythompson_031222.htm+reautho-rization+2003+trafficking+%22Health+and+Human+Services%22+%22punitive+damages%22&hl=en&ct=clnk&cd=1&gl=us
- U.S. Department of Justice, Civil Rights Division. (n.d.). *Involuntary servitude, forced labor, and sex trafficking statutes enforced*. Retrieved November 24, 2006 from <http://www.usdoj.gov/crt/crim/1581fin.htm>
- U. S. Department of State. (2007). "Trafficking in Persons" defined. *Trafficking in Persons Report: June 2007* (p. 18). Washington DC: Author.
- U.S. Department of State, Undersecretary for Democracy & Global Affairs, Office to Monitor and Combat Trafficking of Persons. (2006). *Trafficking Victims Protection Act—Minimum standards for the elimination of trafficking in persons*. Retrieved November 24, 2006, from <http://www.state.gov/g/tip/rls/tiprpt/2005/46770.htm>
- U.S. Department of State, Undersecretary for Democracy & Global Affairs, Office to Monitor and Combat Trafficking of Persons. (2007). *U.S. government anti-trafficking in persons obligated project funding (fiscal year 2006)* [Fact sheet]. Retrieved from <http://www.state.gov/g/tip/rls/fs/07/83371.htm>
- U.S. Government Accountability Office (GAO). (2006). *Human trafficking: Better data, strategy, and reporting needed to enhance U.S. antitrafficking efforts abroad*. Retrieved November 24, 2006 from <http://www.gao.gov/new.items/d06825.pdf>
- Watson, J., & Rodriguez, O. R. (2006, April 16). Many Mexicans secure jobs before crossing border. *The Chicago Tribune*, p. 9.

An Overview of Animal Hoarding

By Anne M. Fleury

Abstract

Animal hoarding is an understudied problem affecting individuals, animals, and the community at large. Animal and human neglect go hand-in-hand as many hoarders also provide inadequate care for vulnerable children and adults living in the home. Appropriate media coverage and strong policies are needed to help combat the problem of animal hoarding. There is no current psychiatric diagnosis that addresses the pervasiveness of hoarding and research on appropriate treatments remains in its infancy. Social workers need to provide appropriate interventions with animal hoarders and educate other professionals about the problem. Animal hoarding will continue to affect many lives until it receives greater research and is better understood.

Introduction

Most people are familiar with the roles companion animals play in our lives and understand the benefits of adopting pets. Less familiar are homes with too many animals, when a pet is no longer “man’s best friend” but rather a liability. These are homes of animal hoarders. Animal hoarders are defined as any individual who possess a large number of companion animals, fails to provide adequate nutrition and veterinary care, and keeps the animals in a severely overcrowded environment.

Further, an animal hoarder fails to recognize or has a reckless disregard for the conditions the animals are living. As expressed in the 2001 Cruelty to Animals Act, animal hoarders

display an inability to recognize or understand the nature of or has a reckless disregard for the conditions under which the companion animals are living and the deleterious impact they have on the companion animals’ and owner’s health and well-being.

The act of animal hoarding poses problems not only for the psychological well-being of the hoarder, the overall welfare of the animals, but also for society’s responsibility to find appropriate ways to intervene to mitigate these concerns.

Hoarding: Effect on Animal Welfare

Individuals who hoard animals put animals at risk when they deprive animals of the basic principles of care. The same basic needs that humans require—appro-

priate food, shelter, healthcare, and stimulation—apply in similar ways to animals. Hoarders may be oblivious to their animals’ health and needs for veterinary care. As the number of animals hoarded increases in a household, conditions may deteriorate and lead to the spread of infectious diseases, animal starvation, and the accumulation of animal feces and urine. Animals that are deprived of care face both physical and psychological problems. Weight loss, parasites, and a poor fur coat may be early signals that animals are suffering. Ill animals may eventually begin eating the corpses of other animals when faced with survival (Wittmeier, 1999 as stated in Avery, 2005, p. 827). Fighting to survive, animals that are deprived of care face both physical and psychological problems.

It is common for hoarders to keep both live and dead animals in the same space. At least one dead animal was found in the homes of approximately 34% of animal hoarders (Berry, Patronek, and Lockwood, 2005): Deceased dogs were the most likely to be found (47.4%), followed by deceased cats (31.6%) (p. 176).

Rescuing animals from hoarding conditions is not as simple as merely taking animals from a hoarder’s home. Often, already stressed by disease and not likely socialized, the animals may be difficult for animal control authorities to confiscate. Animal shelters and the community at large are often faced with the difficulty of sheltering their animals. Once placed in often overcrowded shelters, the majority of animals are often not adoptable due to various behavior problems. It is difficult to ascertain the underlying psychological suffering animals face by confinement, lack of socialization, and overall neglect. Compounded by a multitude of issues, the majority of animals undergo euthanasia after placed in a shelter.

Hoarding: Human neglect as part of a pervasive problem

Animal hoarders have been found to neglect not only their pets, but also the care of other people in their home. These people may include dependent children, elderly, or disabled individuals (HARC, 2002; Patronek, 2001). This neglect surfaces as dangers to both humans and animals develop from the unsanitary conditions found in hoarder homes. HARC (2002) noted, “In a typical case, household interiors were coated, often several inches high, with human and animal urine and feces, sometimes to an extent that floors buckled” (p. 128). Many hoarder houses had no means of storing or preparing food in a safe manner.

Lack of basic utilities such as running water,

functional bathrooms, and electricity are not uncommon in some cases. Worth and Beck (1981) described a hoarder who died from complication of a bacterial infection linked to an organism in cat saliva. Other reports include hoarders becoming anemic after suffering numerous fleabites (Lockwood & Cassidy, 1988). The Occupational Safety and Health Administration (OSHA) (1989) noted that high ammonia levels from urine accumulation impaired ones' health through eye and respiratory tract irritation. OSHA's (1989) study concluded that animals exposed to high levels of ammonia "...were experiencing too much respiratory and eye irritation to be interested in their food" (para. 8). It is possible that vulnerable humans, including children and elders, may face effects of less nutritional intake similar to effects studied in animals.

It is through the effects of living in unsanitary conditions that authorities may learn of hoarders. What appear to be unrelated investigations such as children sent home from school due to poor hygiene, or an elderly individual hospitalized for numerous bedsores, often can be the first step in uncovering hoarding. Animal hoarding is a highly hidden insidious problem.

Further documented by a 2001 joint effort between the Humane Society of the United States and the National Center on Elder Abuse, 92.4% of workers in adult protective services had come across the co-existence of self-neglect and animal neglect. Cook-Daniels (2002) also explored the problem of self-neglect in regard to the animal hoarder's resistance to services, non-compliance with medical treatment, reclusive tendencies, and a hoarder's inability to take care of personal health and home needs. Succinctly stated in the Cook-Daniels study (2002), "...the piece that's been overlooked is that animal neglect is most often going hand-in-hand with human self-neglect" (p. 2).

Hoarding: A Challenge to the Media

The media, with any social issue, plays a central role in how and if the public is able to break apart its various dimensions. In regards to hoarding, media reports have mainly focused on the substandard and subhuman existence found in hoarding houses and stressed that neither animals nor humans should be exposed to the conditions. That said, the disorganized state of hoarders' homes often took precedence over animal suffering and reports of child neglect surpassed reports of animal neglect in both headlines and content (Arluke et al., 2002).

Shaping the public's emotional response continues to be a large component of media coverage. While explaining the cases in understandable formats, the media failed to provide a consistent picture of the depth and seri-

ousness of the problem of hoarding. The vague media portrayal of hoarders may add to the role, or lack thereof, played by government agencies.

Recognized yet often minimized, hoarding cases involving middle-class citizens such as veterinarians, breeders, and white-collar professionals have been portrayed as symbols of irony and inappropriateness. Yet, despite the crime story format of the media, many of these hoarders have been handled leniently in the legal system. Leniency by judges continues the lack of overall concern for hoarding and has supported the media's image of hoarders as harmless.

Hoarding: Current Legal Interventions and Legislation

Common legal problems animal hoarders may face include zoning violation fines, animal cruelty charges, and animal mischief charges. The majority of charges are misdemeanors and penalties include only small fines. It is often difficult to charge hoarders with felony charges since many states do not have specific laws. Prosecution of these charges is also very difficult. With each state and municipality enforcing different laws regarding animals, hoarders often face little reprimand. Further, no federal legislation exists regarding the care of animals by individuals or shelters. However, every state has animal cruelty laws requiring one to provide appropriate nutrition, shelter, and veterinary care, or they have a law that prohibits cruel treatment. Lacking animal hoarding laws, most states and municipalities leave no choice for authorities but to use outdated and ambiguous laws to address hoarding.

Most cases of hoarding are first discovered when a person is charged with animal neglect or cruelty. Numerous citations for lack of adequate shelter, nutrition, and veterinary care often force law enforcement to write a separate ticket for each animal and each offense. Patronek, as cited in Kuehn (2003), stated, "...more serious charges may be buried and it may seem that law enforcement is being overly aggressive and harassing a well-meaning person" (p. 1). Using numerous citations may trivialize the offenses and the hoarder may ultimately gain public sympathy.

Once hoarding situations are identified, states such as Illinois, Vermont, and New Mexico all have excellent laws to intervene on the behalf of animals and individuals. Illinois became the first state to create a law that specifically deals with animal hoarders. Illinois' 2001 Cruelty to Animals Act 92-0454 defines animal hoarders and mandates the court to order all convicted hoarders to undergo a psychological or psychiatric exam and to undergo any treatment deemed appropriate at their own

expense. The laws of Vermont and New Mexico have similar stipulations of required psychological assessment and treatment of hoarders. Upon conviction under these laws, the court may bar the individual from owning any animals or conspiring with others to collect animals on the hoarder's behalf for a period of time that the court deems reasonable. Convicted hoarders will not be allowed to adopt the seized animals.

Despite improvements in legislation, there continue to be concerns. Berry, Patronek & Lockwood's (2005) study of 56 cases from 26 states found that in only 26% of cases studied the court ordered mental health evaluations or pretrial psychological assessments of the defendants. HARC (2002) noted the reluctance to recommend counseling as surprising because many hoarder behaviors appeared to be symptoms of larger psychological concerns based on the neglect of themselves, the animals, and their homes. Some hoarders' attorneys noted the clients had mental health histories and some investigators asked the judges to view the hoarders as irrational and incompetent. Without formal psychological intervention, recidivism has become a persistent problem for animal hoarders following legal action. Patronek (2006) noted recidivism of nearly 100% after prosecution. Animal hoarders who do not stay in their communities often begin hoarding in another location. Handy (1994) describes a case where animal control officers seized more than 50 animals from a hoarder in Maryland and within two days the hoarder had already acquired 20 more animals.

Characteristics of Animal Hoarders

Despite certain stereotypes of types of people with many animals, animal hoarders are not restricted by gender, socioeconomic, or age restrictions. Both males and females, professionals and unemployed, young and old hoarders have been identified. Public perceptions of hoarders as unemployed, retired, or of a lower socioeconomic class may distort the fact that hoarders can be professionals. One study (Patronek, 1999) found that 76% of hoarders are female, and 46% were over 60 years of age. Approximately half of the hoarders lived in a single-person household.

Hoarders have different patterns in terms of animal collection. Worth & Beck determined in a 1981 study that men more often collected dogs, and women more often collected cats. The animals most frequently involved in Patronek's (1999) study were cats, dogs, farm animals, and birds with an average of 39 animals per case. There have been some reports of more than 100 animals in one household. Patronek (1999) reported meeting animal hoarders who organized their dead animals by the date of

death, size, and color.

The varied reasons leading one to hoard animals share certain characteristics reflecting loneliness or isolation, either currently or throughout the lifespan. The majority of animal hoarders reported starting to collect things in childhood (Worth & Beck, 1981). Patronek (2001) stated, "...hoarders grew up in chaotic households with inconsistent parenting, in which animals may have been the only stable feature" (p. 7). Hoarders may choose to keep animals as a reminder of the only stability they knew growing up. Once a person has begun hoarding, characteristics include surrounding oneself with numerous animals that are not being cared for, focusing on either rescuing or accumulating animals, forming deep attachments and losing the ability to part with them even if the animals are deceased (Avery, 2005).

Viewing one's possessions as central to one's identity is common with hoarders. Hoarders often face grief and loss when possessions are lost or taken. So extreme can be these feelings of grief and loss that animal hoarders may keep the dead animals near them to alleviate the symptoms of grief. Approximately 60% of animal hoarders were found with dead animals in their possession (Patronek, 1999).

Finally, the majority of animal hoarders lead solitary lives. Embarrassment of their living conditions causes some to isolate from family and friends. Others may lead social lives while keeping their home life a secret. Worth & Beck (1981) noted social isolation is often a consequence of hoarding, not the cause.

Why hoard?

Common defenses used by hoarders

Like victims of many obsessive or dangerous behaviors, hoarders may go to extreme lengths, often compromising other aspects of their lives, to maintain their pathological hoarding behavior. Justifications and excuses used by hoarders are plentiful. Maintaining a positive self-image and self-esteem are crucial for hoarders to validate their behavior. As their self-esteem is threatened, a larger effort is often made to rationalize the situation. The reason for arguments slowly shifts from normal to pathological as one faces greater threat to self-esteem.

Vaca-Guzman and Arluke (2005) analyzed the justifications used by hoarders in 163 cases. Individuals accepted responsibility, but then denied it as harmful or negative. Denial, one of the most primitive defense mechanisms, can help hoarders dismiss their actions as odd or harmful by rejecting any implications. One hoarder claimed he cleaned up after his 27 dogs and 47 cats living in a loft at least once a day. When the filth and stench

were brought to his attention, his response was to deny the animals' waste as his problem but to report that animals mark their territory (Vaca-Guzman & Arluke, 2005, p. 3).

Hoarders supported their denial with their explanations that the animals in fact had the opposite experience, often claiming that they loved the situation they were in. One hoarder with 37 emaciated dogs noted, "This is heaven for them" (Vaca-Guzman & Arluke, 2005, p. 343). Treating animals as family, naming them, and professing love for them were used as a justification for having them. Extreme grandiosity can be witnessed in some hoarders, who see themselves as a "Good Samaritan," saving animals from death. Hoarders may personify themselves as saviors by claiming a need to rescue animals. Although the hoarders' environment may be less than ideal for an animal, in their mind the setting may lessen the harm of death and provide a noble and purposeful cause. Arguments of keeping animals from death allow hoarders to justify their behavior of animal neglect. Death is not seen as an option by hoarders who believe they are "saving" the animals from this fate. Altruistic beliefs allow hoarders to believe they should be admired for their commitment to animals.

Berry, Patronek & Lockwood (2005) found nine cases of hoarders identifying themselves as the head of rescue groups or sanctuaries. Life, even though appalling, is seen as a better option. A man with a Rottweiler and 64 pit bulls claimed "I took care of dogs people were trying to kill" (Vaca-Guzman & Arluke, 2005, p. 345). Often, hoarders may view themselves as being targeted by authorities who did not understand their plight to save animals.

In some cases, partial responsibility of hoarders was softened through excuses and rationalizations. Animal hoarders who may have accepted the reality of the situation, while denying or deflecting complete responsibility, often used excuses. They felt credit should be given for things they did well to negate their hoarding behavior. They rationalized that it is difficult for anyone to care for numerous animals and that often the situation "got out of hand" (Vaca-Guzman & Arluke, 2005, p. 347). Scapegoating, shifting blame away from oneself and onto another, was found in 15.4% of Vaca-Guzman and Arluke's (2005) cases. Hoarders blamed the lack of community resources for homeless animals, owners who abandon or lose their pets, and those who bring animals to them unsolicited. Some hoarders reported mental, physical, and economic problems. Hoarders often claimed they were not responsible for their behavior because their feelings for the animals transcended their will.

Clinical Models for Understanding the Etiology of Animal Hoarding

With research of hoarding behavior still in its infancy, numerous psychiatric models have been suggested as ways to explain, diagnose, and treat the behavior. They include the delusional, dementia, addictions, zoophilia (where animals provide sexual gratification), attachment, and obsessive compulsive disorder (OCD) models.

The delusional model (Frost, 2000) explains hoarders as believing they hold special powers to communicate and/or empathize with animals (p. 2). The delusional model also recognizes the failure of hoarders to acknowledge that the animals were not getting appropriate care. Delusions may also include reality-based paranoia towards animal control authorities.

Another approach to understanding the etiology of animal hoarding is its potential relationship with dementia (Patronek, 1999). Dementia is a cognitive impairment involving an individual's judgments, communication, coordination, and memory. Patronek (1999) suggested a high prevalence of animal hoarders are placed in a residential facility or under guardianship (26%), and that the individuals showed no insight into the irrationality of their behavior.

Hoarding has also been explained as a form of addictive behavior. A person with addictive behavior is unable to control their dependence on a particular substance or activity. Preoccupation with the animals, denial of the problem, rationalization for the behavior, social segregation, and both environmental and personal neglect are symptoms of addictive behavior (Lockwood, 1994). Hoarding of possessions can be associated with gambling (Meagher et al., 1999) and compulsive shopping (Frost et al., 1998).

Early developmental deprivation of human attachment offers an alternative approach to explain animal hoarding. Hoarders who faced neglect, absent, or abusive caregivers as children may turn to animals for unconditional love. Transferring one's attachment to animals can be safer than trusting other humans and the stability offered by animals can bring a sense of emotional stability (Worth and Beck, 1981). Hoarding becomes pathological when an increasing number of animals are needed to fill the void of attachment.

Congruent with many issues in our mental health system, the explanation most often associated with hoarding behavior is a medical model, which identifies the problem as a psychiatric condition. Individuals with obsessive compulsive disorder may have "an overwhelming sense of responsibility for preventing imagined harm

to animals, and they engage in unrealistic steps to fulfill this responsibility” (Frost, 2000, p. 3). Patronek (1999) noted more than 80% of animal hoarders also hoarded inanimate items, indicative of a diagnosis of OCD. Compulsive hoarding can be described as an individual who alleviates their anxiety by continually acquiring animals or objects without any satisfaction. Individuals feel compelled to repeat their hoarding knowing that it will only be a temporary reprieve for them.

One must first understand the underlying issues behind the animal hoarding to successfully address the issue. The hoarding of animals can be viewed as a symptom, or outcome, of a disorder. The core of hoarding may be traced back to a myriad of other “defined” psychiatric diagnoses.

Interdisciplinary Interventions with Animal Hoarding Cases

Perhaps the most comprehensive, effective intervention enlists the use of an interdisciplinary group of professionals to address the broad problems of animal hoarding on the micro- and macrolevel. Involving human health and social services, housing authorities, legislators, community health professionals, and animal welfare professionals in an integrated approach addresses the numerous concerns of hoarding. Task force members addressing multiple concerns such as animal welfare, child abuse and neglect, animal abuse and neglect, housing issues, and healthcare have greater leverage when confronting the problem than if working separately, or neglecting one aspect while focusing on another.

Both the Dane County (WI) Task Force (1999-2000) and New York City (NY) Task Force (2003-2004) have interdisciplinary approaches in place to facilitate interaction between professionals and hoarders. A cross training manual published by the Humane Society of the United States and the Department of Health and Family Services, Division of Disability and Elder Services Bureau of Aging and Long Term Care Resources (2003) provides information on companion animals, exploitation, self-neglect, and elder abuse. Its focus is to have animal protection and adult protective services agencies collaborate to strengthen communities.

According to Handy (1994), humane societies often use different types of interventions. One intervention is the cooperative approach that encourages the hoarder to voluntarily relinquish some animals. Hoarders may also choose to spay or neuter any animals they keep. Another intervention involves limiting the number of animals one may keep through a court order with ongoing monitoring.

In summary, interdisciplinary groups need to

coordinate services for animals, hoarders, and the community. The members each have a role to play in the group and must work collaboratively while allowing each member to focus on their specialty.

Social Work Implications

There are specific implications for both social work practice and policy. By understanding animal hoarding, professionals will be able to better recognize the pervasiveness of the problem and offer appropriate treatment. With research on hoarders being in its infancy, few mental health treatment standards have been developed. Following, the author will discuss some general principles of treatment that will be helpful in working with animal hoarders.

Social workers may come directly in contact with hoarders as a clinical referral. The importance of the therapeutic alliance, the empathic relationship formed through interactions between the therapist and client, cannot be understated. The real relationship, a genuine connection between the client and therapist, is necessary to have in place before the therapist and client can work purposely together.

Strategies have been noted for becoming more connected and comfortable working with hoarders. Nathanson, (as cited by Cook-Daniels, 2002) noted that social workers should take something they are familiar with, such as self-neglect or crisis intervention, and apply it to working with hoarders. Developing trust may be difficult for an individual who hides their hoarding and denies the problem. The hoarder may have significance transference reactions to the therapist. A hoarder’s feeling of a general mistrust of authorities is a problem social workers must understand and expect when working with hoarders. Being mandated to attend counseling may also lead to resentment toward the social worker. It can take years for some clients to fully understand their problem and be willing to make changes.

Social workers must continually assess their countertransference, the therapist’s feelings in reaction to the experiences, emotions, or problems when working with hoarders. Many professionals are unable to be sympathetic with animal hoarders for a variety of reasons including misinformation, lack of information, or personal feelings on the issue. Individuals who try to intervene need to be aware of their own emotional responses to obtain an appropriate perspective. Social workers may become emotionally reactive not only to the client, but to the animals. Therapists need to remember that they are treating the individual who hoards animals, and not rescuing the hoarded animals. Therapists must also continually engage in reflective practice in which they explore

the natural process of countertransference.

On the macrolevel, social workers must also advocate for this clinical population. The current policies on animal hoarding mandate the hoarder to pay for their own psychological treatment and sheltering of any seized animals. These policies may deter individuals with little funds to seek treatment. Social workers need to advocate on behalf of hoarders who may not be able to afford the legal process currently in place. Also, educating the media, other professionals, and the community about the problem of hoarding is necessary if social workers aim to make any progress in addressing this problem. Lauren Joniaux (as cited in Handy, 1994) noted that one must remember the individuals and the reasons why they hoard instead of strictly enforcing laws.

Conclusion

Animal hoarding is an insidious problem affect-

ing numerous community agencies. Both animals and humans face neglect at the hands of hoarders. This article is intended to expose social workers to a topic that is rarely discussed or studied. Limitations of the article are noted as it was not possible to cover any of the sections of animal hoarding in depth, but rather to expose the breadth of the problem.

Unfortunately, the study of treatment options used with hoarders is minimal: It is difficult to treat a problem that has only recently been acknowledged by professionals. Social workers must convey the seriousness of animal hoarders to other professionals while continuing to advocate on behalf of the hoarder. Hoarding with continue to be addressed with hit-and-miss solutions until the problem of animal hoarding is recognized as a serious mental health issue. Social workers must take the lead in educating the public about the problem and advocating that hoarders receive the best treatment options and services available.

Anne Fleury received her MSW from Loyola in 2007. She became interested in hoarding after visiting a hoarder's house. She plans to continue educating others about animal hoarding and its numerous implications.

References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders*, (4th ed.) Washington, DC: Author.
- Arluke, A., Frost, R., Sketketee, G., Patronek, G., Luke, C., Messner, E., Nathanson, J., & Papazian, M. (2002). Press reports of animal hoarding. *Society and Animals*, 10(2), 113-135.
- Avery, L. (2005). From helping to hoarding to hurting: When the acts of "Good Samaritans" become felony animal cruelty. *Valparaiso University Law Review*, 39(4), 815-858.
- Berry, C., Patronek, G., & Lockwood, R. (2005). Long-term outcomes in animal hoarding cases. *Animal Law*, 11(167), 167-194.
- Centers for Disease Control. (1989). *OSHA comments from the January 19, 1989 final rule on air contaminants project extracted from 54FR2332 et. seq.* Retrieved October 8, 2006 from www.cdc.gov/niosh/pel88/7664-41.html
- Cook-Daniels, L. (2002). Pilot project provides long-term social work assistance to hoarders: An interview with Jane Nathanson. *Adult Abuse Review*, 1(3). Retrieved September 5, 2006 from <http://www.wordbridges.net/elderabuse/AAR>
- Cruelty to Animals Act, 510 ILCS 70/2.10, (2001).
- Dane County Hoarding Task Force. (2000). *This full house: The Dane county hoarding task force report.* Retrieved October 11, 2006 from <http://www.tufts.edu/vet/cfa/hoarding/pubs/dane>
- Frost, R. (2000). People who hoard animals. *Psychiatric Times*, 17(4), 367-382.
- Frost, R., & Steketee, G. (1998). Hoarding: Clinical aspects and treatment strategies. In M.A. Jenike, L. Baer & W.E. Minichiello (Eds.), *Obsessive compulsive disorders: Practical management*, (3rd ed.), (pp. 533-554). St. Louis: Mosby Inc.
- Handy, G. (1994). Handling animal collectors, part 1: Interventions that work. *Shelter Sense*, 16, 3-10.
- Hoarding of Animals Research Consortium. (2002). Health implications of animal hoarding. *Health & Social Work*, 27(2), 125-132.
- Humane Society of the United States (2001). *First strike campaign.* Washington, DC: Author.
- Humane Society of the United States and Wisconsin Department of Health and Family Services, Division of Disability and Elder Services Bureau of Aging and Long Term Care Resources (2003). *Creating safer communities for older adults and companion animals.* Washington, DC: Author.

An Overview of Animal Hoarding

- Kuehn, B. (2003). Lawmakers tackle animal hoarding: States look to new laws to address animal hoarders. *JAVMA News*, 222(9), 1190.
- Lockwood, R. (1994). The psychology of animal collectors. *Trends*, 9, 18-21.
- Lockwood, R. & Cassidy, B. (1988). Killing with kindness? *Humane Society of the United States*, 33(3), 14-18.
- Meagher, E., Frost, R., & Riskind, J. (1999, November). *Compulsive lottery, scratch ticket, and Keno gambling: Its relation to OCD, hoarding, impulsivity, and the urge to buy*. Paper presented at the annual meeting of the Association for the Advancement of Behavior Therapy, Toronto, Canada.
- New York City Hoarding Task Force. (2003). Mission Statement. Retrieved February 6, 2007 from http://www.cornellaging.org/gem/hoa_nyc_hoa_tas.html
- Patronek, G. (1999). Hoarding of animals: An under-recognized public health problem in a difficult-to-study population. *Public Health Reports*, 114, 81-87.
- Patronek, G. (2001). The problem of animal hoarding. *Municipal Lawyer*, 15(3), 6-9.
- Patronek, G. (2006). Animal hoarding: Its roots and recognition. *Veterinary Medicine*, 101(8), 520-531.
- Steketee, G., Frost, R., & Kim, H. (2001). Hoarding by elderly people. *Health & Social Work*, 26(3), 176-184.
- Vaca-Guzman, M. & Arluke, A. (2005). Normalizing passive cruelty: The excuses and justifications of animal hoarders. *Anthrozoos*, 18(4), 338-357.
- Wittmeier, C. (1999). Cat houses of truly ill repute: But why is the neighbourhood "Cat Lady" always a lady? *Alberta Report*, 26(30), 48.
- Worth, D. & Beck, A.M. (1981). Multiple ownership of animals in New York City. *Transactions & Studies of the College of Physicians of Philadelphia*, 3(4), 280-300.

Dissertation Abstracts

Congratulations and best wishes to Bryan Duckham, Christie Mason, Tammy McMillan, Christine Norton, Larry Reynolds and Marian Sharkey. The dissertation topics continue to represent the diversity of interests and the commitment to clinical practice of our Ph.D. students. Dissertations are available on the 8th floor of Loyola's Lewis Library, 25 E. Pearson.

Religion and Empathy: An Exploratory Study

Bryan Duckham

The proposed research seeks to explore, through a qualitative phenomenological study, Christian counselor's practice of surrender and the ways in which this practice may relate to their empathic responses to clients. An understanding of the meaning of surrender and any relationship to counselors' empathy will emerge from semi-structured interviews with ten Christian counselors. Data analysis will not only illuminate the meanings of the phenomena, but will allow the findings of the research to be considered within broader contexts and social work theory, practice, policy, and research. This research will contribute to the renewed interest in social work about how religious and spiritual cosmologies interact with social work's core areas of function. Research studies, such as the proposed study, hold the possibility of augmenting a rich tradition within social work to value how religion and spirituality are integral to individual, group, and community functioning.

Parent and Therapist Perceptions of Therapy with a Late-Placed Foster or Adopted Child

Christie Mason

A number of different therapies are used to address behavioral concerns and facilitate attachment between late-placed foster or adopted children and their caregivers (e.g., Corrective Attachment Therapy, Levy & Orlans, 1998; Dyadic Developmental Therapy, Hughes, 1997, 1998; Theraplay, Jernberg & Booth, 2001; Parent Child Interaction Therapy, McNeil, Herscher, Gurwitsch & Clemens-Mowrer, 2005, and Timmer, Urquiza & Zebell, 2005). The effectiveness of few of these interventions has been tested (Nickman et al., 2005; Craven & Lee, 2006), and fewer studies yet have examined parent participation in or perceptions of these therapies. The present study sought to explore and compare the perceptions by both parents and clinicians of therapy with late-placed foster and adopted children. The study used a mixed methods approach, in which 32 parents and 57 therapists completed surveys about therapy with late-placed children and 6 each of parents and therapists were interviewed. Findings include that parents initially place more emphasis on changing behaviors while therapists seek to address underlying emotional issues, and therapists see more change occurring as a result of therapy than do parents. The results also suggest that parents experience support from therapists as highly beneficial, and that they are more satisfied when therapy is provided by someone specializing in working with late-placed or attachment-disordered children.

The Role Of Object Relations Theory And "Dread" In The Treatment Of Anorexia Nervosa

Tammy Croy McMillian

The qualitative study examined the relationship between body-weight, the psychological and behavioral experience in society, and the client's self-other (object relations) representations over time. The theoretical framework supporting this study is Fairbairn's object relations theory. The research design involved an investigation of patterns related to the internal self-other dynamics (object relations) over time. A single-case study strategy relied on the archival data from the Ellen West Case. To examine the research question, a coding category system for generating data encompassed a five-step deductive process. The results across the analysis from the Ellen West Case were consistent with the relationship depicted in the hypothesis. The investigation of the internal self-other dynamics (object relations) did produce patterns of intra-psyche self-other operations. The findings revealed a five-component sequence where the element of "dread" was discovered and thought of as an unsatisfactory dynamism impeding mature dependency. The study supports social work's interest in intra-interpersonal theories that emphasize human growth and development within a social field. The significance to social work is an inquiry about the intra-interpersonal phenomena of self-other dynamics (object relations) that identified key symbols (e.g. food) which when embedded in relationships inform societies' organization.

Understanding the Impact of Wilderness Therapy on Adolescent Depression and Psychosocial Development

Christine Norton

This study showed that the rates of adolescent depression in the United States have become alarmingly high, and reemphasized a need for a holistic intervention that addresses the psychosocial health of adolescents with depression. In particular, this study examined the impact of wilderness therapy on adolescent depression and psychosocial development. By using a mixed methods research design, this study collected data via pre- and post-tests using the Reynolds Adolescent Depression Scale-2 and the Measures of Psychosocial Development. Qualitative data was also collected via three month, post-course phone interviews. Additionally, this study included survey research to assess the importance of various components of the wilderness therapy intervention.

Through quantitative and qualitative analysis, this study showed the rates and prevalence of depression decreased after the wilderness therapy intervention. Specifically related to depression, participants experienced a decrease in learned helplessness, an increase in self-worth, and an increased sense of future. While on course, youth reported no symptoms of depression. Upon completing the course, participants reported an actual elevation in mood, and three months post-course most youth still reported experiencing more stability in their moods.

Wilderness therapy also proved to increase the levels and prevalence of psychosocial health among participants, and furthered positive psychosocial development in the areas of coping skills, confidence (through the creation of earned self-esteem and self-efficacy), competence, connection and caring. Together, the combination of all of these assets led to increased identity achievement.

Along with improvements in depression and psychosocial development, this study showed relevant gains in areas of school improvement, decreased substance abuse and improved family relationships, even three months post-course.

This study also used survey research to assess the various components of the wilderness therapy intervention to determine which had the greatest impact on adolescent depression and psychosocial development. Statistical analysis revealed the importance of a positive group experience on psychosocial health, as well as on the role that positive communication with family members played in decreasing depression. Likewise, participants reported that being in nature, challenge and adventure, and contemplation were all important aspects of the change process.

This study differentiated between immediate and lasting change, and found that the outcomes evidenced by immediate change, i.e., immediately after the course, were a sense of hope, confidence and family cohesion. However, all of the youth in this study faced barriers upon returning home such as distractions, boredom, negative peer pressure, family instability and lack of follow up. Despite these barriers, the youth who seemed able to sustain the gains made during the wilderness therapy program three months post-course had a renewed (or completely new) sense of purpose, had embraced the wilderness therapy experience as a metaphorical anchor to cling to when times got tough, and all had ongoing family support.

Overall, this study demonstrated the negative correlational relationship between adolescent depression and psychosocial development, and paved the way for consideration of the efficacy of psychosocial interventions such as wilderness therapy in the treatment of adolescent depression.

Predictors of Productive Aging among Older Persons in the United States

Larry Reynolds

The study of productive aging offsets the tendency to conceptualize older adulthood as existing only through the lens of physical and cognitive decline. Social policies dealing with elderly persons frequently establish barriers that impede the older person from full participation in society. Many older persons desire to maintain active engagement with the community-at-large in their post-retirement years through the continued use of skills, talents, and abilities they have honed over a lifetime. Productive aging, defined as an applied concept, is “the capacity to work, whether paid or unpaid, to volunteer, and to assist others in the family; and to maintain, to varying degrees, autonomy and independence for as long as possible (Butler and Schechter, 2001, p. 824). This study examines the significance of a set of ten predictor variables and their relationship to the concept of productive aging in the elderly population.

Employing Wave III from the Americans’ Changing Lives (ACL) longitudinal data set, two models, including various combinations of the independent variables age, gender, race, yearly income, amount of physical activity, the extent of social support, one’s self perception, the ability to carry out activities of daily living, the level of depression, and the extent of cognitive impairment are examined as predictive elements of productive aging. Results of the study shed light on and provide insight into the complexities of productive aging, thereby giving social worker knowledge they need for advocacy and policy development as well as leverages points for establishing practice interventions.

Responses to Loss: An Exploratory Study of How Homeless Adults with Severe Mental Illness and Comorbid Substance Abuse in Residential Treatment Experience and Cope with Loss in the Context of Therapeutic Relationships

Marian Sharkey

Objective: To advance our understanding of the degree to which homeless individuals with severe mental illness including comorbid substance abuse in residential programs make use of their relationships with program staff to cope with loss. **Method:** Content analyses of 90 case records of clients who had participated in a transitional housing program generated four domains: 1) types of experiences clients perceived as losses; 2) types of coping behaviors clients exhibited in response to loss; 3) the process of how clients used staff relationships to cope more adaptively with loss; and 4) relational themes that arose in response to loss. Domains were then analyzed to represent client-staff relationships from 10 different program years. Data included client, program staff, and external treatment provider perspectives. **Results:** Findings from analyses of thirteen questions include: 1) Over time, clients were able to utilize their relationships with staff to cope more adaptively with loss. Four categories of “significant relationship shifts” emerged that represented pivotal moments when clients newly turned to staff relationships to cope with loss rather than responding to loss with the maladaptive coping strategies they exhibited previously. 2) Severe loss was one factor that precipitated significant shifts in constructive use of staff relationships in one-third of cases. 3) Analyses of relationship themes suggest that losses not directly associated with personal relationship experience may be perceived as relationship rejection, abandonment, or mistreatment. 4) Staff absences, terminations, and discharge were among the most challenging losses for clients. 5) One-third of clients responded to current loss by rejection of any staff relationship help by means of threatening to leave the program or, in almost one-quarter of cases, breaking program rules that could lead to discharge. Practice, programming, and policy implications are discussed.