Spring 2001 • Volume1

PRAXIS

Where Reflection & Practice Meet

Editorial

Welcome to Praxis 3
Marian Sharkey

Articles

Embracing a Postmodern Philosophy 5
Amy Derringer

Perspectives from Chicago's Homeless Youths: A Needs and Service Use Assessment 12
Jennifer L. Shaffer

Factors that Influence the Development of Empathy in Group Treatment of Heterosexual Latino Batterers 21
Priscila Rodriguez

The Impact of Personal Therapy on the Decision To Enter Social Work 33
Mark Ferguson, Mary J. Komparda and Helen Montgomery

Socialization and Male Victims of Sexual Assault 41
Gina Bogin

Working with Homeless, Mentally Ill Clients: Fieldwork Reflections 49
Brenda K. Nelson

The Policy Behind the Indian Child Welfare Act 53
Justine van Straaten and Wendi Liss

Codependency Through a Feminist Lens 59
Helen Montgomery

Dissertation Abstracts

Successful Family Reunification: The Contribution of Clinical Social Work 66
Elizabeth Peffer Talbot

Social Workers' Countertransference Issues with Spiritually-Similar Clients 66
James Curtis Raines

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Loyola University Chicago is a Jesuit Catholic University dedicated to freedom of inquiry, action in the service of faith and justice, and care for others, especially vulnerable populations. *Praxis: Where Reflection & Practice Meet*, a journal of student scholarship published by the Loyola University Chicago School of Social Work, is committed to the exploration of clinical social work issues, and 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 undergraduate, masters and doctoral social work students. Submissions to the journal are reviewed anonymously by the Board and are edited with permission from the authors. Submissions should be no longer than 20 pages, submitted on a disk as a Microsoft Word document file (.doc), formatted with double spaced text, 12 point font size (Times New Roman font), and one inch margins (left, right, top, bottom). 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

It is an honor and a privilege to introduce you to the premier edition of the Loyola University Chicago School of Social Work's new student-published journal, *Praxis: Where Reflection & Practice Meet*. As one of the few student-managed social work journals in the country, *Praxis* exemplifies the School of Social Work's commitment to student scholarship. With its arrival, our school now has a forum where the scholarly work of students and alumni can be shared, and where we can learn from and be inspired by the ideas and work of fellow-students and alumni.

The word *Praxis* comes from the Greek, *prassein*, which means "to do, or practice." A name befitting a journal of a school dedicated to the education of clinical social workers, *Praxis* also calls to mind the early roots of our social work practice. In her autobiography, *Twenty Years at Hull-House*, Jane Addams reflects on the development of her convictions about the practice of social justice by sharing an excerpt from an oratorical contest of her youth:

> Those who believe that Justice is but a poetical longing within us, the enthusiast who thinks it will come in the form of a millennium, those who see it established by the strong arm of a hero, are not those who have comprehended the vast truths of life. The actual Justice must come by trained intelligence, by broadened sympathies toward the individual man or woman who crosses our path; one item added to another is the only method by which to build up a conception lofty enough to be of use in the world (Addams, 1910/1961, p. 38).

In the spirit of this "method" Addams proposed, the social work pioneers of Hull-House based their research and practice on the relationships they developed with the neighbors 'who crossed their paths.' Indeed, the early settlers were profoundly moved by the social problems their neighbors endured and the settlers' "sympathies" were the inspiration for momentous research and social reform. For example, knowledge of neighborhood children who were victims of dangerous child labor practices that caused physical deformities, chronic health problems and even death, motivated Florence Kelley to research the sweatshop system in Chicago which led to the reform of child labor laws. When the settlers discovered that neighborhood parents had no place to leave their children when they were at work, they opened a daycare center at Hull-House. When an Italian boy from Hull-House died of a cocaine overdose at age seventeen, the settlers discovered that local druggists were profiting from the legal sale of cocaine to other young boys, and they lobbied to secure better legal regulation of the drug. Through her experiences visiting poorhouses, state prisons, and other public charitable institutions in Illinois, Julia Lathrop was inspired to advocate for more humane facilities, including the provision of separate facilities for delinquent children, the mentally ill, the physically sick and the elderly.

Like the early social workers, our practice and research is rooted in and motivated by our experiences with each client "who crosses our path." Whether our client is an individual, a family, a group or a community, we too are moved by their stories and outraged by the injustices they face; it is our deep and committed care that propels us on an intellectual quest to understand how we can help them, and in doing so, how we can create a better world. At Loyola, the journey begins in fieldwork as interactions with clients open our hearts and our minds and stimulate questions and ideas about how the helping process works. In "Working with Homeless, Mentally Ill Clients: Fieldwork Reflections," Brenda K. Nelson describes this reflective learning process and alludes to the importance of relationships with supervisors, faculty, fellow-students and colleagues, in developing an understanding of our clients' worlds and how we can help them. Out of her fieldwork practice with substance abusers and their families, Helen Montgomery became concerned about the negative impact the term "codependency" has on women, and wrote "Codependency through a Feminist Lens." Priscila Rodriguez's research on Latino batterers has its origins in her clinical work with Latina victims and their children, and her commitment to further understanding the phenomena of domestic violence.

As Jane Addams proposed, our scholarly work is indeed a combination of our "sympathies" and our "trained intelligence," and these pages before you - *where reflection & practice meet* - represent our dedication as social workers to generating social work knowledge that will enhance the lives of our clients and help us become more effective practitioners. By sharing our research and practice knowledge in our new journal, *Praxis*, we also provide support and inspiration for each other. One of our core values as social workers is that we embrace

diversity, and this ideal should be upheld in the development and publication of social work knowledge. In an editorial she wrote as Editor-in-Chief of *Social Work*, Ann Hartman's words resonate with our ideal: "...[T]here are many truths and there are many ways of knowing. Each discovery contributes to our knowledge, and each way of knowing deepens our understanding and adds another dimension to our view of the world" (Hartman, 1994, p.13). In this spirit and as defined in our mission statement, *Praxis* respects and welcomes "many ways of knowing."

When the Editorial Board initially conceptualized this journal, our hope was that it would represent the wondrous diversity that is social work by encompassing research, practice, policy and reflective pieces - we are delighted with the outcome! In "Embracing a Postmodern Philosophy," Amy Derringer takes us on a journey from modernism to postmodernism and considers contemporary efforts to re-conceptualize the treatment process. Through the voices of Chicago's homeless youth, Jennifer L. Shaffer's research explores their perceptions of their needs and the services they utilize. In "The Impact of Personal Therapy on the Decision to Enter Social Work," Mark Ferguson, Mary J. Komparda and Helen Montgomery conducted a study to examine whether social work students' personal therapy experiences influenced their career choices. An analysis of the Indian Child Welfare Act by Justine van Straaten and Wendi Liss reminds us of the atrocities committed against Native Americans, and recommends how the child welfare system can uphold this important legislation in working with Native American children and families. In "Socialization and Male Victims of Sexual Assault," Gina Bogin explores the male victim's experience of rape and makes recommendations for more gender-sensitive therapeutic interventions.

The arrival of this first edition of *Praxis: Where Reflection & Practice Meet* represents a creative process that began over a year ago when the Editorial Board began to meet. The creators and founding Editorial Board of *Praxis* are social work students Mark Ferguson, Mary J. Komparda, Leah Olson-McBride and Erin A. Scanlon. It is their commitment, creativity, thoughtfulness, and collaborative spirit that has transformed an idea into the first journal of the School of Social Work, and it has been a privilege to work with such devoted and caring individuals. Dr. Terry Northcut, our Faculty Liaison for *Praxis*, has acted as our steadfast guide and mentor through every phase in the development of this journal. Her consistent availability, positive encouragement, and warm spirit have both supported and invigorated the creative process. Joyce Dinello and Debra Lewis of Loyola Printing Services provided invaluable expertise in the design of *Praxis*, and Debra's creative ideas and open and welcoming style were greatly appreciated during this process. Finally, it is the result of Dean Joseph Walsh's vision and support in launching this project that our school now has a journal of student scholarship.

Praxis is our journal - students and alumni of the School of Social Work - and we encourage your involvement in *Praxis* by joining the Editorial Board, submitting articles, subscribing to the journal, writing letters to the editor, or letters conversing with the authors. Your ideas, suggestions and input are important in the development of our journal. It is the hope of the founding Editorial Board that *Praxis* will serve as an ongoing connection and dialogue between alumni and students in the School of Social Work. We are interested in hearing about alumni's professional experiences after they leave Loyola. What is it like to be a clinical social worker in your work environment? What is the transition from school to field like? What kinds of programs, theories and interventions do you find effective in working with your clients? How has your education impacted your practice? What are current issues or trends in our field or in your area of practice?

We hope you enjoy this first issue of *Praxis: Where Reflection & Practice Meet* and we look forward to your feedback and involvement as our journal evolves.

Welcome to *Praxis*!

Marian Sharkey, LCSW
Editor-in-Chief

References

Addams, J. (1910/1961). *Twenty years at Hull-House*. New York: New American Library.

Hartman, A. (1994). *Reflection & controversy*. Washington, D.C.: NASW Press.

Embracing a Postmodern Philosophy

by Amy Derringer

"There is fiction in the space between you and reality." Tracy Chapman

In the past twenty years postmodernism has gained popularity and merit within the field of clinical social work. This has left today's clinical social worker grappling with the questions: what is this new approach to therapy, how should it be embraced, and why should clinical social workers embrace it?

What is This New Approach to Therapy?

Perhaps the best way to explain postmodernism is to first understand what is modern. Modernism is a philosophical viewpoint that has its roots in the Age of Enlightenment. In modernism "reason was the path to knowledge, and truth was something objective 'out there' that could be discovered by carefully following the steps of the scientific method" (Howe cited in Applegate, 2000, p. 141). "Modernists were interested in large-scale theories that could explain human behavior ... facts that didn't fit theories were ignored, and, all too often, therapists put more faith in their technologies than in their clients' experiences" (Nichols & Schwartz, 1998, p. 317). Not much regard was given to the role of culture, gender, ethnicity, religion, socioeconomic status or sexual orientation. In modernism, truth existed and it was the therapist's job as expert to successfully figure out the truth, make interpretations, and implement the correct interventions necessary in helping clients.

Sigmund Freud's drive theory was at the heart of the modernist model, as were his ideas on mental health. Freud believed that the human mind should be looked at as an "archeological site," where the psychotherapist used techniques of free association and interpretation as a way of "exposing the underlying structure of the human mind" (Mitchell & Black, 1995, p. 1). Influenced by his neurological background, Freud took a scientific approach to exploring his patients, and felt that there was an objective truth to be found. Following in his footsteps, Anna Freud and Heinz Hartmann's ego psychologies are also examples of the modern approach to psychotherapy.

Horowitz (1998) states "contemporary psychoanalysis also starts with Freud, but it involves a paradigm shift toward postmodernism" (p. 370). While Freud's work has undoubtedly shaped all models and theories that followed, today's paradigm shift towards postmodernism has been influenced by many transitions along the way. As Applegate (2000) explains, "following World War II, scholars from a variety of disciplines began to question the hegemony of the modern emphasis on reason and science and to suggest that no single rational system can define a universal truth" (p. 141). In the discipline of psychotherapy, "Winnicott and Kohut were both important figures in the shift from rationalism and objectivism to subjectivism and personal meaning" (Mitchell & Black, 1995, p. 168).

D. W. Winnicott and other object relationists shifted the focus from the inner drives, defenses, and ego functions, towards how outside relationships with others (mainly the mother) are internalized. Rather than applying Freud's psychological structure of the id, ego, and superego to his clients, Winnicott talked about individuals in terms of the self. This self was a subjective entity whose goal was to attain a "true," creative and spontaneous self with the help of a "good-enough" mothering environment.

Winnicott also strayed from Freud's view that there were definite techniques that could be applied to therapy in order to get at truth. He, along with other object relationists, proposed "working in the immediacy and unpredictability of the evolving therapeutic relationship and only retrospectively trying to make sense of it" (Applegate, 2000, p. 146). "Winnicott's ideas about the treatment process ... include an understanding of treatment in which the relationship, rather than interpretation, is the critical curative element" (Saari, 1996, p. 152). The therapist steps down from his "expert" role of interpreter of absolute truth and, instead, asks the client "what is true for you?"

In the same vein, Heinz Kohut also broke away from the psychic determinism and therapist as expert mentality of the modern theories. While Kohut began his career practicing under a classical, modern paradigm, he found it to be unsuccessful in his work with narcissistic clients. He therefore

reformulated Freud's theories on narcissism, self-love, and the need for interpretation, and developed a new theory that centered on the concepts of self-objects and empathy. Kohut's theory focused more on caring than curing.

Kohut also looked at psychological structure in terms of the self. He posed transmuting internalization as a process through which a function performed by another is taken into the self in a way that is unique to that individual (Elson, 1986). The idea of internalizing in a way that is unique to the self was an integral shift from modern to postmodern thinking. Kohut would eventually conclude that "an overly rigid adherence to the content of Freud's particular theories, such as his theory of narcissism, encouraged the analyst to impose a preformed belief system on the process that fit the patient's communications into predetermined categories of meanings, rather than formulating tentative hypotheses that would allow continual, open receptivity to the patient's unique experience of his plight" (Mitchell & Black, 1995, p. 156).

Winnicott and Kohut transformed the modern approach to psychotherapy. With this transformation came the ideas that perhaps truth was not an objective entity and perhaps there was not one correct theory to be used as a tool to dictate technique in direct practice. However, Winnicott and Kohut were not alone in this transformation. Harry Stack Sullivan believed that "human beings are inseparable, always and inevitably, from their interpersonal field. [And that] the personality or self is not something that resides 'inside' the individual, but rather something that appears in interactions with others" (Mitchell & Black, 1995, p. 62). There is a shift from the Freudian view of the individual as an autonomous individual who is motivated by her internal drives, to a view of the individual as a self that is influenced and created through interactions with an environment. Also, there is a broadening of Winnicott's idea of a "good-enough mother" to encompass a "good-enough environment." He emphasized that clients must be looked at in terms of their context and "to try to understand them outside of those contexts is a serious mistake" (Mitchell & Black, 1995, p. 63).

Another way in which Sullivan's work presented a shift away from modernism towards a more postmodern perspective is in regards to his beliefs about language.

> In Sullivan's view, each of us uses language in a largely idiosyncratic fashion ... For the analyst to assume she knows what the patient means by the words he is using and to make interpretations based on that assumed understanding is, for Sullivan, to greatly compound confusion and to lose any hope of meaningful insight. The only way for the analyst to know what the patient is really talking about is to ask detailed questions" (Mitchell & Black, 1995, p. 72).

For Sullivan, language is a vehicle for which people can come to a shared, consensual sense of meaning. The idea that individuals take their own idiosyncratic meanings from the world and that language can be used to bridge those subjective meanings represents, again, a shift towards postmodernism.

Similar to Sullivan, Daniel Stern viewed the self as being social from birth. For Stern, the self was not a result of something innate or predetermined, but rather a result of representations of interactions that get generalized, or RIGs. "The intent in creating RIGs is to have schemas to evaluate experiences and guide reactions ... They are memories of lived episodes that thus become represented preverbally and that serve to create a sense of continuity" (Sanville, 1991, p. 207-208). RIGs are unique to individual persons and are constantly updated as individuals encounter new experiences with the world.

Also, similar to Sullivan, Stern viewed language as a vehicle for people to create shared meaning. Saari (1996) quotes Stern in saying "meaning results from interpersonal negotiations involving what can be agreed upon as shared. And such mutually negotiated meanings (the relation of thought to word) grow, change, develop, and are struggled over by two people and thus ultimately owned by us" (p. 146). This view of language is right in line with the postmodern view that "identity does not fundamentally exist inside the isolated individual, waiting to be uncovered through an archeological exploration of the layers of an unconscious, but is a meaning system created through dialogue with others" (Saari, 1996, p. 148). Stern's theory becomes even more related to the postmodern discipline in his revisions, when he talks about the individual as a narrative self.

Winnicott, Kohut, Sullivan and Stern are singled out here. However, they are not the only ones who influenced the transition from modern to postmodern thought. Many other psychoanalytic and psychodynamic theorists impacted that shift. Erik Erikson's stages of psychosocial development refocused normal development from an emphasis on mastering inner psychosexual drives, to mastering

outer, social functions in relation to others and tasks in the outside world. Feminist and relational models drew attention to the role of society and culture. They asked the questions: How does the larger societal environment affect who people are? And how does it shape a person's view of what is healthy and normal versus pathological and abnormal? Feminist writer Judith Jordan (1997) talks about empathy as "the attempt to be with the truth of another person's experience" (p.27). This thought is complementary to postmodernism where empathy becomes a process of attempting to co-construct a shared meaning and understanding of clients' experiences. Others have also added to a climate where subjectivity, meaning systems, social construction, and a co-created dialogue have paved the way for postmodernism in the psychotherapeutic field.

Now that a historical perspective has been gained for how psychological theory has been transformed since Freud, the question is asked again, what is postmodernism? One can see pieces of Winnicott, Kohut, Sullivan, and Stern in the postmodern philosophy. However, postmodernism has taken from a variety of disciplines in formulating a new psychological paradigm. Influenced by the writing of Bateson, Foucault, Gergen, von Glaserfeld, Heisenberg, Hoffman, Kelly, Maturana, and others, postmodernism offers a new philosophy for viewing and making sense of the world (Horowitz, 1998; Mills & Sprenkle, 1995; Northcut, 2000b; White and Epston, 1990). Today, many concepts and theories fall under the postmodern umbrella. These include second-order cybernetics, constructivism, social constructionism, personal construct theory, narrative therapy, solution-focused therapy, collaborative language theory, and others (Mills & Sprenkle, 1995; Northcut, 2000b).

From a postmodern viewpoint "reality as we know it is a construct of our own private and idiosyncratic way of organizing information rather than an accurate and universally true representation of what is out there" (Mills & Sprenkle, 1995, p. 368). Reality is subjective, as each person creates his or her own truth and meaning from experiences. Postmodernism "recognizes that many realities, selves, and truths co-exist and that reality is not discovered but socially constructed as people interact with other people and with societal beliefs" (Neiymeyer cited in McQuaide, 1999b, p. 343).

The postmodern approach to looking at reality has had major implications for clinical practice. Where the modern psychotherapist was once seen as an expert, the postmodern therapist looks to the client as the expert. As stated in Applegate (2000), while "the dramatizations co-created by the client and social worker are in part orchestrated by the worker's skills, derived in part from theory, reflection, intuition, common sense, and rich experience with complex human dilemma" (what Applegate refers to as practice wisdom), the client is the expert on her story of life and the meaning she has taken from it (p. 150). Therefore, the therapist is continuously attempting to gain an understanding of how the client constructs her world. "To understand the individual is, at least partly, to understand his or her personal way of making meaning out of experience" (Soldz, 1996, p. 286). This involves empathic listening, gaining a detailed inquiry of events and experiences, and creating a dialogue so that the therapist and the client can begin to co-construct a mutual understanding of the meaning of those events.

It is important to recognize, however, that the client is not alone in bringing subjective meanings to the therapeutic relationship. The therapist also brings her constructs and personal understandings of the world into therapy. These constructs include biases and prejudices that may interfere with her understanding of the client. These beliefs also impact her reactions to clients and her "personal experience of the [client]" (Mitchell & Black, 1995, p. 79), or countertransference. The concept of transference, or the client's personal experience and reaction to the therapist, has been talked about since Freud, while the concept of countertransference became a critical part of Sullivan's interpersonal therapy. The concept of countertransference emphasizes the importance of awareness and reflection in regards to the therapist's reactions to a client. It is important for the therapist to recognize how her countertransference may be preventing a meaningful and liberating therapy.

The postmodern client-therapist relationship is more of a partnership. While the dynamics of power within that relationship are not completely equal, a postmodern therapist is aware and cognizant of those dynamics. In looking to the client as the obvious expert on her life, the playing field is somewhat leveled so that the client experiences empowerment and self-efficacy within the treatment process. This process "emphasizes multiple truths and clients' rights to develop their own story or truth, rather than having one imposed on them by the therapist" (Northcut, 2000b, p. 6). As was true for Winnicott, the therapist is working together with the client to interpret meaning and truth. "Utilizing constructivism compels the clinician to articulate his or her understanding of the concepts, to ask for the client's

definitions and also suggests that the act of discussing these concepts with clients produces a third definition - one that is constructed between the client and the clinician" (Northcut, 2000, p. 58). The therapist brings to the relationship her practice wisdom, the client brings her current way of constructing reality, and *together* these constructs are addressed and re-evaluated. The partnership that is created allows for a healthier, more empowering treatment.

For the postmodern therapist, what "really" happened in the client's experiences does not matter. There is not an objective reality to be found. Since truth is subjective and idiosyncratic, what becomes important is the meaning that the client attaches to her experiences. "The goal becomes not to arrive at truth, but to hone abilities to engage in a process of ever fresh 'retranscribing'" (Sanville, 1991, p. 207). Take, for example, couples or family work in which each individual has his or her own version of an event. In attempting to find an objective truth from two or more differing stories, the therapist will most likely run into a great deal of frustration and grief trying to decipher what "really" happened. However, in adopting the philosophy that the meaning constructed from events is more important than the events themselves, a therapist can redirect the focus. The emphasis becomes helping the individuals in the couple or family to gain a better understanding and appreciation for how each of them is constructing and making sense out of the conflictual events. The possible end result is to arrive at a new transcription of the event. This new transcription allows for a shared meaning of the event which is healthier and more viable to the couple or family system.

In talking about the meaning one takes from events, narrative therapy enters the picture. White and Epston (1990) state that "in order to make sense out of our lives and to express ourselves, experience must be 'storied' and it is this storying that determines the meaning ascribed to experience" (pp. 9-10). They go on to say that "the success of this storying of experience provides persons with a sense of continuity and meaning in their lives, and this is relied upon for the ordering of daily lives and for the interpretation of further experiences" (p. 10). In the same vein as Stern's concept of RIGs, White and Epston propose a subjective means by which people makes sense of and order their lives. This way of attributing meaning to events changes and gets revised over time. The fact that constructs change and develop is central to narrative therapy and to postmodernism in general.

"Constructivists ... tend toward the position that life can (or should) consist of continuous growth and change" (Soldz, 1996, p. 290). The self is not seen as a unitary entity, but rather a complex being where multiple truths and realities exist. Past theories have looked at self in terms of the "good self" and "bad self," the "true self" and "false self," the "libidinal ego" and the "anti-libidinal ego." Postmodernism allows those models to hold true, but also goes beyond the two contrasting poles of self. It redefines the self as complex and capable of multiple layers within its one self. McQuaide (1999b) states "the different ways a person constructs the story of his or her life can be a source of strength and resilience or a source of weakness and vulnerability" (p. 343). A goal, then, becomes "helping the client to accept and integrate both vulnerable and resilient selves" in a way that is "optimally empowering for the client" (p. 413).

Social constructionism also plays a key role in postmodernism. "Social constructionism suggests that 'when a sufficient number of people reach a consensual definition on something, that thing is then viewed as an objective reality. The construction process and the accompanying social agreement recede into the background, and a sense emerges that what has been constructed by a consensual definition exists out there, in the foreground of the real world'" (Rosen cited in Northcut, 2000b, p. 5). Social constructionism "questions the existence of an essential self apart from others" (Mills & Sprenkle, 1995, p. 369). To this end, social constructionism takes into account the "truths" of a society or a culture and the impact that those truths have on an individual's way of experiencing and making sense out of the world.

> Constructivism asserts that the 'knower' constructs all knowledge and that we cannot know 'truth' with any certainty because our personal and social context is always influencing what we see ... Families, groups, communities, and societies have a history that influences the truths they purport to be as facts ... Members of these groups may not be aware of the idiosyncratic nature of the truth they have been immersed in because they have not known another reality" (Northcut, 2000b, p. 3).

Taking the role of social construction into account, the postmodern therapist allows for the client's social and cultural surround to become an integral part of the understanding and co-construc-

tion of meaning. This leads to a greater awareness, where the therapist and client focus less on the ways in which problems exist within the client and more on how the client's environment might be working to limit and constrain the client. Also, in allowing social constructionism to play such a central role in therapy, issues such as prejudice, racism, sexism and homophobia can be addressed in a welcoming and flexible therapeutic environment.

How Should Postmodernism be Embraced?

Now that a basic history and understanding of postmodernism has been gained, the focus shifts to the question, how should postmodernism be embraced? I propose that postmodernism should be embraced as a philosophical framework from which therapists can base their interactions with and understanding of clients. Northcut (2000a) states that "constructivism is not a practice theory per se, but a conceptual framework that can inform practice approaches" (p. 156). In embracing postmodernism as a philosophical framework, therapists are given a guideline or perspective for how to proceed in direct practice; yet they are also given a great deal of freedom, flexibility, and creativity in working with clients. One theory or technique is not necessarily placed above others. "The formulaic rules of technique ... no longer make sense, and the analyst's decisions have to be thought out individually" (Horowitz, 1998, p. 378).

It was stated earlier that Winnicott believed a therapist should not go into a session with a preconceived theory or technique on how to interpret the client. Rather, a therapist should retrospectively make sense out of what goes on in therapy. McQuaide (1999b) states,

> If postmodern theories teach us anything, it is that our theories about therapy and the stories we tell about them, like history, do not proceed according to some grand narrative or master plan. Like our conversations with clients, they are messy processes, each one with its own unique rhythms and patterns ... Like the character in the old folk tale, first we shoot holes in the fence and then we paint the bull's eye around them (p. 340).

However, while a therapist may not enter therapy with a defined technique for working with the client, it is unavoidable that the therapist comes in with a frame of mind for how therapy will proceed. In embracing postmodernism as a philosophy, the therapist walks into the therapeutic relationship with beliefs of the client as an expert, the client as being a subjective constructor of reality, and the client as having multiple-selves. This philosophy allows for a very different kind of therapy than what Freud and modern psychotherapists proposed. This is a philosophy that has empathy, caring, self-determination, and empowerment at its core.

Why Should Clinical Social Workers Embrace Postmodernism?

"From its inception in the modern period, social work has turned to a variety of theories to try to divine the truth of the human dilemma in order to better understand and help people" (Applegate, 2000, p. 142). Postmodernism believes that there is no one, absolute truth. Since there is no one truth, it follows that one theory is not sufficient in explaining truth. Under a postmodern philosophy, multiple theories are encouraged as the only way to account for the multitude of concerns, problems, and truths clients may present with. Soldz (1996) states "the effort to draw upon approaches is part of a larger tendency in the therapy world. That tendency is the increasing recognition that no therapeutic school has a monopoly on wisdom" (p. 283). Soldz promotes an integrated model, stating that "a stream running throughout most of [my] theoretical and empirical work is the relationship between reality and the multiplicity of perspectives we can have on it" (p. 278).

John Barthes (1980) describes his ideal postmodernist author as one who "neither merely repudiates nor merely imitates either his 20th Century modernist parents or his 19th Century premodernist grandparents" (Northcut, 2000b, p. 1). Postmodernism does not call for abandoning of past, modernist, premodernist, or transitional theories. Rather it poses that those theories should be looked at and utilized in a way that adheres to the subjectivity of truth and the diversity of meanings. Clinical social workers of today should embrace postmodernism as a philosophy for direct practice because it does allow for an integration of many theories and techniques, both old and new. This appreciation for multiple theories reflects postmodernism's appreciation for client uniqueness and the multiple realities that can and do exist within all individuals.

A second reason why clinical social workers should embrace a postmodern philosophy is that it complements social work values and standards. Horowitz (1998) states that what theorists like Heisenberg and Hoffman posited from their studies

of physics and philosophy, social workers knew all along. Horowitz quotes Mary Richmond, a founding mother of the social work discipline, in saying, "fortunately for the social case worker, the human mind is not a fixed and unalterable thing" (p. 381).

Postmodernism disputes the idea of the human mind as fixed and unchangeable, just as it disputes the idea of objective, definitive reality. In doing so, it promotes the need to start where the client is, as the client is the expert of her own truth and her own story. Applegate (2000) states "it is [the] respect for the client's perspective on things that leads us to start where the client is and to honor the client as a collaborator in re-storying that reality in ways that foster her well-being" (p. 150). Also, in seeing the client as the expert on her experiences, postmodernism fosters the social work ethical standard of self-determination. Along with that come the client's feelings of self-efficacy and confidence in taking the necessary steps in re-authoring her life.

Postmodernism looks at the larger social and cultural implications surrounding a client's environment. In doing so, it broadens the scope of therapy to include a person-in-environment perspective.

> Broadening the scope may mean discovering that the reason one feels inadequate is because one is African American, gay, female, poor, working class, or old, and that one has been given a certain script to follow which contains the culture's dominant narrative of what these 'facts' mean in this society. Or broadening the scope may mean realizing that what one wishes for is what one also fears, that one has hidden feelings, that unfulfilled dreams from childhood are influencing present choices, that negative thinking affects one's mood or that guilt is blocking the progressive use of the imagination. New explanations open space for more complex and less limiting narratives (McQuaide, 1999b, p. 345).

The person-in-environment perspective is integral and unique to the social work discipline, as it gives a person's context the same emphasis and value as it does a person's inner psychology. Postmodernism also holds a person's contextual and social surround as essential to the understanding of the individual and the meanings that the individual attaches to experiences with the world.

A third reason for embracing postmodernism in clinical social work is its construct of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is a diagnostic tool that has received both applause and criticism within the clinical social work field. While the criticism is based in part on its failure to look at the client's larger social surround and on its emphasis on pathology versus health, McQuaide (1999a) talks about taking a postmodern approach to the DSM in order to empower, rather than disempower, clients.

> Viewed through a postmodern lens, the 'realities' of the DSM are seen as social constructions. These social constructions may be useful in helping clients, but remain social constructions, not pieces of a fixed reality. As social constructions, they reflect the achievements and blind spots (e.g., racism, sexism, ageism, classism, homophobia) of the society that created them ... Consequently, our beliefs about mental, emotional, and behavioral dysfunction reflect the beliefs of our times" (p. 412).

McQuaide goes on to explain that by using a narrative approach to DSM labels, labels can be seen as one part of the client's many selves. A label can then be named and talked about as a problem within itself, rather than a dominant part of the client's person. "The DSM's insistence on giving names to constellations of feelings and behaviors can be utilized to help give clients a sense of control over their troubles ... The goal of treatment is for that unique individual to be empowered over the problem" (p. 414).

A postmodern philosophy offers clinical social workers a new lens from which to view clients, the client-therapist relationship, and therapy in general. This lens allows each client to be seen as a unique, important, and active agent in the world. In subscribing to the belief that truth is subjective and in making the client's meaning the central element, clinical social workers can enter into partnerships with their clients. In these partnerships, therapists will offer their practice wisdom and clients will offer their understandings of the world into a transitional space from which healthier and more viable meanings can be constructed. In broadening the scope of understanding, therapists and clients can together create a more flexible and more liberating therapy.

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References

Applegate, J. S. (2000). Theory as story: A postmodern tale. *Clinical Social Work Journal, 28*(2), 141-153.

Elson, M. (1986). *Self psychology in clinical social work.* New York: W. W. Norton & Co.

Horowitz, J. (1998). Contemporary psychoanalysis and social work theory. *Clinical Social Work Journal, 26*(4), 369-383.

Jordan, J. (Ed.) (1997). *Women's growth and diversity*. New York: Guilford Press.

McQuaide, S. (1999a). A social worker's use of the diagnostic and statistical manual. *Families in Society: The Journal of Contemporary Human Services, 80*(4), 410-416.

McQuaide, S. (1999b). Using psychodynamic, cognitive-behavioral, and solution focused questioning to co-construct a new narrative. *Clinical Social Work Journal, 27*(4), 339-353.

Mills, S. D. & Sprenkle, D. H. (1995). Family therapy in the postmodern era. *Family Relations, 44*, 368-376.

Mitchell, S. A. & Black, M. J. (1995). *Freud and beyond: A history of modern psychoanalytic thought.* New York: Basic Books.

Nichols, M. P. & Schwartz, R. C. (1998). *Family therapy: Concepts and methods (4th Ed.).* Needham Heights, MA: Allyn & Bacon.

Northcut, T. (2000a). Constructing a place for religion and spirituality in psychodynamic practice. *Clinical Social Work Journal, 28*(2), 155-169.

Northcut, T. (2000b). *What is constructivism anyway? An overview.* Unpublished Manuscript.

Saari, C. (1996). Relationship factors in the creation of identity: A psychodynamic perspective. In H. Rosen & K. T. Kuehlwein (Eds.), *Constructing realities: Meaning-making perspectives for psychotherapists*, (pp. 141-166). San Francisco: Jossey-Bass.

Sanville, J. (1991). *The playground of psychoanalytic therapy*. New York: Analytic Press.

Soldz, S. (1996). Psychoanalysis and constructivism: Convergence in meaning making perspectives. In H. Rosen & K. T. Kuehlwein (Eds.), *Constructing Realities: Meaning-making perspectives for psychotherapists*, (pp. 227-306). San Francisco: Jossey-Bass.

White, M. & Epston, D. (1990). *Narrative means to therapeutic ends*. New York, NY: W.W. Norton & Co.

Perspectives from Chicago's Homeless Youths: A Needs and Service Use Assessment

by Jennifer L. Shaffer

Abstract

This study investigated what five homeless youths in Chicago, Illinois, perceived as their primary and secondary service needs and their awareness, use and assessment of services designed to meet those needs. For the purpose of sampling, homeless youths were considered those teenagers or young adults who had no permanent address for any length of time, no parents or family to rely on for daily support, and no regular source of income, food, or shelter, except through homeless shelters and food pantries. The five youths interviewed for this study were self-selected off of the streets of Chicago's Lakeview neighborhood and from a night-time activity program sponsored by two local organizations that work with homeless children. The study utilized a descriptive research method, and the respondents were administered a survey designed by the investigator to elicit both qualitative and quantitative data.

Problem Formulation

Rothman and David found that "the number of youth who run away from home or who experience homelessness in the course of a year is unknown, and any estimate of their population size is considered highly problematic" (cited in Robertson, 1991, p. 33). However, in 1985 the Illinois Governor's Task Force on Homeless Youth estimated that there were as many as 21,535 homeless youths in Illinois alone (Governor's Task Force on Homeless Youth, 1985, p. 5). Regardless of the large size of this population, there remains a lack of information about these forgotten children. "Only limited empirical information is available, and most of it is based on data from client samples from shelters (Shaffer & Canton, 1984), health clinics (Yates, 1988), or institutions (Mundy et al., 1989) which likely misrepresent the larger homeless youth population" (Robertson, 1991, p. 33).

Additionally, as Robertson stated, the information that does exist is drawn from interviews with service providers and homeless youths engaged in services. Those children not receiving services are not having their voices heard by the people who may be able to help them. Unfortunately, while this is happening the situation is worsening. "Recent surveys of service providers nationally suggest that their contemporary clients seem to be younger, more troubled, and more likely to have multiple problems compared to clients in previous years" (Robertson, 1991, p. 39). For these reasons, this study was designed to examine the service needs and uses of homeless youths in Chicago, Illinois, from their own perspectives.

In order to begin such a project, certain ontological assumptions had to be made. First, homelessness is a reality for some minors. Second, homelessness can be defined as a period in a person's life when they have no permanent address, no parents or family to rely on for daily support, and no regular source of income, food, or shelter except through homeless shelters or food pantries. Given the lack of other data, epistemologically, it was assumed that an assessment of the needs and service use of this population could be known by analyzing their own answers to survey questions.

Literature Review

In a review of the literature the investigator found a wealth of definitions of homeless youths but a lack of a narrow, consistent definition of the population as a whole. In her own literature review, Marjorie Robertson indicates that there are a variety of terms used to describe this population, "including 'homeless,' 'runaways,' 'throwaways,' 'push-outs,' 'system kids,' 'street kids,' 'unaccompanied youth,' 'damaged teens,' 'outcasts,' and 'hard-to-serve youth'" (Adams, Gullotta, & Clancy, 1985; Chelimsky 1982; Greater Boston 1985; National Network 1985, p. 34). Several researchers have attempted to manage this problem by breaking down the larger homeless population into subcategories or typologies (Adams, Gullotta, & Clancy, 1985; Cherry, 1993; Jones, 1988; and Zide & Cherry, 1992). However, as Robertson states, so many descriptions prove problematic because "they require assumptions about the youths' motives and the degree of access youths may have to homes" (p. 34).

Furthermore, in the literature reviewed, most researchers sampled only those homeless youths who were engaged in services at schools, shelters, and other youth agencies (Kurtz, Kurtz, & Jarvis, 1991; Levine Powers, Eckenrode, & Jaklitsch, 1989; Lundy, 1995; Ray & Roloff, 1993; Shai Levine, Metzendorf, & VanBoskirk, 1986; Shane, 1989;

Teare et al., 1994; and Vissing & Diament, 1997). However, a report from the Illinois Governor's Task Force on Homeless Youth indicates that "... only 20% ... of the homeless youth population [in Illinois] seek help from youth service agencies" (p. 5). Therefore, an estimated 80% of this population remains uninvestigated. Without knowledge of those youths not engaged in services, it is dubious to conclude that the arrived at descriptions or typologies are generalizable to the population as a whole.

In addition, this investigator found that while there is a body of information available regarding the histories and specialized problems of homeless youths, little data exists on the ways in which this population in general perceives its service needs. "The bulk of research on runaway and homeless youths focused on their past histories and their personality attributes. There is a paucity of research exploring the lived experiences of such youths or the meanings they assign to their experiences" (Lundy, 1995, p. 26). Again, because in many studies these youths are interviewed either in or through service agencies, a significant amount of data is missing for that larger portion of the population that does not seek services. As Canton (1986), Deisher and Farrow (1986), Kennedy et al. (1990), Manov and Lowther (1983), and Wilkenson (1987) discovered, "Estranged and alienated from family and other supportive structures, these youths congregate in isolated areas and seek to avoid contact with mainstream institutions and individuals" (cited in Lundy, 1995, p. 5).

All of the works reviewed suggested that problem areas for homeless children were extensive. They consisted of mental health problems including depression and suicidal behavior; school related problems such as truancy, bad grades, and lack of educational support; family problems, including physical and sexual abuse; substance abuse problems; issues related to their sexuality or sexual experiences; problems with deficits in social relationships; and problems with criminal activity. In addition, homeless youths were found to have the greatest problems in the areas of housing, income, food and clothing. In their evaluation of a program serving homeless youths, Ray and Roloff (1993) found that "Most frequently identified needed services included the basic necessities of food, clothing, and shelter, along with education, employment training, medical care, transportation, and recreation" (p. 503). However, further problems are identified in various specialized portions of the population such as those children with HIV/AIDS who are struggling with serious health and mental health issues (Athey, 1991), children who incurred severe sexual or physical abuse who have continuing mental health and sexual identity issues (Kurtz, Hick-Coolick, Jarvis, & Kurtz, 1996; Kurtz, Kurtz, & Jarvis, 1991; and Levine Powers, Eckenrode, & Jaklitsch, 1989), and the portion of the population that tries to stay in school and struggles with attendance and educational performance because of their homeless status (Shai Levine, Metzendorf, & VanBoskirk, 1986).

In a study focusing on the problems incurred by homeless youth in Illinois specifically, the Governor's Task Force on Homeless Youth interviewed service providers at various youth agencies around the state. Based on the respondents' answers to survey questions, they concluded that the top five service priorities for 0-17 year olds were emergency shelter, counseling, emergency foster care, employment assistance, drop-in center services, and services for independent living. For 17-20 year olds, the top five service priorities included service for independent living, a tie between emergency shelter and employment assistance, counseling, drop-in center services, and educational assistance (Governor's Task Force on Homeless Youth, 1985). Because this study included only responses given by service providers working with homeless youths who were engaged in services, the results may not be an accurate reflection of the service priorities of the young homeless population as a whole.

The Chicago Coalition for the Homeless Youth Committee conducted a study of the local homeless youth population in their area. With regard to service needs and priorities, their sample of street youth engaged in services stated that they had multiple needs. They indicated that they are lacking non-transient housing: "Homeless youth, like homeless adults, are highly mobile, and drift from one transient living situation to another. Although they rely on family and friends as much as possible, very often they are left to their own resources" (Chicago Coalition for the Homeless Youth Committee [CCHYC], 1993, p. 8). They also stated that they need to feel safe and protected while on the streets. Respondents indicated needing help with family problems, which included abuse and neglect, parental substance abuse, and sexual abuse by family members. As with other studies, CCHYC found that homeless children had difficulty with school in that "sixty-eight percent of the youth said they had been suspended from school ... and twenty-seven percent had been expelled ... and almost one-fourth had been in special education ... Of

these, over half were placed in special ed for behavior disorders" (p. 13). Furthermore, the homeless youths reported that they needed help in attaining employment via skills training, educational services and support. Again, as with other studies, CCHYC found a high rate of suicidal behavior and other mental health problems needing to be addressed in services. Finally, homeless youths indicated that they needed assistance with substance abuse problems and problems incurred due to their sexual experiences, such as health services for pregnancy and sexually transmitted diseases (CCHYC, 1993).

With regard to evaluations of the effectiveness of youth programs, this literature review suggested two different results. In some of these studies, youths were enlisted to evaluate the programs (Teare et al., 1994), and at other times the evaluations were based on the outcomes of the programs, meaning the drop-out rates of recipients, movement of recipients into healthier lifestyles, and placement of recipients in non-transient housing (Ray & Roloff, 1993). However, all of the studies indicate that there is room for improvement in service delivery to this population. "Many community services are available, but they do not accommodate the cultural and mental health needs of adolescents, who often are unaware of and reluctant to use them" (Kurtz, Kurtz, & Jarvis, 1991, p. 553).

Research Questions/Hypothesis

After reviewing the literature, four different research questions were formulated. Each of the questions was designed to enhance the amount of information available about service needs and use by homeless youths, including both those receiving services and those receiving few or no services. The questions were: (1) What do homeless children in Chicago, Illinois, perceive as their primary and secondary service needs? (2) Are they aware of programs designed to address those needs? (3) Do they feel that such programs are meeting those needs? (4) Do they use such programs?

Based on the information gathered in the literature review, it was hypothesized that homeless children in Chicago would list their primary needs as shelter, clothing, food, and income/money. They would state that their secondary needs included counseling, education, vocational training, and employment. Furthermore, these children would report that they are aware of programs that exist to address those needs, but many of them do not use the services or do not feel that the services actually meet their needs.

Ethical Issues/ Concerns

The foremost ethical concern in this study was the level of risk to this vulnerable population. As a result of the youths' status as homeless and on the streets, it was not possible to obtain consents from the parents or legal guardians of those children under the age of eighteen. Therefore, only assents were collected from those youths and consents were signed by youths over the age of eighteen. In order to reduce potential harm, participation in the study was thoroughly explained to them. The participants were assured that they could stop participating at any time they wished to without consequence, and that even if they dropped out they would still receive their meal coupons.

Furthermore, youths were apprised of the risks involved in their participation in the study. The risks here were minimal. Essentially, the only risk was that of discomfort the respondents might have felt at being asked about their homeless status. They may have also felt embarrassed about talking about their needs. All of this was explained to them in a manner that can be easily understood by people their age (relatively speaking 9-21years).

The interviewer explained to the respondents that all information they provided would be kept confidential and anonymous, with the exception of information regarding child abuse and/or a subject's indication that he/she wanted to harm him/herself or someone else. The youths were told that, for their protection and to meet mandated reporter guidelines, this type of information must be reported to the child abuse hotline or a mental health professional so that they can receive the help and protection that they need. To ensure confidentiality and anonymity, interviews were given a number only and the interviewer only asked for youths' first names. Furthermore, youths were asked to sign their assent/consent forms with their first name and an X only.

At the end of the interview, each participant, or any youth on the street who wanted one, was given a list of services and programs that work with homeless youth. The logic behind this was that youths would be hearing about these services during the interview and they may want to get involved with them. Therefore, they were given a resource packet so that they could get help if they wanted to.

Metatheory and Theory Base

This study was approached from the perspective of the heuristic paradigm as well as a systems theory base. The heuristic paradigm was chosen

because "it provides conceptual foundations for generating social work knowledge that is important and relevant to practitioners" (Tyson, 1995, p. 11). The investigator felt that it was imperative that this study provide information that would be useful for social work practitioners and aid in solving problems relating to service delivery to homeless youths. She also felt that the methodological prescriptions imposed by positivist theorists "do not solve [the "problem of other minds"] and unjustifiably devalue other ways of generating scientific knowledge" (Tyson, 1995, p. 224). Furthermore, the investigator recognized the inherent existence of bias in research and felt that the heuristic paradigm addressed it in a more realistic and less negative manner than other metatheories such as positivism.

In addition, the investigator used a systems theory base to approach this project because she recognized that homeless youths are part of a complexity of systems. The environment-system boundary, as it was drawn for the purpose of this study, focused on the homeless youth system and their perception and use of the homeless service system. Other systems such as the family, school or court systems were not included in the environment-system boundary. In addition, service agency staff were not interviewed, but all of these other systems could be included in future research in order to help with bias recognition. Changing the environment-system boundary and conducting multilevel reductionistic analysis could provide an even richer knowledge base about this population.

Research Design

This study was designed to use a survey research method. There was no comparison group and sampling was not random. Furthermore, the study utilized a descriptive methodology. The purpose of the study was to provide an exploratory assessment of the perceived service needs and uses of the population as a whole and not to cross tabulate the responses of one group (age, race, or gender) against another.

Problems that are inherent in this type of study are related to the generalizability of the data collected. Because this project was isolated to a large metropolitan area and it was limited to a cross-section in time, it may not be applicable in all communities or in the future. Future researchers may consider conducting such a project in several different locations using a trend study design. However, this study was limited because of time and financial constraints.

In addition to the threat that lack of generalizability posed to external validity, internal validity may have also been compromised by the fact that subjects were self-selecting instead of randomly selected, and they received compensation for their participation in the project. Respondents received five dollars in meal coupons from a fast-food restaurant after they answered the survey. In order to reduce the threat to internal validity as well as to meet institutional review board guidelines for incentives, they were assured that they would get the meal coupons regardless of whether or not they completed the instrument. However, this may not have reduced the effect of the incentive on their desire to participate.

Sampling/Subjects

Originally, the investigator intended to interview ten homeless children directly off of the streets of a Chicago neighborhood. For several reasons, however, this proved problematic. First, the investigator discovered that it is difficult to recognize a homeless youth. They blend in with the rest of the population in their dress, demeanor and appearance. Through consultations with agents at two homeless organizations, The Night Ministry and Teen Living Programs, the investigator learned that homeless youths may stand out because they carry backpacks or sit in doorways, but as she discovered, so do a lot of domiciled people in Chicago. Next, the investigator found that homeless youths are reluctant to talk to others in a research context. They may be willing to let someone sit with them, but without an introduction by someone with whom they have already established a trusting relationship, such as agency staff, they are skeptical about sharing information about themselves in an interview format. Finally, more time was needed to establish a rapport with these kids than was allotted by the constraints of the semester.

At the end of data collection, the sample included five homeless youths. They were sampled from the streets of Chicago's Lakeview neighborhood and from a nighttime activity program called "Kill the Chill" which was sponsored by both The Night Ministry and Teen Living Programs. The Lakeview neighborhood was chosen as the site for data collection because it is where many homeless youth congregate. In addition, the logic behind selecting the "Kill the Chill" program was that it did not offer comprehensive services such as shelter, educational or vocational training, and health services. Therefore, the youths attending the event were not automatically engaged in a lot of services, and the

original aim of the study, to interview both youths involved in or minimally involved in services, was not inherently compromised.

The sample consisted of two African-American males, one Caucasian female, one Hispanic male, and one Native American/Caucasian male. They were all young adults or teenagers under the age of twenty-two, and they were all homeless. For the purpose of this study, youths were considered homeless if they were a young adult or teenager, had no permanent address for any length of time, no parents or family to rely on for daily support, and no regular source of income, food, or shelter except through homeless shelters and food pantries. No one was excluded from the sample because of race, gender, sexual orientation, or length of time on the streets. One respondent had been on the streets for eight years, two for three years, and one for two years. The reasons that precipitated their homelessness included physical abuse in the home, family drug use, death of parent(s), incarceration of parent(s), and lack of extended family that could help. Finally, the respondents all lived on between five and fifty dollars a week.

Procedures

The investigator located the respondents either on the streets of Lakeview or at the agency-sponsored event. Homeless youths were identified by questions asked according to the sampling criteria. Once they were located, the interviewer explained the study to the potential respondents and then thoroughly reviewed the assent form with them, highlighting the risks involved and the rights of the youths to withdraw at any time.

If the potential respondents agreed to participate, they accompanied the interviewer to a cubical at the agency or a relatively quiet spot on the sidewalk. Both locations allowed for some privacy, yet were public arenas that provided protection for both the interviewer and the respondents. When the interview was complete the respondents were given a packet with service information and their meal coupons.

Measures

The investigator designed the data collection instrument used in this survey. It was a survey with questions designed to elicit both qualitative and quantitative data. Pilot interviews would have been an optimal means by which to test the reliability of the questionnaire, however, financial limitations and time constraints made such interviews impossible. Instead, the interviewer tested reliability after data collection through inter-coder reliability analysis.

Triangulation in Data Analysis

Questions on the instrument were designed to be both open-ended and closed-ended. Therefore, both qualitative and quantitative data analysis were used in this study. This type of triangulation in data analysis helped address bias recognition. For the closed-ended questions, SPSS was used to compile frequencies of service needs and service use. The open-ended questions were analyzed using a thematic analysis, in which codes and definitions of themes were assigned. Themes were observed over time and reported qualitatively. The goal of the analysis was to produce a rich description of perceived service needs and uses as well as respondent evaluations of homeless youth services.

Findings

The investigator examined several questions that were designed to enhance the amount of information available about service needs and service use by homeless youths. First, the investigator looked at what homeless youths perceived as their primary and secondary service needs. Next, she examined whether or not they were of aware of service agencies that were designed to address those needs. Then she looked at whether or not the youths used these services and at reasons why they did or did not. In addition, she analyzed whether or not the respondents felt that such programs were meeting their needs. Finally, the investigator examined what services these youths felt agencies should offer that would help them meet their needs and who else other than service agencies could help them meet their needs.

When asked about which needs they felt were their first most important, the majority of the respondents listed food, employment, shelter, and income. Other primary needs that were indicated included clothing, healthcare, and respect (Table 1.1). In addition, when asked what they would list as their secondary needs, respondents listed shelter, income, food, friends, employment, and healthcare more than other needs (Table 1.2).

Next, respondents were given a list of fifty-one agencies that offer services to homeless youths and were asked if they had ever heard of these agencies. On average, respondents indicated that they had heard of eighteen of the listed agencies (Table 2.1). However, the standard deviation among the respons-

es was high because of a skewed distribution. One respondent had heard of a much greater number of the agencies than the other respondents. In addition, the youths were asked if they were aware of the services offered by these agencies. Overall, the respondents knew about services offered by the agencies 89% of the time (Table 2.1). The mean response to this question was 15.2 and again the standard deviation was high because of a skewed distribution of responses.

When asked if they used any of the service agencies, 100% of the youths surveyed stated that they did use some of the agencies, but only a few. Most of the respondents said that they used some of the agencies because they offered services that met their basic needs: "Yeah, I go to TLP [Teen Living Programs] for showers and lunch, Night Ministry for food and a place to hang out, and Neon Street, Open Door Shelter and the YMCA for a place to sleep." They also indicated that they use those agencies that are in the area where they stay. However, they said that they did not use most of the agencies or did not like the programs those agencies offered because they felt these places constricted their independence by forcing values, unwanted services, and/or rules on them.

One respondent stated, "They help me when I need a place to stay during the day or night and they get me food. But I don't like going to most of the places because they all have too many rules. They don't let me do the things I want, instead they tell me to do what they think I should do. I have been out here for awhile taking care of myself and I can't just go into a place and follow someone else's plan for me." Another respondent said, "They give me shelter and I know that they're there. But most of the time you can make something better on the streets than you can at those places. You can make some money on the streets and find squats that are cool plus you have more independence on your own. There's no one to tell you what to do, but then again sometimes you wish you did have someone to tell you what to do." In addition, one respondent said that he did not use agencies that are located in neighborhoods where there is frequent harassment of homeless people by the police. This respondent also stated that he did not like going to places where "the residents show a lot of negative peer behavior." Finally, another youth said that he does not use the agencies that offer the specialized services that he does not need.

Furthermore, respondents were asked whether or not they felt that the service agencies they were aware of really did meet their needs. All of the

Primary Service Need	% of Affirmative Responses
Food	80%
Employment	60%
Shelter	60%
Income	60%
Clothing	20%
Health Care	20%
Respect	20%

N=5
Table 1.1

Secondary Service Need	% of Affirmative Responses
Shelter	60%
Income	40%
Food	40%
Friends	40%
Employment	40%
Health Care	40%
Counseling	20%
Clothing	20%
Education	20%
Family Services	20%

N=5
Table 1.2

Respondents N=5	Knowledge of services offered by agencies
Youth A	100%
Youth B	81%
Youth C	85%
Youth D	79%
Youth E	100%

N=5
Table 2.1

youths stated that yes, some of the agencies met some of their needs. When asked how those agencies met their needs, the theme that arose in every respondent's answer was that those agencies helped with their short-term needs or met their immediate needs while they were on the streets. One respondent also said, "Those programs that really help are open-minded. You can talk about pretty much anything and they look into things for you. I have friends at those places and there are no police around unless someone calls them." Reasons the respondents did not find other agencies helpful included: constricted independence, favoritism for some youths over others, inadequate services, services in areas that were not accessible to the youths, and only offered short-term services that were not aimed at helping the youths meet their permanency goals. "Some help with things like food, shelter, and counseling, but I don't like going to them because they force things on you. I like to go to places that let me come and go on my own, where I can be independent."

Others who can help meet youths' needs	% of responses
People on the streets	60%
Friends	20%
Family	20%
Elected Officials	20%
General Population	20%

N=5
Table 3.1

Respondents suggested several different types of services that they felt agencies should offer to help them meet their needs. All of these types of services were aimed at helping homeless youths attain, and maintain, independent living. They included education, vocational training, job placement in jobs that offered a realistic living wage, transportation, and income support. One of the participants elaborated, "A small place of my own, more transportation, interview-fit clothing. A place that you can go to wash your clothes and borrow interview appropriate clothes so that you can get a job." Another youth said, "They need to give us more help meeting our needs realistically and not setting us up to fail. They need to give us education that works for us, a job that pays more than minimum wage and an affordable apartment, and they need to remember that it's hard to motivate yourself to follow through with things when you're on the streets." And another added, "I would like one place that has everything. A place that would support independence and be like a family. Most kids would like to be part of a family. We miss that out here, but we need to be independent too and not have everything forced on us." Summing up why agencies need to provide these types of services, one respondent said, "You can't change your situation if you don't have a way to make it better permanently."

Finally, when asked who else besides service agencies could help meet their needs, a majority of the respondents said "people on the streets" (Table 3.1). One respondent said that the way that people could help was to "just be kind and remember that their money really does help. I like it when people talk to me more than anything and they're not asking for something in return." The youth who said that elected officials and the general population could help stated that, "People need to write their congressmen and be aware of the people they vote for so they'll work for you. Officials need to use resources for their proper use. They need to fix up abandoned buildings for housing and prevent suburban residents from over-running jobs in the city."

Discussion of Findings

Prior to conducting the research, the investigator hypothesized that the respondents would list shelter, clothing, food, and income as their primary needs and counseling, education, vocational training, and employment as their secondary needs. The data both supported and contradicted this hypothesis. While the respondents did indicate that food, shelter, and income were among their first most important service needs, they also listed employment. Only one person felt that clothing was a primary need. In addition, the youths interviewed did not rank counseling, education, and vocational training as their highest priorities for secondary service needs. Instead, they stated that shelter, income, food, friends, employment, and health care were their second most important needs

When examining the qualitative data this result can be explained. Themes in the data indicate that youths think of service needs not in terms of primary and secondary but rather in terms of immediate and long-term. Shelter, food and income were ranked highest in both categories because they are examples of both immediate and long-term service needs. Kids on the streets are hungry, broke, and in need of a place to stay, therefore they see food, income, and shelter as immediate needs. However, as the central theme in all of the data indicated, respondents desire to live independently in a home, with a job and a sufficient wage. This is their long-term goal and they

need food, shelter, and an income to both attain, and maintain, this lifestyle.

Furthermore, the respondents indicated that while they do know of and use services that help them meet their immediate needs, they would like more services aimed at helping them achieve their long-term goals. They felt that many services were ineffective because they did not support independence. Respondents suggested several types of services that would be useful in helping them move toward an independent lifestyle.

Finally, respondents indicated that those people who could also be helpful in meeting their needs and achieving their goals were people on the streets. They felt that people passing by them could help to supplement their incomes and provide them with food and shelter. Consistently, the respondents seemed to desire significant contact with other systems, outside of their homeless youth and service agency network.

Implications for the Field of Social Work

This study provided useful information about how social workers may better approach their casework with homeless youths. However, it should not be interpreted as a conclusive indication that services aimed at meeting the long-term goals of homeless youths do not exist. Rather, it can only show that there is a portion of the population that is not aware of such services.

Social workers and agency staff may use this data to aid them in offering services to homeless youths. Understanding that these youths have long-term goals may help service providers in designing programs. However, it should not diminish the importance of meeting immediate needs through services. It may, however, help social workers better understand the manner in which they provide short-term services. As the respondents indicated, they were deterred from using services at agencies that constricted their sense of independence. Therefore, in designing and implementing short-term services, social workers should be mindful that programs will be most useful if they provide the recipients with a sense of self-reliance. Children on the streets mature very fast in some ways and need to feel that others are there to help them, but not at the cost of their freedom.

Implications for Future Research

In the future, it would be useful to include agency staff in the sample. Redrawing the environment-system boundary in this way would not only increase the reliability of the study, but also help illuminate the approach that the service providers take in offering services to homeless youths. In addition, sampling a larger portion of the population may increase the generalizability of the data. Furthermore, future researchers may consider cross-tabulating the data they collect between various age groups. Doing so may show that youths from different age groups rank their immediate and long-term needs differently.

Conclusion

In this study the researcher examined the perceived service needs and service use of five homeless youths in Chicago, Illinois. She found that, while she had originally thought of service needs in terms of primary and secondary, homeless youths think of them in terms of immediate and long-term. In addition, the data she collected supported her hypothesis that this population is aware of agencies that offer services to homeless youths, but does not use a majority of those services. Furthermore, the data indicated that this population does not feel that agencies offer services in a manner that is conducive to supporting their long-term goals. Through qualitative analysis the investigator found that homeless youths reported a great desire to attain independence and felt that agencies should provide services in a manner that supports that goal.

In approaching future research and service delivery, social workers should be aware of the way in which this population categorizes its service needs. The short-term needs and long-term goals of homeless youths should be considered in designing future studies and service programs. In addition, investigators and service providers should consider how these needs and goals may differ among various age groups and how shifting the environment-system boundary may provide richer information about how service delivery is approached by agency staff and if their approach is conducive to helping homeless youths meet their needs.

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References

Adams, G.R., Gullotta, T., & Clancy, M.A (1985). Homeless adolescents: A descriptive study of similarities and differences between runaways and throwaways. *Adolescence, 20*, 715-724.

Anastas, J.W., & MacDonald, M.L. (1994). *Research design for social work and the human services*. New York: Lexington Books.

Athey, J.L. (1991). HIV infection and homeless adolescents. *Child Welfare, LXX*, 517-528.

Cherry, A. (1993). Combining cluster and discriminant analysis to develop a social bond typology of runaway youth. *Research on Social Work Practice, 3*, 175-190.

Johnson, G. (1985). Final Report: Governor's Task Force on Homeless Youth. Springfield, IL: Governor's Task Force on Homeless Youth.

Jones, L. (1988). A typology of adolescent runaways. *Child and Adolescent Social Work, 5*, 16-29.

Kurtz, P.D., Hick-Coolick, A., Jarvis, S., & Kurtz, G. (1996). Assessment of abuse in runaway and homeless youth. *Child and Youth Care Forum, 25*, 183-194.

Kurtz, P.D., Kurtz, G., & Jarvis, S. (1991). Problems of maltreated runaway youth. *Adolescence, 42*, 31-41.

Levine Powers, J., Eckenrode, J., & Jaklitsch, B. (1989). Maltreatment among runaway and homeless youth. *Child Abuse and Neglect, 14*, 87-97.

Lundy, K.C. (1995). *Sidewalks talk: A naturalistic study of street kids*. New York: Garland Publishing.

McCarthy, B. & Hagan, J. (1992). Surviving on the street: The experiences of homeless youth. *Journal of Adolescent Research, 7*, 412-430.

Ray, J. & Roloff, M. (1993). Church suppers, ponytails and mentors: Developing a program for street kids. *Child and Adolescent Social Work Journal, 10*, 497-508.

Robertson, M.J. (1991). Homeless youth: An overview of recent literature. In J.H. Kryder-Coe, L.M. Salamon, & J.M. Molnar (Eds.), *Homeless children and youth: A new American dilemma*. (pp. 33-68). New Brunswick: Transaction Publishers.

Shai Levine, R., Metzendorf, D., & VanBoskirk, K.A. (1986). Runaway and throwaway youth: A case for early intervention with truants. *Social Work In Education, 86*, 93-106.

Shane, P. (1989). Changing patterns among homeless and runaway youth. *American Journal of Orthopsychiatry, 59*, 208-214.

Teare, J.F., Peterson, R.W., Furst, D., Authier, K., Baker, G., & Daley, D.L. (1994). Treatment implementation in a short term emergency shelter program. *Child Welfare, LXXIII*, 271-281.

Terrell, N.E. (1997). Street life: Aggravated and sexual assaults among homeless and runaway adolescents. *Youth and Society, 28*, 267-290.

The Youth Committee of the Chicago Coalition for the Homeless. (1993). Alone after dark: A survey of homeless youth in Chicago. Chicago, IL: Author.

Timberlake, E.M. (1994). Children with no place to call home: Survival in the cars and on the streets. *Child and Adolescent Social Work Journal, 11*, 259-278.

Tyson, K. (1995). *New foundations for scientific, social and behavioral research: The heuristic paradigm*. Needham Heights, MA: Allyn & Bacon.

Vissing, Y.M. & Diament, J. (1997). Housing distress among high school students. *Social Work, 42*, 31-41.

Zide, M.R. & Cherry, A.L. (1992). A typology of runaway youths: An empirically based definition. *Child and Adolescent Social Work Journal, 9*, 155-168.

Factors that Influence the Development of Empathy in Group Treatment of Heterosexual Latino Batterers

by Priscila Rodriguez

Introduction

The field of domestic violence has both attracted and intimidated me. The reason for the appeal is that as a woman, I have had a longstanding interest in issues that affect women, particularly the complexities of women's interpersonal relationships. As my knowledge about domestic violence increased, however, I realized that the issue is not only about gender, since this explanation could not account for the many victims of domestic violence in the gay, lesbian, bisexual, and transgender communities. While gender is relevant, as the available research on the subject reflects, domestic violence is much more complex than I had initially conceptualized.

Domestic violence intimidated me because it seemed to be a problem that was intense, painful and potentially dangerous. Indeed, I would have never guessed how involved I would become in working with victims and their children. As I soul-searched the reasons for my involvement, I discovered that my motivation is related to my deep commitment to social justice in general and to healthy relationships in particular. The result has been a profound undertaking that began as a gradual modification of my own biases and attitudes about domestic violence to a commitment to address the need for further understanding of this problem. Even though there has been an increase in the awareness of this issue as evidenced by the establishment and enforcement of domestic violence laws, there is still much to be done in terms of the impact of societal attitudes on defining relationships.

As my own growth as a clinical social worker progressed, I began to realize how my process may not have been so unusual, considering the messages and attitudes conveyed about relationships throughout a person's development. The fact that society has a role in shaping such sexist attitudes is important due to its insidiousness. Furthermore, it is interesting to note how certain beliefs, such as the importance of a power differential in relationships, are similar across many cultures. The reasoning behind attitudes, their acceptance, their source, as well as a culture's sanction on beliefs can differ, while the results may not. In the case of domestic violence, often the result is to blame the victim, using psychological problems to explain why a victim may choose to stay in such an unhealthy situation. It is less common for the result to be an attempt to ask the questions, why does a person choose to batter another person? And why do they often get away with it?

As a Latina, I am also deeply committed to increasing awareness on issues that impact my community. Unfortunately, domestic violence is one of them. As my work with Latina victims and their children taught me about the struggle and plight of their situation, I began to feel the need to also learn about the batterer. My definition of "victim safety" broadened, resulting in one that included working with the batterer. While my commitment to victims was unwavering, I began to question my lack of knowledge about the batterer. I wondered how realistic the eradication of domestic violence would be if more focus was not given to the batterer. What domestic violence advocates frequently hear from victims is that the batterer either re-offends or he shifts to other types of abusive behavior, even after receiving group intervention.

For all of the above reasons, I chose to become more informed about issues relevant to batterer intervention. At present, I work at different settings with victims and with batterers. My specific interest is learning more about the male Latino batterer. As my understanding increases through my work with these men, I believe that the challenges inherent in this work are important to articulate. One challenge is how to establish empathy in order to engage batterers in the therapeutic process. Even though I have many other questions, the focus of this paper will be the factors that seem to influence the development of empathy, which in turn may impact what seems to be the most influential aspect of treatment: the therapeutic alliance.

In order to understand the Latino batterer, an overview of Latino culture and a review of the phenomena of domestic violence will be provided. Next, a discussion on empathy will consider various conceptualizations of the concept as well as my own view of empathy based on these views and my clinical experience. Since group treatment is currently a modality often used with batterers, the development of empathy will be considered in this therapeutic context. This discussion will look at facilitator characteristics that appear to promote empathy, the challenge of establishing empathy with court-mandated

clients where the facilitator has a dual role of clinician and court reporter, and specific issues in working with the Latino batterer. Finally, suggestions regarding further areas of research in working with this population will be discussed.

Overview of Latino Culture

The Latin community is a diverse group. In the United States there are Latino groups from a number of countries, including Mexico, Puerto Rico, Cuba, as well as Central and South America, and Spain. Although the term "Hispanic" has been used to refer to these communities, in my experience it seems that most of its members identify best with the term "Latino," perhaps due to the fact that the latter term was determined by its people and not by non-Latino sources. To some, the term "Latino" has come to signify not only an identifier -- it is a political term as well.

Latinos are a growing population. The second largest ethnic minority group in the United States, it has grown at least 53 percent between 1980 and 1990, increasing from 6.4 percent of the total U.S. population in 1980 to 9 percent in 1990, excluding undocumented Latino Immigrants (Sue et al., 1994). It has been predicted that the U.S. population mix will shift even more substantially by the year 2010, particularly for Asian and Latino Americans (McGee, 1997). Due to high levels of immigration, the largest groups of Latinos in the U.S. are Mexican-Americans who comprise 58 percent of Latinos, followed by Puerto Ricans at 13 percent; Cubans represent 7 percent of the Latino population, and others originally from South and Central American countries total 23 percent (Sue et al., 1994). One consequence of the predicted population shift is that "traditional" mainstream European-based values may not be as widely accepted as they have been. This has implications for the delivery of culturally compatible interventions in social work.

While there have been a number of studies that attempt to address the issue of providing culture-sensitive services to ethnic minorities (Bridgers et al., 1997; Flaskerud, 1986; Rogler et al., 1987; Sue et al., 1987; Sue, 1988), there still seems to be some controversy about what culturally-competent services are. One common theme in the literature is that there seems to be a difference amongst the so-called minorities in terms of how they utilize counseling services. "In general, most studies reveal that African-American and American Indians overutilize services, and Asian-Americans and Latino-Americans underutilize them" (Sue et al., 1994, p. 786). The authors point out that the populations that underutilize services are predominantly foreign born and speak English as a second language, and that minority group utilization is directly related to the availability of minority group staff (Sue et al., 1994). However, studies that discuss issues in serving culturally diverse populations have a variety of methodological problems that make it difficult to examine the influence of ethnicity and culture in treatment processes and outcomes.

As mentioned previously, Latinos are not members of a single, homogeneous cultural group in the sense that they do not share a common history, heritage, values, and tradition. Latin America was impacted in various ways by a similar beginning, however. In the latter part of the 15th century, Spanish explorers/conquerors arrived on the American continent and affected these lands forever. They altered the natives' beliefs and intermarried with them. In some cases, such as in Puerto Rico, they practically annihilated the natives and then brought slaves from Africa for labor. This cultural fusion occurred throughout Latin America. Skin color became more varied when the different ethnic groups intermixed so that the range of skin colors goes from "white," to mestizo and mulatto "brown," to African "black." A number of subcultures emerged when the local traditions and rituals became intermingled with the ideas and beliefs of the Spaniards. In Mexico, for example, syncretism of the Indian religious traditions and the Catholic traditions brought by the Spanish created a new version of Catholicism that reflected influences from both traditions.

As is true for all races and ethnicities, further diversification results from the circumstances surrounding the decision to migrate, whether immigration was from an urban or rural society, the educational and socioeconomic level of the immigrant, and the region of residency the immigrant arrives at within the United States (Casas et al., 1989). Not all groups fare the same in these areas. For example, although many Latinos are poor, Cubans and people from some countries in South America tend to be in the higher economic bracket than are people from countries such as Mexico and Puerto Rico. In order to understand these intragroup differences, it is important to learn about their immigration and migration factors as well as their sociopolitical history (Casas et al., 1989).

The process of acculturation of Latinos is another very important factor in understanding their culture. A definition of acculturation suggested in Casas et al. (1989) is "... those phenomena, which

result when groups of individuals having different cultures come into continuous firsthand contact, with subsequent changes in the original pattern of either or both groups." These authors state that acculturation not only occurs in individuals but also takes place within groups. Furthermore, acculturation is not unidirectional; for example, a person can act "Americanized" in one setting, such as work, 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 et al., 1989). This means that one Latino may understand little English, have low socioeconomic status, and be very traditional in family orientation, while a more acculturated Latino may speak no Spanish, have higher socioeconomic status, and identify more with mainstream American values. 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.

As a variety of considerations are explored in understanding the Latino culture, one must always remember that while information and categorization can be useful, there are individual differences in areas such as education, socioeconomic status, religion, country of origin, and level of acculturation that may not fall into neat categories. Life factors, such as family size, birth order, childhood illnesses, family mobility, family deaths, authoritarian parenting, and family protectiveness also impact the functioning of Latino families. Additional elements are racism, segregation, unequal opportunities for education, unequal accessibility to health and social services, unfair employment (or unemployment) practices, and political disenfranchisement (Casas et al., 1989). It is indeed difficult to understand the experience of a person of color without "assessing cultural factors as well as the individual's experience of oppression"(Casas et al., 1989). Even when a Latino social worker is working with a Latino client, individual differences must be considered, since being Latino does not account for each person's unique experience. For this reason, the reader should keep in mind that to "start where the client is" may mean to approach a client with a general understanding of the dynamics that impinge a Latino family, but not to have a preconceived notion of what a particular Latino family is like before they share their view of their problem. This way, we can attempt to view the client's issues from their perspective instead of fitting their view into our own theoretical perspective.

Latinos often have a "here and now" outlook and frequently attribute control to an external locus, such as supernatural powers, acts of God, and luck. They favor an extended family support system as opposed to the nuclear family structure. Latinos often take a concrete, tangible approach to life rather than an abstract, long-term outlook. With authority figures, Latinos may practice a unilateral communication pattern using avoidance of eye contact, deference, and silence as signs of respect as opposed to more self-assertive patterns. In language, they may develop multilingual communication skills, using English, Spanish, and "Spanglish," a hybrid of the two (Casas et al., 1989).

An additional pattern of behavior that seems to distinguish Latinos from non-Latinos are looser boundaries or "personalismo," a term that, according to Ruiz et al. (1983), denotes a preference for personal contact and individualized attention in dealing with power structures, such as social institutions. This often translates into more physical contact, such as handshakes with men, and kissing on the cheek or hugging between women when they greet or depart from each other. They often also prefer to use first names rather than formal titles in centers offering counseling and psychotherapy services (Ruiz et al., 1983). Although some of these views have been challenged (Ruiz et al., 1983) due to apparent concern about their interpretation, it is important to approach such information with a critical mind as suggested previously.

What is Domestic Violence?

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults and adolescents use against their intimate partners (Schechter et al., 1995). It is also known as wife abuse, marital assault, woman battery, spouse abuse, wife beating, conjugal violence, intimate violence, battering and partner abuse (Schechter et al., 1995). This paper will focus on intimate violence in heterosexual relationships. However, it is important to remember that domestic violence is also present in gay, lesbian, bisexual, transgender, and dating relationships, as well as in caretaking relationships with the elderly or frail and with people who have disabilities. The intimate context of the abuse influences how both the perpetrator and victim relate to, and are affected by, the violence (Schechter et al., 1995). According to

Schechter et al. (1995), even though violence by a stranger may appear similar to domestic violence, there are important differences. In domestic violence the trauma is a repeated rather than a singular event, and the effects of the trauma are accentuated due to the intimate nature of the relationship between the victim and the perpetrator. For example, the domestic violence perpetrator has ongoing access to the victim, knows the victim's routine, and can continue to exercise considerable physical and emotional control over the victim's daily life. Furthermore, the relationship with the victim gives the perpetrator social, if not legal permission for the abuse, and it is the strength of the intimate nature of the relationship that creates the complexity that can make separation difficult for the victim (Schechter et al., 1995).

As stated by Pence et al. (1993), the theory that guides practice in working with batterers is based on the belief that violence is used to control people's behavior. Domestic violence is a pattern of behaviors rather than isolated incidents of abuse or cyclical explosions of pent-up anger, frustration, or painful feelings (Pence et al., 1994). These authors contend that while many men may experience themselves as out of control or controlled by emotional outbursts when battering, their behaviors do have intent. Furthermore, they posit that batterers live within cultures that teach men to dominate.

Latino Men and Domestic Violence

There is an alarming deficiency of research on Latino spousal abuse (Olona, 1993). For example, there are no studies on the differences in incidence rates between Latino groups, except that some research seems to indicate a higher incidence in lower socioeconomic classes (Vasquez, 1994). Without studies that illuminate the issue of domestic violence among the various Latino groups, professionals may use assumptions, generalizations, and stereotypes in working with Latino batterers. For example, the stereotype that "macho" Latino men are more violent is unfounded because we do not know whether there is more violence among Latinos compared to other groups, just as we do not know whether Latina women are encouraged to develop in ways that are different from other cultures.

The notion of "machismo" is one that is frequently used to describe Latino men. This term, in its most general sense, is an ethos comprised of traits and behaviors prized by and expected of men in Latin countries (Olona, 1993). The ideal of machismo or "muy hombre" (manliness or virility) dictates that men be aggressive, sexually experienced, courageous, and protective of their women (who include mother, sisters, and wives) and their children (Falicov, 1982). Notwithstanding, it is important to recognize that this term has positive values, such as loyalty, fairness, responsibility, and family centrality, and that these qualities can become a bridge, rather than a barrier in engaging Latino men (Falicov, 1982). Moreover, it can be argued that the above qualities are not exclusive to Latino men, but of men from other cultures as well.

The Latino culture has typically been considered patriarchal with an authoritarian father and a submissive mother (Olona, 1993). Traditional family characteristics include respect for the authority of a dominant father who rules the household, unwavering love for a mother who serves a unifying function within the family, formalized kinship relations such as "compadrazgo" ("godparent" system), and loyalty to the family that takes precedence over other social institutions (Ruiz et al., 1983). Latino gender roles are usually described as traditionally rigid (Ruiz et al., 1983; McGee, 1997), although these views have been challenged (Oropesa, 1997; Vasquez, 1994). From this perspective, relative power differential, a factor in setting the stage for spousal abuse, is great in Latino American families (McGee, 1997).

In discussing marital power and the ways development impacts economic and social change, as well as the status of women in Mexico, Oropesa (1997) offers the view that husband dominance is neither universal nor insurmountable. Furthermore, the author posits that female educational attainment is a key variable affecting a wife's exposure to domestic violence. Education also impacts the likelihood of having an equal say in decisions and satisfaction with influence in decisions. Even though this study seems to have some problematic methodological issues that may have influenced the results, it seems important to consider the above variables in approaching Latino batterers who are recent immigrants and have lower educational attainment.

Another study cited by Vasquez (1994) concluded that gender-related interactions within the Mexican-American family were more complex than previously assumed. She makes a distinction between healthy and unhealthy families based on her research. In the healthy families, the traditional roles do not exclude equity in decision-making and conflict resolution. In dysfunctional families, traditional roles are carried out in a more oppressive and pathological manner, with power battles, abusive

behavior, poor conflict resolution, and low marital satisfaction (Vasquez, 1994).

Empathy

The concept of empathy has been a subject of much controversy. While the psychological literature has defined empathy as both a cognitive and affective response (Miller et al., 1988), the definition of empathy itself has evolved with contributions from George Mead, Dan H. Buie, Louis Agosta, Heinz Kohut, Michael Franz Basch, and Daniel Stern, among others. A consistent problem seems to be how to articulate this term in a way that can be acquired or taught as well as the notion that as long as empathy is limited to a basis that is cognitive/affective, empathy will be limited to those processes only, when it may be a collection of processes (Saari, 1994).

I wish to use ideas from a number of the above contributors in order to formulate a definition for the purpose of this paper. Using a constructivist perspective, the fact that I am choosing elements from their thinking portrays my own bias and worldview, which in turn is influenced by factors such as my own context, gender, background, educational level, life experience, and level of acculturation. The selection process of the theories themselves implies that I am considering certain aspects while disregarding others. In my attempt to define empathy using points of views of others, I am also focusing on features that fit with my experience. It is my belief that my own self surfaces in my attempt to make sense of my world, including the way I relate to others. This process is particularly relevant in trying to define empathy or any concept.

I agree with Stern (1985) that empathy is more than affect attunement, since empathy involves the mediation of cognitive processes. I also agree with his belief that it is through the experience of affect attunement that an inner life can develop, and that a clinician must also have prior experience with affect attunement in order to function empathically. Hence, while the capacity for affect attunement may be necessary for empathic awareness, empathy goes further (Saari, 1994).

Empathy is not the same as sympathy. In Goldstein and Michaels (1985), Katz (1963) makes a distinction between the two. He defines empathy as a focus on the feelings and context of the other person and sympathy as a heightened attention to one's own feelings and the assumed similarity between such feelings and those of the person who is the stimulus for them. He explains that the empathizer is able to be sensitive to the range of feelings of another and can proceed fully to be present emotionally, process cognitively, and provide feedback accurately. The sympathizer, on the other hand, will be more preoccupied with his or her own feelings and for this reason have more difficulty in responding to the other person. Goldstein et al. (1985) also make distinctions between empathy, and projection and identification. There is a belief that in projection, the person attributes wishes, attitudes and behavior to the other while identification involves role taking that is more lasting, less frequent, and more emotional than empathy (Goldstein et al., 1985). It seems that while empathy and sympathy have similarities in terms of eliciting an affective response, the difference is that in empathy the clinician is able to be intentionally aware of his or her own processes, while in sympathy, he or she may not.

I concur with Saari (1991) that in order to understand the meaning of human actions and to establish an empathic relationship, one has to take into consideration the cultural context in which the actions took place. Creating culture in the context of defining empathy could also mean establishing an environment where the client and clinician co-create meaning. Agosta (1984) believes that a clinician is not really introspecting the experience of the client, but rather the client's feelings are eliciting an affective experience in the clinician. Stern might go further to say that empathy is not necessarily the feelings elicited in the clinician, but an experience evoked by the interaction with the client, since Stern's view is that a person internalizes as a child an experience of the world, not merely a representation. However, as Saari (1994) points out, it is necessary to be able to distinguish "me" from "you" in order for a clinician to be able to have a sense of the client. This means that a clinician must have self-awareness and be able to move back and forth from the client's experience to his or her own. As Buie states in his article, *Empathy: Its nature and limitations*, "It is reasonable to designate the ego as the executor of empathy" (1981, pp. 293-294).

According to Basch (1983), the greater the similarity between clinician and client, the more likely it is that the clinician will be receptive to and understand the client's unspoken affective communications. This idea seems to have implications for working with clients from a variety of backgrounds. Although it makes sense to consider empathy from the point of view of a clinician's ability to see his or her experience separate from the client's experience, clinicians from the same background as their

clients are not exempt from countertransference issues. Indeed, it is important that a clinician respond affectively to the client's verbal and nonverbal communications and, in the process, learn from him or her (Basch, 1983). In addition, the issue of psychic space is also relevant in understanding empathy since it is important for the clinician to make adjustments in the interactions with the client in order to maximally respond to any changes in the client. Saari (1994) suggests that people regulate the degree of interpsychic space to exercise their capacity to create meaning/identity. This holds true also for the interaction between the clinician and the client.

As we explore the definition of empathy it also seems important to discuss its limitations. According to Buie (1981), while countertransference by the clinician may be part of the explanation for empathic failure, it does not fully explain it. The question of empathy's limitations arose when suicidal clients misled clinicians into believing they were stable only to later commit suicide. Buie (1981) refers to Greenson's (1960) observation that a person's "... capacity for the other person's resistance or readiness for empathic understanding can influence empathy. There are patients who consciously or unconsciously want to remain misunderstood; they dread being understood" (Buie, 1981, pp. 281-282). Starcevic et al. (1997) also speak to the limitations of empathy when they assert that: "While the importance of empathic understanding can hardly be overestimated, it is not a panacea. Understanding per se has little healing power and patients are not treated and cured by it" (p. 325).

The definition of empathy with all its complexity defies a simple explanation. My own definition of empathy encompasses the points of view of the authors discussed above. To summarize, I believe empathy involves both affective and cognitive responses and that in order to be empathic a therapist must have had prior experience with affect attunement. I believe that in order for clinicians to show empathy, they must be able to be introspective about the affective experience elicited by the client's feelings, and that in order for empathy to occur clinicians must have the ability to separate their own experience from the client's experience. I also hold the opinion that the cultural context is important. The notion of psychic space makes sense as a place for the client to make meaning of their experience; it would be interesting to find out what this psychic space may mean for different ethnic groups. Finally, I recognize there is nothing magical about empathy and that its limitations are strongly related to the client's willingness to be understood.

Treatment of Batterers

The issue of domestic violence has political components to it. In my experience, a feminist framework is used as the theoretical underpinning in most batterer programs. This perspective assumes that domestic violence is a social problem that has its roots in a patriarchal society, which often translates into a type of intervention that attempts to address batterer's belief systems in order to change violent behavior. While the ultimate goal is to eradicate domestic violence, attempting to alter beliefs is a serious responsibility. I do believe in the importance of holding batterers accountable for their violent behavior. However, I also acknowledge the fact that I bring my own worldview to the treatment of batterers, which colors the way I approach them. Although I am interested in promoting healthy relationships and families, it is nonetheless a perspective influenced by the belief that patriarchy is the major reason for violence against women.

At this time, there is no empirical evidence that one theoretical orientation or particular intervention is better than another in working with batterers (Larry Bennett Ph.D., personal communication, November 3, 2000). In fact, there is considerable controversy about the choice of modality for treatment of batterers and whether abuser treatment programs are effective at all. The reason efficacy has been difficult to assess is because a common problem in evaluating batterer programs is how to define success. Many studies use ending physical violence as the criteria for success and do not measure whether there have been changes in emotional abuse and power and control issues (Brandl, 1990). Other measures that have been used are psychological measures, such as a decrease in depression, as means to determine the end of violence.

Success rates for ending physical violence range from approximately 53-85 percent (Brandl, 1990). However, some batterers become more skillful in shifting from one mode of abuse to another. Many victims have reported that while their partner stopped the physical violence, the psychological abuse continued or increased. This is consistent with findings that after treatment, most men continued to use emotionally abusive tactics such as stomping out during arguments, insulting partners, restricting liberty, or threatening to leave the partner (Brandl, 1990). For this reason, some experts in the

field believe success should be measured based on improvement in the life of the partners of the batterers. If the circumstances of her life have not improved - if she is not less isolated, terrorized, or has no more autonomy than before her abuser began education/treatment - then the program should not be seen as successful (Brandl, 1990).

Research on treatment methods has found no empirical evidence to support individual or couples counseling for batterers and groups have become the preferred method of education/treatment. Proponents of groups believe they are important because they break down isolation, provide emotional support and can be an opportunity for mutual self-help (Brandl, 1990). Furthermore, groups can address denial, blame and the minimization of abuse. Many experts in the field suggest that in addition to being a less expensive method of treatment, groups can also provide role models of men who have been abusive and are learning and practicing other behaviors (Brandl, 1990). To the contrary, a study cited by Brandl (1990) conducted by Tolman and Bennett revealed that groups are not successful in ending controlling and abusive behavior. They also found that a lower percentage of success occurred based on a lengthier follow-up after group was completed and based on reports from battered women. Brandl (1990) also makes reference to studies by Edleson & Brygger (1986) and Saunders (1988) that found that in most cases battered women report more frequent and severe abuse than their partners report. For this reason, victim reports are generally seen as the most accurate, although if the victim fears retaliation she may minimize the abuse.

In considering factors related to successful outcomes as well as choice of treatment modality, the diversity among abusers themselves must be taken into account. Classifications have been developed by a variety of authors in an attempt to capture the differences between these men, such as Jacobson and Gottman's conceptualization of "pit bulls" and "cobras" (Jacobson et al., 1998). Furthermore, there are special populations of abusers, such as men of color, older men, gay men, men with alcohol or substance abuse, men with limitations in their literacy abilities, women abusers, lesbian batterers, as well as individuals with physical and mental disabilities (Brandl, 1990). Due to their specialized needs, these populations may feel different than other group members or facilitators, which can result in uncooperative behavior. In addition, there are varying degrees of motivation among batterers.

Group Treatment

Establishing empathy within groups that have such diversity is certainly a challenge. Just as there are a variety of problems that may accompany domestic violence, the group members themselves present with different educational levels, developmental issues, ages, levels of acculturation, ethnic backgrounds, and socioeconomic status. As such, even when the group is predominantly heterogeneous in terms of ethnicity, these factors make establishing empathy difficult.

Because the majority of batterers are court-mandated clients, another consideration in developing the therapeutic relationship is their involuntary status. Not only are they in a group against their will, but they often view themselves as victims who have been wrongly or unjustly accused and convicted. Moreover, batterers often minimize and blame others for their behavior. This results in a dual role for the facilitators, where they must not only be empathic and therapeutic, but firm and consistent in following through with consequences for behaviors that stray from the contract each group member agrees to abide by before they enter the group. The dual role also means that in addition to monitoring transgressions, facilitators must report client progress or lack thereof. They are also expected to make judgement calls and recommendations if a client is deemed to be not benefiting from the group experience. Hence, while the worker strives to establish a therapeutic environment that is conducive to empathy and relationship building, the parameters of the treatment contract are besieged with expectations that seem to work against it.

Another challenge to developing empathy in groups is that abuser intervention groups are frequently open groups. For this reason, while some members may be new, there are other participants that have been in the group for a short period, and others who are close to ending. Due to the nature of open groups, there is an ongoing influx of new members, which also impacts group cohesiveness. It often seems that once the group process has stabilized, new members arrive and the group dynamics shift once again. There are positive aspects to this process, namely the possible advantage of having more seasoned group members "socialize" new participants into the group. However, a downside to the ongoing adaptation the group makes is that more seasoned members may lose interest in topics new members raise that have already been addressed, but that are important for newcomers to express. From the facilitator's perspective, it can also be challenging to establish empathy with every

new participant as they arrive. However, it is fair to say that the formerly established group rapport does seem to assist the process as the new members can observe the interactions between facilitators, and between facilitators and group members who have been in the group for some time.

Facilitator Characteristics

There are many characteristics of a group facilitator that may affect the development of empathy in therapeutic work with Latino batterers. One must consider gender, age, developmental process, ethnic background, level of education and socioeconomic status, length of professional experience, and level of acculturation. Of course the differences in these areas impact not only the interaction between facilitators and group members, but between the facilitators themselves. Another element to keep in mind is the individual facilitator's ability to share vulnerability, to establish a safe environment where meaning can be co-created, and to have the capacity to feel comfortable with conflict and anger. As a female co-facilitator who works with both victims and batterers, I have found it challenging to "start where the batterer is" while also keeping victim safety as a priority. The reason for this conflict is that often batterers feel sorry for themselves, or feel victimized. It is sometimes difficult to acknowledge and validate these feelings when one believes that the real victim is their partner.

Treatment groups for batterers are often co-facilitated and, ideally, a team is composed of a female and male facilitator. Thus, one must consider the relationship dynamic between facilitators as another factor that impacts the establishment of empathy within a group. The female co-facilitator acts as a strong female role model who can relate to both the clients and the male facilitator. Men who relate in terms of power and control are often challenged in relating to a woman who is also in a position of power. This can be an opportunity for growth. It is necessary for the female co-facilitator to be grounded and secure in her own identity to avoid falling into the trap of acting out her own experiences with sexism or feelings of anger. This can be a formidable task for the only woman present in the group.

The idea of having a female leader is to offer a woman's perspective in the group discussion and, in a sense, to represent the victim. The female co-facilitator can serve as a sounding board for how male actions affect women. Interestingly, some of the intervention programs with batterers do have as a goal to increase the batterer's level of empathy for his partner. There seems to be some evidence that increase of empathy can inhibit aggressive behavior regardless of the sex of the individual, although these studies have been focused on parental and child aggression (Miller et al., 1988). Although more evidence is needed to support this contention, it is possible that a batterer can increase his ability for empathy by experiencing empathy himself from the facilitators.

Carl Rogers (1951) presented a number of commonly accepted leadership functions in a group. His principles of unconditional regard and acceptance seem to fit with my vision of the therapeutic relationship with clients. While these functions apply to any group, I would like to describe them in the context of my experience as a Latina co-facilitator in a Latino batterer group (predominantly Mexican and Mexican-descent) to present the unique dilemmas these functions present.

Rogers (1951) asserts that, "The very existence of a group leader, either real or perceived, may be a deterrent to the distribution of leadership throughout the group" (p. 332). In batterer groups there are usually group members who take on some leadership in terms of being outspoken participants. These members may represent a new generation of thinking, or men who feel confident enough to express their views, including dissent. They may also express views that reflect group views, which in heterosexual male batterer groups often are their views about women and relationships, or about male beliefs.

An effective group leader, according to Rogers (1951), ".... is one who can create the conditions by which he will actually lose the leadership" (p. 334). Ideally, the environment in a group is non-hierarchical, which means that the leader relinquishes leadership to become a group member. However, due to the dual role nature of the facilitator of the batterer group, members seem to be reluctant to accept the facilitator(s) as just another member of the group. In a batterer group it is not possible to become "one of them" since there is an inherent power differential that comes with being a reporter to the court. Another fact to keep in mind is that the Latino culture is predominantly hierarchical, which influences the need for most Latinos to view leadership in this manner.

According to Rogers (1951), group-centered leadership uses principles from client-centered psychotherapy and applies them to the group context. He expresses the belief that the group leader must accept the members of the group and respect them

as individuals different from himself. He goes on to state that the leader must not see the group members as persons to be used, influenced, or directed for the leader's own personal goals. The group leader must see the group as a vehicle for self-expression and the satisfaction of individual member's needs and view them as capable of self-actualization.

In terms of the conditions that have to be present for the client to achieve his maximum potential, Rogers points to the importance of group members having the opportunity to participate in matters that affect them. In my experience co-facilitating a Latino batterer group in Illinois, there are standards by which programs must abide that do not include batterer participation. Every abuser intervention program has to go through a state approval process where certain views are promoted. In Illinois, the focus in domestic violence treatment is on "the paramount importance of victim safety, the need for individual accountability for, and state-wide response to, domestic abuse and the necessity of changing the attitudes, beliefs and behaviors which lie behind illegal acts" (Illinois Department of Human Services & Domestic Violence Council, 2000). In other words, for the most part, abuser intervention programs use curricula that cover topics not selected by the batterers themselves, although there is some variability among programs in terms of their focus across the state (Larry Bennett, personal communication, November 3, 2000).

A second condition that Rogers (1951) views as important in creating a growth-promoting group is the removal of barriers to free communication. In order to get to the meanings behind individual communication within the group, there has to be an environment where people can express themselves freely. Rogers asserts that barriers to communication within groups exist only as members view them as barriers. As stated previously, the fact that the male abuser may perceive the facilitators as an extension of the courts can be a barrier to expressing his feelings and thoughts freely for fear of reprisal. Many batterers may have a difficult time with self-disclosure because of the possibility of a negative consequence, for example, if the disclosure has to do with a threat to victim safety such as a new incident of violence, or substance use.

Finally, Rogers (1951) views a non-threatening psychological climate as a way to remove barriers that may hinder group process. Based on client reports, Rogers was able to determine that clients feel "safe" when they are not feeling threatened, they are not being judged or evaluated, and they feel understood and accepted. Once again, it appears difficult to implement a "safe" environment for batterers under the aforementioned conditions since the environment in the abuser intervention program is highly judgmental and evaluative. In addition, one has to consider that even though the concept of establishing a "safe environment" in the group makes sense, it does not address the issue of what this means to each member on an individual level. As Eagle (1987) puts it: "The difficult clinical challenge is to be sensitive to what constitutes 'conditions of safety' for a particular client in the light of his or her particular constellation of early conflicts, fears, and traumas" (p. 106).

In reviewing the leadership styles that promote a safe group climate and lay the foundation for self-exploration, it seems clear that a facilitator must be reflective about the "pattern of behavior which manifests itself in the leader's speech, his facial expression, and his gestures" (Rogers, 1951, p. 348). It also seems important to consider the philosophical foundation of the facilitator's own beliefs about working with batterers. For instance, if a facilitator has misgivings about a batterer's ability to change his violent behavior, this non-accepting or pessimistic attitude can be reflected in the way he or she approaches interventions. Once again, the leader's ability to separate his sense of self from the group process and focus his attention on the contributions of group members conveys acceptance and respect. To clarify the concept of acceptance, Miller and Rollnick (1991) distinguish that it is not the same as agreement. They suggest that it is acceptance of people "as they are" which seems to free them to change, whereas insistent non-acceptance ("you're not OK; you have to change") can have the effect of keeping people as they are.

The worker can further show understanding of the group members by reflecting meanings and intents back to the clients, which in turn can contribute to establishing an empathic connection. Rogers (1951) makes the distinction between interpretation and reflecting meaning and intents. His view is that interpretation attempts to bring to conscious attention material that may be out of awareness. Reflection, on the other hand, is an attempt to perceive only the conscious information that is present at the moment.

Yalom (1985) also recommends what he terms "transparency" in relating to clients in a group. He cautions, however, in focusing too much on being "transparent" or using self-disclosure indiscriminately, since timing is of the essence. He believes

that flexibility is important in order to allow group need to guide the process. He also discusses transference in the group as a powerful and ubiquitous response that plays out as members attempt to be the leaders' "favorite." While I do believe there is transference in groups, my view is more syntonic with ego psychology in that the facilitators are not considered transference figures that replicate reactions to significant people in the client's early childhood. Instead, the leaders encourage batterers to perceive them accurately in the here-and-now. By providing supportive strategies, the facilitators can encourage the clients in the group to use the group process as a way to point out ways of interacting that they may need to look at and evaluate.

Finally, the interaction between facilitators cannot be ignored nor minimized. It is important to realize how gender roles are played out in the context of the facilitator "subsystem." Establishing a working relationship with the co-facilitator can also promote growth for the workers involved. In the partnership that is established between co-facilitators, it seems necessary to be willing to become vulnerable or "transparent" with each other, before being able to do so in the group. The presence of trust and the willingness to look at each other not only as professionals but also in terms of each person's understanding of gender appears important as the co-facilitators set out to be role models for the group. The group attentively observes the interaction between co-facilitators. For example, they observe the way the facilitators agree or disagree, how decisions are made, the manner in which they interrupt each other or the time each takes to express a point of view. These are all behaviors that can elicit further respect and openness or confirm preconceived notions about the way power and control play out between the sexes. An interesting observation from some male Latino facilitators is how their own bias about gender relations has to be constantly challenged and adjusted internally in order to advocate beliefs that are consistent with the beliefs promoted in the group.

Developing Empathy with Latino Clients

In attempting to establish an empathic therapeutic relationship with Latino batterers, it is important to keep in mind that issues that affect the larger Latino community, such as immigration and the process of acculturation, impact them. While these issues are not an excuse for domestic violence, not considering how families are affected by these processes would be a serious oversight, since they can and do impact the way families function. In working with Latinos, American concepts such as individualism and equality may not make sense from a Latino culture perspective. Hence, interventions used with this population to promote empathy may have to take into consideration ideals that are consonant with the particular group with which one is working. An example may be to use concepts such as "respect" (a notion that for Latinos does not have the same internalized meaning of dutifulness and obligation that it does for Anglo-Americans), "fairness" (equity versus equality), or "what is best for the family" in working with Latino batterers. In other words, interventions with Latinos require a more family or group orientation, which is often in conflict with the individualistic orientation of American values.

Furthermore, the Latino batterer may relate more openly to a less detached approach by the co-facilitators, since Latinos tend to feel more comfortable with relationships where the person is able to relate to them in a more personal way (K. Martin-Ocasio, personal communication, March 23, 2001). For example, the ability to interact using slang, popular expressions, and to answer direct questions about the experience of being a woman in various situations can result in more self-disclosures in the group (K. Martin-Ocasio, personal communication, March 23, 2001). Non-Latino facilitators who work with Latinos may have to become more aware of their cultural countertransference so that they do not impose their own worldview.

Further research is needed to provide more information about whether there are particular strategies that may promote empathy in working with Latino batterers. Is it helpful to match facilitators and client groups from the same ethnic background? Certainly the assumption that because a facilitator is Latino(a) he or she will "automatically" be understanding and accepting falls into "lumping" all Latinos into one homogenous group when, as discussed, the Latino culture is extremely diverse. On the other hand, a potential problem for facilitators from similar backgrounds that should not be overlooked is overidentification, since it may create "blind spots" that may interfere in the therapeutic process. As with any clinician, but especially those who work with diverse populations, the importance of supervision should not be underestimated. The consistent provision of supervision for facilitators of batterer groups is an issue that needs further research. A concern among facilitators, particularly female facilitators, is the lack of support for the particular issues that arise in the co-facilitation team.

Another issue is the establishment of empathy between facilitators and batterers from different cultures and/or ethnicities or sexual orientations. There is a dearth of information about battering in the Latino gay, lesbian, bisexual and transgender communities. It would also be interesting to find out if once the empathic process is established, does it result in further engagement by the batterer and does the process of engagement look differently for batterers from different ethnic backgrounds? In working with Latino batterers, what are facilitator behaviors that seem to promote conditions for change despite their dual role? Is there a difference from the batterer's perspective if the behaviors come from the male or the female facilitator?

Conclusion

As one can see, there is still much to be discovered in the area of developing empathy in Latino batterer groups. Clinical theories continue to evolve that are more sensitive to historical context, gender, sexual orientation, and other variables that influence knowledge. However, I believe that there still is a need for further understanding about the interventions used with batterers in general and Latino batterers in particular. My position is that there are multiple realities. Since one person's experience will be different from another's, it makes sense to gain a broader understanding of the Latino batterer from his perspective, not in an effort to condone his behavior, but to engage him in the process of change. Of course there are challenges inherent in this approach that one has to be continuously aware of, particularly as a woman. My challenge has been to focus on where the batterer is in order to engage him, while also keeping in mind victim safety. At times it seems difficult to do both, particularly when one has listened to so many narratives from the victim's perspective. I find it helpful to keep in mind that a person's behavior does not necessarily reflect the person. Yet remembering the victim's side is also necessary to avoid minimization of the batterer's violent behavior.

While this paper has focused on Latino heterosexual relationships, much remains to be known about other non-heterosexual Latino populations in domestic violence. As research promotes discovery and builds theory, the hope is that domestic violence services will become more culturally competent. If we can increase our knowledge about what is most effective in establishing empathy with Latino batterers, we might learn more about their worldview. If we learn more about their worldview, we might be able to engage them, which could in turn impact their decision to change their violent behavior. And while the criminal justice system may be the reason many batterers begin their journey toward change, for those of us who facilitate groups, it is important to understand better the therapeutic context that can best promote that change.

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References

Agosta, L. (1984). Empathy and intersubjectivity. In Lichtenberg, J., Bornstein, M., & Silver, D. (Eds.). *Empathy I*. Hillsdale, NJ: Analytic Press.

Basch, M.B. (1983). Empathic understanding: A review of the concept and some theoretical considerations. *Journal of the American Psychoanalytic Association, 31*(1), 101-126.

Brandl, B. (1990). *Programs for batterers: a discussion paper*. Department of Health and Social Services. Division of Community Services, Bureau for Children, Youth and Families. Wisconsin.

Bridgers, B., Brown, P.M., Breger, J., & Roark, H.A. (1997). Cross-cultural considerations in family preservation practice. *Journal of Family Social Work, 2*(2), 141-158.

Buie, D.H. (1981). Empathy: Its nature and limitations. *Journal of the American Psychoanalytic Association, 31*(1), 281-307.

Casas, J.M., & Vasquez, M.J.T. (1989). Counseling the Hispanic client: A theoretical 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.

Eagle, M.N. (1987). *Recent developments in psychoanalysis: A critical evaluation*. Cambridge, MA: Harvard University Press.

Falicov, C.J. (1982). Mexican families. In McGoldrick, M., Pearce, J.K., & Giordano, J. (Eds.), *Ethnicity and family therapy* (pp. 134-163). New York: The Guilford Press.

Flaskerud, J.H. (1986). The effects of culture-compatible intervention on the utilization of mental

health services by minority clients. *Community Mental Health Journal, 22*(2), 127-141.

Goldstein, A.P., & Michaels, G.Y. (1985). *Empathy: Development, training, and consequences*. New Jersey: Lawrence Erlbaum Associates.

Illinois Department of Human Services Domestic Violence Advisory Council. Illinois Protocol for Partner Abuser Intervention Programs. Section I. *Male Perpetrators of Woman Abuse*. Revised March 2000.

Jacobson, J., & Gottman, J. (1998). *When men batter women: New insights into ending abusive relationships*. New York: Simon & Schuster.

McGee, M.P. (1997). Cultural values and domestic violence. *Journal of Family Social Work, 2*(2), 139-140.

Miller, I.J. (1989). The therapeutic empathic communication (TEC) process. *The American Journal of Psychotherapy, 43*(4), 531-545.

Miller, W.R., & Rollnick, S. (1991). Motivational interviewing: *Preparing people to change addictive behavior*. New York: The Guilford Press.

Miller, P.A., & Eisenberg, N. (1988). The relation of empathy to aggressive and externalizing/antisocial behavior. *Psychological Bulletin, 103*(3), 324-344.

Olona, T.C. (1994). *An examination of predictors of domestic violence in Latino males*. (Doctoral dissertation, California School of Professional Psychology, Los Angeles, 1993). Dissertation Abstracts International: Section B: the Sciences and Engineering. 54(9-B), 4929.

Oropesa, R.S.(1997). Development and marital power in Mexico. *Social Forces, 75*(4), 1291-1317.

Pence, E., & Paymar, M. (1993). *Education groups for men who batter: The Duluth model*. New York: Springer Publishing Company.

Rogers, C. (1951). *Client-centered therapy*. Boston: Houghton Mifflin Company.

Rogler, L.H., Malgady, R.G., Constantino, G., & Blumenthal, R. (1987). What do culturally sensitive mental health services mean? The case of Hispanics. *American Psychologist, 42*(6), 565-570.

Ruiz, R.A., & Padilla, A.M. Counseling Latinos. In Atkinson, D.R., Morten, G., & Wing Sue (Eds.), (1983). *Counseling American minorities: A cross cultural perspective*. (2nd Ed.). Dubuque, Iowa: Wm. C. Brown Company.

Saari, C. (1994). Empathy in clinical social work: Playing in the transcontextual space. *Journal of Analytic Social Work, 2*(1), 25-41.

Saari, C. (1993). Identity complexity as an indicator of health. *Clinical Social Work Journal, 21*(1), 11-24.

Saari, C. (1991). *The creation of meaning in clinical social work*. New York: The Guilford Press.

Schechter, S., & Ganley, A.L. (1995). In Carter, J. (Ed.), *Domestic violence: A national curriculum for family preservation practitioners* (pp.133-165). San Francisco: The Family Violence Prevention Fund.

Stern, D. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stephan, W.G., & Finlay, K. (1999). The role of empathy in improving intergroup relations. *Journal of Social Issues, 55*(4), 729-743.

Starcevic,V., & Piontek, C.M. (1997). Empathic understanding revisited: Conceptualizations, controversies, and limitations. *American Journal of Psychotherapy, 51*(3), 317-328.

Sue, S., Zane, N., & Young, K. (1994). Research on psychotherapy with culturally diverse populations. In Bergin, A.E., & Garfield, S.L., *Handbook of psychotherapy and behavior change* (4th Ed.), (pp.783-817). New York: John Wiley & Sons, Inc.

Sue, S. (1988). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*(4), 301-308.

Sue, S. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42*(1), 37-45.

Vasquez, M.J.T. (1994). Latinas. In Comas-Diaz, L., & Greene, B. (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy*, (pp.114-138). New York: The Guilford Press.

Yalom, I. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books.

The Impact of Personal Therapy on the Decision to Enter Social Work

by Mark Ferguson, Mary J. Komparda and Helen Montgomery

Abstract

An area of research that has received little attention to date is the impact of personal therapy on the decision of students to enter the profession of social work, and the influence of personal therapy on the focus chosen. Thus, this exploratory, quantitative study was undertaken to answer two questions: (1) What percentage of graduate students in social work feel that their experience of personal therapy influenced their career choice; and (2) Did therapy influence the direction of their social work career (e.g., clinical, policy/administration, casework, or research). A survey instrument was developed and anonymously administered to graduate-level social work students at two Chicago-area schools of social work. While no results were found to be statistically significant, the following results were notable: 1) therapy, when perceived as beneficial, was viewed as influential in the decision to enter social work, 2) the likelihood of the choice of policy/administration as an area of specialization increased when therapy was perceived as not beneficial, and 3) participation in therapy was related to one's choice of a clinical specialization. Implications of the results for areas of future research are discussed.

Introduction

Social workers come from a variety of backgrounds, and are diverse socioeconomically, ethnically, and religiously. The question underlying this research study was what influences people to choose the profession of social work? Numerous studies have already examined this question, investigating possible background influences as well as career aspirations of social workers. One area that has received little attention in research thus far is the impact of personal therapy on the decision to become a social worker. This study attempted to explore such questions, as well as examine the influence of personal therapy on the track of social work specialization chosen.

Rationale for the Study

There are several gaps in the literature regarding the impact of personal therapy on the decision to enter social work as a profession. Currently, the literature is unclear and even contradictory on whether or not negative psychosocial history plays a role in choosing social work as a profession. The studies reviewed do not examine further whether or not students with that negative history have experienced psychotherapy. Studies that have examined how students and clinicians view their own therapy typically do not explore the possibility of that therapy influencing their decision to become a social worker and/or psychotherapist.

Due to the lack of research thus far, it is difficult to form a hypothesis. This exploratory study sought to identify possible trends that could indicate future research in this area. A review of the literature reveals that the study of influences on the choice of social work has been of interest to some researchers; this study reflects a continuance of that interest.

Literature Review

Several studies have investigated why people are drawn to careers in social work. Beginning with Rubin and Johnson (1984), people have sought to define which characteristics or events in people's lives lead them to social work, and from there, what leads them to the various "tracks" (e.g., policy, clinical) within the profession.

Rubin and Johnson (1984) surveyed students beginning a masters program in social work. They found that 51% of the entering students wanted to "increase their opportunity to perform a particular helping function that appealed to them" (p. 8). Of that group, 68% (35% of the full sample) indicated that the helping function that most appealed to them was psychotherapy or counseling (p. 8). Other studies have also found that counseling or psychotherapy modalities were preferred by MSW students (Abell & McDonell, 1990; Butler, 1990; Butler, 1994).

Bogo, Raphael, and Roberts (1993) asked MSW students about their patterns of interest and how these interests had an impact on their identity as "social workers." They found four distinct subgroups: policy and research, private/direct practice with voluntary clients, traditional social work, and undifferentiated (p. 285). Twenty-six percent of the sample chose private/direct practice with voluntary clients, much like the proportions found in the

above studies. While many of the students identified themselves as preparing to be social workers, a substantial number chose to identify as a "therapist," again indicative of the desire to work in counseling or psychotherapy.

While these studies indicate the direction that many social work students are heading toward, most of the studies do not ask why these students chose social work in the first place. Abell and McDonell (1990) found that many MSW students considered other fields of graduate study, including psychology, law, and education, before deciding upon the MSW (p. 59). The subjects in their study indicated that the versatility of the MSW degree was of primary importance in their decision to pursue the degree (p. 59). A study by Csikai and Rozensky (1997) looked at how idealistic MSW students are, and found that the higher the level of "idealism," the more likely the students were to claim entering social work for altruistic reasons.

Several studies examined the background experiences of social workers. Lackie (1983) found that social workers reported taking on more parentified roles within their families. Black, Jeffreys, and Hartley (1993) found that social work students, in comparison with business students, reported higher instances of physical, sexual, and emotional abuse, death or suicide, and other traumatic events. Several studies have also found that social workers come from families with drug and alcohol problems, with some showing that approximately 50% of social workers come from families with a history of alcohol abuse (Black et al., 1993; Marsh, 1988; Russel, Gill, Coyne, & Woody, 1993). However, a study by Hawkins and Hawkins (1996) cautioned that previous studies used self-reports to obtain the data about familial alcohol abuse instead of standardized instruments, which may lead to overestimation of alcohol abuse. Rompf and Royse (1994) also caution that, "In fact, much of the literature indicating that social work students come from less-than-healthy families of origin cannot be considered definitive because of small sample sizes, absence of comparison groups, or reliance upon anecdotal accounts" (p.164).

A continuing problem with most of the studies looking at the instance of traumatic childhood events is that they do not consider whether or not these experiences impacted the decision to enter social work. The Csikai and Rozensky (1997) study found that negative psychosocial history was an unimportant factor in the choice of social work as a career (p. 537). As this was not the main research question in the study, their results must be considered with caution. McClure (1999) found that students in graduate psychology programs did not report more personal counseling or more personal or family trauma which motivated them to do therapy than a comparison group of students in non-psychology graduate programs.

On the other hand, Rompf and Royse (1994) compared social work students (both BSW and MSW) with English majors, and found statistically significantly differences between the two groups. Social work students were more likely to report their parents as unhappily married, that alcohol and/or drug addiction was a problem in the family, and that child abuse or neglect occurred (p. 167). Also, when asked if the experiences, "influence[d] your choice of occupation or career?" 39% of the social work students (n=415) reported that it did, compared with only 14% of the non-social work students (n=203), a statistically significant difference (p. 168). The authors are quick to point out that these experiences are not the only influence on career choice, and that their data do not present evidence that students are drawn to social work because of their own mental health problems (p. 169).

None of the studies reviewed so far inquired as to whether or not these students have engaged in personal psychotherapy, whether for the traumatic issues of childhood, or for the personal growth that many theorists believe is necessary to become a good therapist. Traditionally, many theorists posited that personal treatment was not only desirable for therapists, but necessary (Mackey & Mackey, 1993; Norcross, Strausser-Kirtland, & Missar, 1988a; Wampler & Strupp, 1976).

Numerous studies have indicated that over 50% of practicing psychotherapists (psychologists and/or social workers) have participated in personal therapy (MacDevitt, 1987; Mackey & Mackey, 1993; Norcross et al., 1988a; Norcross, Strausser, & Faltus, 1988b). Marital or relationship conflict has been a primary reason for seeking treatment, ranging from 20% to 47% in some studies (Deutsche, 1985; Holzman, Searight, & Hughes, 1996; Mackey & Mackey, 1993; Norcross et al., 1988a). Another strong reason for seeking treatment was depression, ranging from 13% to 38% (Deutsche, 1985; Holzman et al., 1996; Norcross et al., 1988a). When considering the research that indicates social workers come from more dysfunctional family backgrounds, such statistics are not surprising.

Another high-ranking set of reasons for seeking treatment include "personal growth" and improving as a therapist. Holzman et al. (1996) found that 65%

of their respondents listed improving as a therapist among their reasons for treatment, and 71% listed personal growth. Personal treatment has often been encouraged of those people who plan to become clinicians themselves. Wampler and Strupp (1976) review the benefits from a psychoanalytical perspective:

> The chief purposes of personal analysis are: to enhance the analyst's ability to conduct therapy as a more sensitive and unbiased clinical observer whose "blind spots" and countertransference potential have been mitigated ... facilitate the mastery of technique by providing a first-hand model, and to make the therapist's life less neurotic and more gratifying, so that the stresses of conducting therapy can be better tolerated (p. 195).

While the roots of requiring personal therapy are to be found in psychoanalytic theory, other theories have embraced the concept as well. "Indeed, the practice is recommended by appeal to the dictum 'Physician, heal thyself' or a commonsense unwillingness on the part of the profession to permit the blind to lead the blind" (Wampler & Strupp, 1976, p. 196).

MacDevitt (1987) reported that 82% of the therapists in his sample (n=185) who had received therapy reported that it was "very valuable, extremely valuable, or absolutely essential to them professionally" (p. 701). Many other studies looked at what features of therapy made it valuable to their own clinical practice. Mackey and Mackey (1993) reported that there were three themes: therapist as model, understanding the therapeutic process, and integration, i.e., inter-relationship of personal and professional dimensions (p. 101). These themes were echoed in other studies as well. Improved empathy with the client (Holzman et al., 1996; Mackey & Mackey, 1993; Norcross et al., 1988a), importance of transference and countertransference (Mackey & Mackey, 1993; Norcross et al., 1988), avoiding labels and value judgments (Norcross et al., 1988a), importance of unconscious motivations and material (Norcross et al., 1988a), and the efficacy of psychotherapy (Mackey & Mackey, 1993; Norcross et al., 1988a) were commonly reported benefits of personal psychotherapy. In the sample of graduate students (as opposed to practicing therapists), Mackey and Mackey (1993) also found that students felt their own therapy complimented their supervision and helped them to integrate therapeutic concepts (p. 100).

In addition to professional benefits, as discussed earlier, a high percentage of therapists enter therapy for the treatment of personal distress. Norcross et al. (1988a) found that 90% of their sample of psychologists and social workers (n=234) indicated improvement in terms of behavior/symptomatology, cognitions/insight, and emotions/relief (p. 40). Buckley, Toksoz, and Charles (1981) found improvements in self-esteem, work function, social/sex life, and character change (p. 301). Unfortunately, there seem to be very few studies that have looked specifically at the efficacy of treatment for therapists who seek therapy to alleviate personal distress. Additionally, while these studies show that therapists believe personal therapy is valuable to their clinical practice, a review of the literature by Clark (1986) notes that there is no clear empirical data on this premise. In his review, he "attempted to answer ... whether the therapist who has undergone psychotherapy can be shown to be more effective than colleagues who have not received such treatment" (p. 541). He found that the empirical evidence is contradictory, and further research is needed on the subject.

In summary, the literature reviewed indicates a wide variety of influential variables on the decision to become a social worker and the specialty chosen within the profession. Additionally, research on the value of psychotherapy to clinicians does not clarify the impact of earlier psychotherapeutic experiences on their choice of career. This potentially influential variable - previous experience of psychotherapy - invites further research.

Purpose of the Study

The review of the literature shows that studies have looked at influences on choosing social work as a career, on the backgrounds of social workers, and on the number of social workers (and other mental health clinicians) who have participated in their own personal therapy. None of the reviewed studies on influences looked at the question of the effect of personal therapy on career choice. While studies have illustrated that a high percentage of social workers come from dysfunctional families, none of the studies reviewed for purposes of this project asked if those students participated in therapy. The studies that did look at reasons for seeking treatment found that therapists and students believe that personal therapy will make them better clinicians, but did not consider the impact of therapy on their decision to become clinicians.

This exploratory study sought to add to the cur-

rent body of knowledge. The two questions explored were (1) Do graduate students in social work feel that their experience of personal therapy influenced their decision to enter social work as a profession; and (2) Did the therapy influence the direction of their social work career (e.g., clinical, policy/administration, or research).

Research Design

This study utilized a survey to collect data. The survey was chosen as the research instrument for several reasons. First, surveys are a simple way to collect descriptive data fairly quickly from a large sample. Second, surveys provide a quick, convenient method for respondents, who can ultimately complete the survey when convenient for them. Finally, surveys can be administered anonymously, which is important when collecting potentially sensitive data.

Study Subjects

The subjects for this study came from a convenience sample of graduate level (Masters) social work students. All students from two Chicago-area social work schools were surveyed: Loyola University Chicago School of Social Work and the University of Chicago School of Social Administration. Surveying all students of social work in these schools rendered the largest possible sample and allowed for student self-selection in study participation for which the researchers could not control. Student self-selection is a limitation within the study sample. Additionally, reasons for study subjects opting not to participate could not be collected.

These two schools were chosen for their convenience to the researchers, and also because of the question regarding influence on the track chosen within social work. The program at Loyola is single-track and focused on clinical work, the University of Chicago is duo-track offering both policy/ administration and clinical work. By surveying the two schools, the researchers sought a more representative sample of all tracks of social work.

Measurement

A survey was developed for the purpose of this study. As the researchers focused on very specific descriptive questions, it was believed that a specially designed survey would be more appropriate than any surveys that currently exist. Age and gender were requested giving demographic information describing study subjects. The first question was the defining question for purposes of this research project as it addressed the fundamental issue of whether or not there has been a personal experience of therapy. Questions Two, Three and Four served to garner a more complete set of data regarding the individual experience of therapy. Questions Five and Six sought information required to answer the first research question regarding the influence of therapy on the decision to enter a social work program. Question Seven, in asking what area, or areas, for focus have been chosen, gathered the required information needed to answer the second research question regarding the influence of therapy on the choice of track or specialty. Thus, the main comparison categories within this study are the choice of clinical social work focus versus other foci and the experience of therapy prior to entry into a school of social work.

As this was an exploratory study, the questions of reliability and validity were of lesser importance than would be the case in an experimental study. The survey did not consist of scales that need to be tested for internal consistency, and since it was administered anonymously, procedural reliability could not be tested.

For this study, the independent variable was the student's experience of personal therapy. This was defined as participating in any form of psychotherapy, psychoanalysis, or counseling (individual, family, couples, group, or pastoral). This was measured as a "yes/no" question; that is, have they ever had therapy. There were two dependent variables: 1) Did the experience of therapy influence their decision to enter social work, and 2) Did the experience of therapy influence the track of social work chosen. The tracks were defined as clinical (counseling/therapy oriented), policy/administration, schools, or research oriented.

Data Collection

Consent letters and surveys were left for MSW students at two Chicago-area schools of social work (Loyola University Chicago and University of Chicago), which rendered an approximate sample of 844 students. The surveys were left in each student's individual mailbox, and a sealed return box was also left at each site. As there is still some stigma attached to participating in therapy, the consent letter specified that all responses were anonymous, and participation was voluntary. In this way, stu-

dents who wished to avoid any residual emotional trauma associated with their therapy were able to refuse to participate, and there was thus no risk of public knowledge of their therapeutic history. The consent letter also informed participants of the purpose of the study, and the procedures that were used to ensure confidentiality. Responses were collected and kept in a locked office at Loyola's School of Social Work, and all responses were subsequently destroyed at the conclusion of the study. The consent letter also provided a contact name and phone number that could have been utilized if any questions or concerns arose. Additionally, the completion and return of the survey served as the students' consent for participation in the study. The survey responses were coded for more efficient data entry. Additionally, a statistical package for the computer, SPSS, was used to analyze the data.

Results

Five hundred twenty-four surveys were distributed at Loyola University Chicago School of Social Work, and 133 were returned (25%). Three hundred twenty surveys were distributed at the University of Chicago, with a return rate of 94 (29%). The total return rate was 27%, with a total n of 227. Two hundred five respondents were female, 20 were male, and two did not identify their gender. The age of the respondents ranged from 21 to 56, with one unidentified.

Of the 227 respondents, 166 students (73%) reported participation in therapy, 60 students (26%) said they have not participated, and one did not answer. Students reported having seen as few as one therapist (31%) to as many as 16 therapists (0.6%). One therapist was the most common response, followed by two (29%) and three (17%). Most of the students identified their most recent therapist as having a MSW/LCSW degree (40%), followed by a Ph.D. (28%). There was not a statistically significant relationship between the degree of the most recent therapist with either the benefit of therapy or influence of therapy on the decision to enter a social work program. Ninety-three percent of students with a MSW/LCSW as a therapist found the experience to be beneficial and 88.3% of the students who had a non-MSW therapist found the experience to be beneficial. Of the students who had a MSW/LCSW as a therapist, 56.1% said that the experience influenced their decision to enter a social work program, compared to 53.3% for students who saw a non-MSW/LCSW therapist.

Of the 166 students who have had therapy, 133 had therapy prior to their decision to enter a graduate level social work program. Of these students, 50.4%, said that the experience influenced their decision to enter a social work program, and 48.9% said it did not influence them. Looking specifically at these 133 students, 118 (88.7%) said that they found the experience to be beneficial. For the 118 that found the experience to be beneficial, 62 (53%) said that the experience influenced their decision to enter a social work program. For the 14 students that did not find their experience to be beneficial, only four (28.6%) credited the experience with having any influence on their decision. Analysis of the data revealed a relationship of borderline significance (chi-square = 2.983, df = 1, p = .084).

The track chosen for specialization was analyzed based on whether or not the student had participated in therapy prior to their decision to enter a social work program. Students were allowed to choose more than one track. Of the 133 students that fell into this category, 68 students chose clinical as one of their tracks of specialization (51.1%). Twenty-four students (18%) chose policy/administrative, 25 (18.8%) chose health/medical, and 27 (20.3%) chose school social work. None of the other categories received more than a 10% response. Of the 93 students who did not participate in therapy prior to their decision to enter a social work program or who have never had therapy, 39 students (41.9%) indicated clinical as one of their specializations. Twenty-six students (28%) chose schools, 19 (20.4%) chose policy/administrative, and 12 (12.9%) chose health/medical, with the remainder of the categories receiving a less than 10% distribution each.

Analysis of the relationship between therapy and track choice for all respondents (regardless of whether the therapy occurred prior to the decision to enter social work) indicated that approximately 50% of those who had therapy (n = 166) chose the clinical track as one of their choices of specialty, while about half did not (51.2% chose clinical, 48.8% did not choose clinical). Of the respondents who have never participated in therapy (n = 60), approximately one-third (36.7%) chose clinical work as a specialty, compared to two-thirds (63.3%) who did not choose this specialty. This relationship proved to be of borderline statistical significance (chi-square = 3.36, df = 1, p = .053). When controlling for only those respondents who had therapy prior to the decision to enter social work (n = 133), there was no longer a relationship of statistical significance between the groups. For this group, 51.1% of those who had therapy chose the clinical

specialization, and 41.9% of those who did not have therapy prior to the decision, or at all, also chose this specialization (chi-square = 1.855, df = 1, p = .173).

When the researchers controlled for only the 133 respondents who had therapy prior to the decision, analysis of the relationship between benefit of therapy and track did not show a significant relationship between the benefit of therapy and choice of a clinical track. There was, however, a relationship of borderline statistical significance between benefit of therapy and choice of policy/administrative as a specialty. Of those who found therapy beneficial, only 16.1% chose policy as a track, compared to 35.7% for those who did not find therapy to be beneficial (chi-square = 3.236, df = 1, p = .072).

As the two schools surveyed are perceived as attracting different populations of students, the data was analyzed based on the school attended. Sixty-four (68.8%) of the University of Chicago students participated in therapy, and 29 (31.2%) never had therapy. One hundred two (76.7%) of the Loyola students participated in therapy, versus 31 (23.3%) who had not had therapy. There was no statistically significant relationship between having had therapy at any time with the school attended (chi-square = 1.740, df = 1, p = .187). Of the 133 students who had therapy prior to their decision to enter a social work program, 52 (39.1%) attend the University of Chicago, and 81 (60.9%) attend Loyola. Forty-seven (92.2%) of the University of Chicago students found the experience to be beneficial (n = 51, one respondent did not answer), and 71 (87.7%) of the Loyola students found the experience to be beneficial. There was not a statistically significant relationship between the two schools regarding this variable. The relationship between prior experience of therapy and the track chosen was also analyzed based on school attended. There was no statistically significant relationship between a prior experience of therapy with the choice of a clinical track as a specialty.

Discussion

Overall, there was little difference (50.4% versus 48.9%) between the students who participated in therapy and those who did not with regard to the experience of personal therapy influencing their career choice. However, the data revealed that for those students whose experience of therapy was perceived to be beneficial, there was a near-significant relationship with the perception that the experience influenced their decision to enter a social work program. There was no significant relationship between the experience of therapy and the choice of a clinical specialization, although students who did not find their experience of therapy to be beneficial were more likely to choose policy/administration as a specialty than those who found the experience to be beneficial.

The majority of students who participated in therapy found their most recent experience to be beneficial, regardless of the degree of their therapist. This finding corresponds with prior studies that show therapists usually find the experience of therapy to be helpful for many reasons (MacDevitt, 1987; Mackey and Mackey, 1993; Norcross et al., 1988a). The degree of the most recent therapist seen also had no significant relationship to the decision to become a social worker. As the survey did not ask for the degrees of all prior therapists, it should not be ruled out that a prior therapist could be a MSW/LCSW and had an influence on the student's choice of profession.

When the data was analyzed concerning the influence of therapy on the decision to enter social work, it was statistically a near-equal split. The question that followed was why was therapy not perceived as influential? This led to analyzing the perception of the benefit(s) of therapy and the relationship of said benefit(s) and the influence it had to enter the field of social work. Here it was found that there was a near-statistically significant relationship. Students who found their experience of therapy to be beneficial were more likely to perceive the experience as being influential, compared to students who did not find their experience beneficial. It was therefore concluded that the experience of therapy itself is influential if it was perceived as a positive experience. From this, a further question arises for future studies: what is the degree of influence of positive experiences upon decisions made by people in making career choices as contrasted with affinity, talent, skill base, and other variables?

In terms of the second research question, the influence of therapy on the track of specialization chosen was examined. As a result, a borderline statistically significant relationship between having participated in therapy and the choice of a clinical specialization was found. However, when controlled for only those students who had therapy prior to their decision to enter social work, the relationship was no longer significant. One possible explanation for the lack of statistical significance is that students who planned to go into a clinical track may have decided that it would be useful to participate in their own therapy - to experience being "on

the other side of the desk." This is consistent with early psychoanalytic theory that posits a necessity for therapists to undergo personal psychotherapy (Mackey & Mackey, 1993; Norcross et al. 1988a; Wampler & Strupp, 1976). A second possible explanation is that students were offered multiple choices for track designation. It is possible that students who selected, for instance, Health or Schools, might be planning to do clinical work, but did not select Clinical on the questionnaire.

As perceived benefit was related to influence of entering the profession at all, the relationship of benefit with chosen track was analyzed. A borderline significant relationship showing that students who did not perceive their experience of therapy as beneficial were more likely to choose policy/administration as a specialty than students who found therapy beneficial was discerned. Finally, analysis of the data was undertaken to see if there was a relationship between the school attended and the track chosen. No significant relationships were found.

The results, while intriguing, must certainly be viewed with the limitations of the study in mind. First, there are the limitations of the sample. The sample was chosen for convenience. There are over six schools of social work in the greater Chicagoland area, but time restrictions only allowed for surveying of two of the schools. It should also be noted that the schools chosen are private universities. There was no control over self-selection out of the sample by students who chose to not participate. The sample size was not representative of the number of students in each school, which limits generalizability of the results.

Secondly, in terms of study limitations, the survey instrument itself poses limitations to the generalizability of results. The survey was not tested for reliability and validity, as this was designed as an exploratory study. The survey did not address issues such as why the student went into therapy or how long the therapy lasted, which may be of importance. The survey also did not control for other variables that have been shown to be influential on the decision to enter social work, as described in the literature.

This exploratory study provides a direction for future research. While the results were not of statistical significance, some were close to significant. These results might prove to be of statistical significance should the limitations of the current study be addressed in future research. This study also indicates additional areas that could be explored, including research into what experiences are ranked as most influential on the decision to enter social work as a profession, and the degree of influence that positive perception of experience has upon career decisions. Future research in these areas could be of use to recruitment efforts in social work schools, as well as generating knowledge on the importance of the perception of prior experiences upon career choices.

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References

Abell, N., & McDonell, J. R. (1990). Preparing for practice: Motivations, expectations and aspirations of the MSW class of 1990. *Journal of Social Work Education, 26*(1), 57-64.

Black, P. N., Jeffreys, D., & Hartley, E. K. (1993). Personal history of psychosocial trauma in the early life of social work and business students. *Journal of Social Work Education, 29*(2), 171-180.

Bogo, M., Raphael, D., & Roberts, R. (1993). Interests, activities, and self-identification among social work students: Toward a definition of social work identity. *Journal of Social Work Education, 29*(3), 279-292.

Buckley, P., Toksoz, B. K., & Charles, E. (1981). Psychotherapists view their personal therapy. *Psychotherapy: Theory, Research and Practice, 18*(3), 299-305.

Butler, A. C. (1990). A reevaluation of social work students' career interests. *Journal of Social Work Education, 26*(1), 45-56.

Butler, A. C. (1992). The attractions of private practice. *Journal of Social Work Education, 28*(1), 47-60.

Clark, M. M. (1986). Personal therapy: A review of empirical research. *Professional Psychology: Research and Practice, 17*(6), 541-543.

Csikai, E. L., & Rozensky, C. (1997). "Social work idealism" and students' perceived reasons for entering social work. *Journal of*

Social Work Education, 33(3), 529-538.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. *Professional Psychology: Research and Practice, 16*(2), 305-315.

Guy, J. D., Stark, M. J., & Poelstra, P. L. (1988). Personal therapy for psychotherapists before and after entering professional practice. *Professional Psychology: Research and Practice, 19*(4), 474-476.

Hawkins, C., & Hawkins II, R. C. (1996). Alcoholism in the families of origin of MSW students: Estimating the prevalence of mental health problems using standardized measures. *Journal of Social Work Education, 32*(1), 127-134.

Holzman, L. A., Searight, H. R., & Hughes, H. M. (1996). Clinical psychology graduate students and personal psychotherapy: Results of an exploratory survey. *Professional Psychology: Research and Practice, 27*(1), 98-101.

Lackie, B. (1983). The families of origin of social workers. *Clinical Social Work Journal, 11*, 309-322.

MacDevitt, J. W. (1987). Therapists' personal therapy and professional self-awareness. *Psychotherapy, 24*(4), 693-703.

Mackey, R. A., & Mackey, E. F. (1993). The value of personal psychotherapy to clinical practice. *Clinical Social Work Journal, 21*(1), 97-110.

Marsh, S. R. (1988). Antecedents to choice of a helping career: Social work students vs. business majors. *Smith College Studies in Social Work, 58*(2), 85-100.

McClure, R. (1999). Do students studying therapy have more problems? *Psychological Reports, 84*, 591-592.

Norcross, J. C., Strausser-Kirtland, D., & Missar, C. D. (1988a). The processes and outcomes of psychotherapists' personal treatment experiences. *Psychotherapy, 25*(1), 36-43.

Norcross, J. C., Strausser, D. J., & Faltus, F. J. (1988b). The therapist's therapist. *American Journal of Psychotherapy, 42(*1), 53-66.

Rompf, E. L., & Royse, D. (1994). Choice of social work as a career: Possible influences. *Journal of Social Work Education, 30*(2), 163-171.

Rubin, A., & Johnson, P. J. (1984). Direct practice interests of entering MSW students. *Journal of Education for Social Work, 20*(2), 5-16.

Russel, R., Gill, P., Coyne, A., & Woody, J. (1993). Dysfunction in the family of origin of MSW and other graduate students. *Journal of Social Work Education, 29*(1), 121-129.

Wampler, L. D., & Strupp, H. H. (1976). Personal therapy for students in clinical psychology: A matter of faith? *Professional Psychology, 7*, 195-201.

Socialization and Male Victims of Sexual Assault

by Gina Bogin

Little girls are made of sugar and spice and everything nice,
Snips and snails and puppy dog tails and such are little boys made of.
Robert Southey (Bartlett, 1945, p. 322).

Abstract

This paper will explore how a male victim's experience of a sexual assault is impacted by society's construction of gender roles. Specifically, how cultural expectations of manliness or "machismo" and homophobia impact the meaning of sexual assault for male victims will be explored. How do the victim's construction of the meaning of the assault and societal views on the assault contribute to the type of services available and the utilization of these services by the victims? When victims access services, how do the attitudes of police, hospital personnel, therapists, friends and families from whom they seek support impact their recovery? Are there differences in the therapeutic needs of a male victim from a female victim? Clinically, how can we help a male victim work through issues that result from the assault? And finally, what types of education and programs might be helpful to improve the services available to a male victim of sexual assault?

Societal Values and Myths

People have values and beliefs that determine the context in which they form opinions and make judgments about their own life experiences and about the experiences of those with whom they interact. Whether they are accepting and supportive of another or destructive and uncaring is based on their personal and societal values and beliefs and the scripts they write based on these values and beliefs. Scripts "are necessarily learned, the product of experience ... Research with adults has demonstrated that the event schemas individuals bring to a situation influence their interpretation of new experiences, their understanding of stories and ability to carry on discourse, and enable them to form plans and make inferences and predictions" (Nelson, 1985, pp. 15-16).

Since the implicit messages impact the way one experiences events, society must be careful about promoting myths about male victims of sexual assault. These myths include the idea that male rape does not happen, or that it only happens to homosexual men, that men enjoy it, that men are strong enough to prevent sexual assault and that men would not physically respond if they really were raped. When such myths are promoted, they impact the experience of male sexual assault because, as a function of the environment, the myths help organize the self. "We instinctively process our experiences in such a way that they appear to belong to some kind of unique subjective organization that we commonly call the sense of self ... [T]he sense of self stands as an important subjective reality ... How we experience ourselves in relation to others provides a basic organizing perspective for all interpersonal events" (Stern, 1985, pp. 5-6). Images are not shaped in isolation, but in the intersubjective space of social exchange. Incorporating the stereotypic male into the self may socialize male victims of sexual assault to remain silent about their assault. This silence is the result of the stigma of reporting male sexual assault derived from fears related to societal messages regarding homophobia and machismo (Gartner, 1999). Silence, combined with the lack of services for men, makes one suspect that many men struggle alone with the traumatic aftermath of sexual assault. In order to facilitate the healing of the pain caused by the misunderstanding and isolation of male victims of sexual assault, the silence needs to be broken and light needs to be shed on the issue of male rape. Until that occurs, societal stereotypes of men and the denial of male rape will continue to support the suffering of thousands in a deafening silence.

Promoting Myths about Men

Societal stereotypes are communicated to children from birth. We wrap boys in blue blankets and decorate their rooms with fire trucks, astronauts and sports. We wrap girls in pink blankets and put ballerinas, pink hearts and dolls on their walls. It appears that infants, through their implicit memory, learn these subtle messages. "Overall, evidence exists to support the hypothesis that human infants are equipped with a functional memory system at birth, and one that is more capable of implicit learn-

ing than explicit" (Amini, 1996, p. 226). These implicit memories help to organize experiences without conscious awareness. After a sexual assault, these implicit memories and societal messages may help define the experience for the victim. This implicit learning can result "in a clear processing bias, and one that becomes self-perpetuating in the face of nonconfirmatory evidence" (Amini, 1996, pp. 228).

Implicit stereotypical messages may be one of the ways society fails to protect its members by socializing them to behave in unsafe ways. For example, many victims later blame themselves because they had felt pre-assault discomfort. The victim intuitively felt that the perpetrator was dangerous, but since the victim had been socialized to be polite they ignored these early warning signals (Burgess, 1979). An example of how children are taught to ignore their intuitive feelings is when a child is forced to kiss a relative whom they are afraid of. The implicit message to the child is that he is to ignore his own "icky" feelings and kiss the aunt rather than hurt her feelings. Another example can be found in the following exchange between father and son in the movie *The Graduate*. The son, Ben, has come home from college and his parents are throwing a large party for his graduation. Ben is concerned about his future and escapes to the bathroom. His father comes into the bathroom and questions him:

> Father: "Hey, what's the matter, the guests are all downstairs, Ben, waiting to see you."
> Ben: "Dad, could you just explain to them that I have to be alone for awhile?"
> Father: "These are all our good friends, Ben. Most of them have known you since, well frankly, since you were born!" (Turman, 1967).

The message is that Ben's feelings are less important than those of the guests, people who, even after knowing him all his life, would not be able to understand his need for privacy.

Movies are portrayers of society and can powerfully impact how we script and relate to the environment. In the case of male rape, if the media acknowledges male rape at all, it is generally with the idea that if a man is raped it is his own fault.

> Who have been the male rape victims portrayed or presented in the media? With one clear exception, Richard Crenna, most have been negative examples of current views of traditional masculinity: the boys in *Midnight Express*; the young man in *Glass Cage*; (and) the chubby guy in *Deliverance* ... Jon Voight's character, in a very quick scene in *Midnight Cowboy*, is raped for his apparently unacceptable behavior with a young woman who had been used by most of the high school. This again portrays the theme that sexual victimization of males by males is somehow 'deserved' for the victim's not quite measuring up to some currently accepted image of masculinity (Grubman-Black, 1990, p. 8).

The "accepted image of masculinity" is described in the best selling book, *Men are from Mars; Women are from Venus*: "Martians (men) value power, competency, efficiency, and achievement. They are always doing things to prove themselves and develop their power and skills. Their sense of self is defined through their ability to achieve results" (Gray, 1992, p. 16). This is contrasted to "Venusians, (women who) value love, communication, beauty and relationships ... Because proving one's competence is not as important to a Venusian, offering help is not offensive, and needing help is not a sign of weakness" (Gray, 1992, pp. 18-19). The implication is that men should be strong and not need help like women might. Men are socialized to assume that they can and are in control; they are conditioned to believe that they are powerful. Women are socialized to believe they are weak. A woman overpowered during a sexual assault is experiencing an anticipated trauma. After all, from early childhood women are warned that they are vulnerable to assault and may invite trouble because of how they dress, talk or where they go. Men are not warned of their vulnerability, as the sexual assault of males is barely spoken of. Men are far more aware of the possibility that they could be struck by lightning on a golf course than they are of the more likely possibility that they might be raped.

Recent studies on sexual assault have shown that an estimated 1 out of 5 men have been sexually assaulted. This compares to estimates that 1 out of 4 women are sexually assaulted (Gartner, 1999). The highest risk of rape for both genders is during the teen and college years (Isely, 1998). However, for males, thinking about the possibility of being raped conflicts with the socialized images they are to maintain of being full of strength and prowess. Males are socialized from birth with gender stereotypes that say that men are to be strong and masculine and the corollary idea that strong masculine men cannot be raped. Men are not socialized to

acknowledge feeling vulnerable, but to posture and fight in order to save face. Thus, unlike women who are socialized to perceive the possibility of a sexual assault, sexual assault may be a total shock for a male victim. These differences in perspective are important when coping with an assault. "Constructivist approaches to knowledge normally emphasize differences in perspective, that is, that the ideas created by two individuals who experience the same event will inevitably have some differences about the nature and significance of that event" (Saari, 1991, p. 178). Male victims need to have the opportunity to tell their story surrounding their rape. When victims are free to speak about their experiences, they may be able to create new meaning of the experience free from societal stereotypes.

Legal Victimization

Societal stereotypes have not only impacted the ability of men to seek support after an assault, they have also impacted the legal system. Although most states recognize that forced sex is a crime against both men and women, several states have laws that do not recognize male sexual assault as a crime. Their laws are set up on the basis that men are perpetrators and women are victims (Scarce, 1997). This skewed and inaccurate view of male sexual assault leaves men little chance of obtaining due process and legal protection. Assailants are given free reign to continue their criminal assaults. Furthermore, the lack of legal protection for male victims may inhibit men from seeking legal and therapeutic support. How can a society that does not recognize the plight of male victims effectively legislate laws that protect its male citizenry?

> Without adequate formal legal protection, it is unlikely male survivors will turn to this system for protection. What's worse, when male survivors do summon the courage to turn to the legal system, formal legal rules make consensual homosexual sex a crime in nearly 20 states; with fear that his allegations of force might not be believed, the male rape survivor faces the additional burden of fearing that he himself will be charged with sodomy! (Scarce, 1997, p. ix).

Scarce's words underscore how treatment by the legal system may revictimize a person.

Revictimization can occur even in states that have laws that cover male sexual assault victims. If the service providers and significant others the victim encounters after assault blame the victim or act repulsed by him, the victim may internalize their responses (Washington, 1999). This may result from the idea that "the police officer's physical presence is an embodiment of society ... If the officer is judgmental and negative in his manner, he is perceived as reflecting the opinion of all society ... The victim may assume feelings of shame and worthlessness which may take years to resolve" (O'Reilly, Undated reprint, p. 3). Because of the reports of negative experiences of men who have sought help, "men expect and often receive unsympathetic and even hostile treatment from the police, medical personnel, and the court system" (Struckman-Johnson, 1991, p. 194). "When there are negative or counterproductive values held by any of the people involved, walls are raised" (Grubman-Black, 1990, p. 131). These victim-blaming experiences imply either that the victim was responsible for the action of the assailant or that they should have been responsible for their own actions and prevented the assault.

Special Issues for Male Victims

"As a result, then, of a combination of cultural, social, legal, and psychological issues, male rape remains one of the most unaddressed issues in our society today" (Groth, 1980, p. 810).

> While the number of men who are victims of sex crimes is unknown, a growing body of evidence suggests that such victimization is more prevalent in our society than previously realized. Young men appear to be at particular risk for sexual assault, and many are raped during their college years. Such sexual victimization can be developmentally very disruptive and result in significant levels of psychosocial dysfunction (Isely, 1998, p. 311).

To counter the effects of the assault, mental health workers need to be educated regarding the clinical needs of male victims. Otherwise, revictimization may occur. This is especially true if the victim comes forward and is met by disbelief.

> Goyer and Eddleman (1984) described the case of a 20-year-old heterosexual male in the Navy who was assaulted by three shipmates. The victim was overpowered, beaten, and dragged to a secluded area of the ship but managed to escape as the men attempted anal intercourse. Three weeks later, the victim was overpowered by the same

> assailants, two of whom held him down while the third raped him anally. He was afraid to tell anyone of the assault for fear of being labeled homosexual and discharged from the Navy. When he eventually did inform superiors, no one believed him (Struckman-Johnson, 1991, p. 199).

Believing him would be risky for his superiors who cannot tolerate the threat of invulnerability that this presents. Disbelieving the victim protects the illusionary security of powerful masculine invulnerability. Apparently, society does not want to recognize that men can be raped. Lack of belief in male victimization and lack of understanding of the crime has broad implications for the victims of this crime. For example, Washington (1999) in her study, *Second Assault of Male Survivors of Sexual Violence,* saw evidence that family, intimate partners and friends were responsible for revictimization of male victims. This was the result of their denial of the legitimacy of the victim's experience and/or the abandonment of the victim after the assault. Washington (1999) further found that when male victims sought support from therapists or counselors, "a theme that appeared in nearly every survivor's account was the lack of therapeutic intervention designed to address male concerns in particular" (p. 726). Part of the problem is the myth of the "'female as victim/male as perpetrator' paradigm used in the sexual abuse prevention education programs" (Washington, 1999, p. 727). Training based on this myth fails to address the special needs of male victims.

Additionally, a society that does not recognize the problem of male rape does not provide supports for its victims. In Washington's study (1999), one male victim reported that "he was repeatedly denied funding because civic and community agencies could not fathom that males can be victims of sexual assault" (p. 728). Gartner (1999) has experienced this same disbelief in working with boys who have been sexually abused. He notes that "People may assume that all these men have themselves been abusive, or that they are all gay, or that their abusers were always strangers and always male" (p. 321). Washington (1999) also found that these attitudes precipitated a reluctance of male victims to seek support from the police. She noted the low number of male victims who sought support from the police and observed that

> ... [A]s both historical and contemporary reports confirm, there is some validity to their fear of being revictimized by police because of their gender and real or perceived sexual orientation. For instance, the most recent report of the National Coalition of Anti-Violence Programs documented an 83% annual increase in anti-gay violence occurring in police precincts and jails and a 76% annual increase in the number of anti-gay incidents involving police (pp.726-727).

Washington's study (1999) makes the point that all men can be victims of sexual assault - white, black, gay, straight - and that they all deserve to be treated with respect and sensitivity. "If heterosexual men have strong fears about reporting their assault, what does that suggest for gay men who have been sexually assaulted? It seems likely that when it comes to reporting a male rape, homosexual victims may have even more misgivings than heterosexual victims" (Mitchell, 1999, p. 369). Gay men may be justified in fearing that society would react to them with the victim blaming idea that "he asked for it."

Machismo and Homophobia

Victim blaming may be more intense when the victim is a homosexual man. Damon Mitchell, Richard Hirschman and Gordon C. N. Hall found in their research study, *Attributions of Victim Responsibility, Pleasure, and Trauma in Male Rape*, that

> Participants held the male rape victim more responsible for being assaulted when he was described as homosexual than when he was described as heterosexual. In addition, participants rated the sexual assault as being less traumatic when the victim was described as homosexual than when he was described as heterosexual. These differing reactions to the homosexual victim versus the heterosexual victim may be related to factors such as negative attitudes toward homosexuals, stereotypes about homosexual males, and the nature of male rape (Mitchell, 1999, p. 372).

In addition to intensified victim blaming, homosexual men do not have some of the same legal protections afforded other victims of sexual assault. "Although federal guidelines have precluded the introduction of the female victim's sexual reputation as a defense in rape cases, the sexual lifestyle of the male victim can still be used as a defense" (Groth, 1980, p. 810). Thus because of society's negative attitudes toward homosexual men, under

the law it becomes safer to rape a homosexual man than a woman or a heterosexual man.

Another group of men whose credibility about victimization may be questioned are heterosexual men who are raped by women. Studies by Musialowski and Kelley found that "subjects perceived a man raped by a woman as more likely to experience orgasm and enjoy the sexual activity, as less likely to feel frightened, and less in need of sympathy as compared to a woman raped by a man or a heterosexual man raped by another man. Contrary to these beliefs, preliminary evidence indicates that men can be seriously harmed by assault perpetrated by females" (Struckman-Johnson, 1991, p. 205). Primary concerns about emotional harm are associated with societal expectations of male "machismo." When a man is raped, his sense of masculinity is attacked. If the rapist is a woman, one whom he responds to physiologically, then his core sense of masculinity may be destroyed (Struckman-Johnson, 1991). "Many male victims feel that because they failed to fight off or escape from an assailant, they are responsible for what happened. If victims do report the rape, their feelings of blame may be reinforced by incredulous and critical reactions of police and medical personnel" (Struckman-Johnson, 1992, p. 87). The fear of societal repulsion may force a lack of reporting. "The thing that moves us to pride or shame is not the mere mechanical reflection of ourselves, but an imputed sentiment, the imagined effect of this reflection upon another's mind" (Cooley, 1964, p. 184). Indeeed, male rape might be more underreported than female rape due to the fear of social rejection (Mitchell, 1999). "Perhaps the major reason why heterosexual men do not report being raped by another man is that they are afraid of being labeled homosexual. Closeted gay men who are raped fear that an official investigation and trial will reveal their sexual identity to the public" (Struckman-Johnson, 1991, p. 193). Adolescent and young men, the high-risk group for sexual assault, may also be struggling with their own sexual identity issues. This struggle may cause them to remain silent about the assault. At all levels, misunderstanding, stereotyping and prejudice compromise men's protection.

Coping with the Assault

Differences in victim needs arise based on gender, sexual identity, race, religion, culture, individual experiences and support systems. Additionally, the therapist must be alert to the possibility of prior victimizations, which were never reported or processed. The trauma of the current situation may be aggravated by previous assaults about which "some of the victims never told anyone and kept the burden within themselves. The current rape reactivate(s) their emotional reaction to the prior experience. The victim ... talk(s) as vividly about the previous assault as the present one, thus indicating that the incident had never been adequately settled or integrated as part of a victim experience" (Burgess, 1979, p. 48). The victim's experience encompasses the assault as well as the aftermath of the assault. "Given the view of rape as comprised of both intrinsic and extrinsic meaning, it seems clear that the act itself is but one aspect of the larger experience with which victims must cope. The way significant others and representatives of service delivery systems relate to and treat rape victims comprises no small part of the total rape experience" (Williams, 1981, p. 87). Reality is manufactured in the relationships we have and the meanings we put on events as reflected in the reactions of those with whom we interact.

Sexual assault changes the victim's understanding of the world in that men who have been socialized to believe that they cannot be overpowered and sexually assaulted are faced with the vulnerabilities of their humanness.

> No set of cultural understandings, then, provides a perfectly applicable solution to any problem people have to solve in the course of their day, and they therefore must remake those solutions, adapt their understandings to the new situation in the light of what is different about it. Even the most conscious and determined effort to keep things as they are would necessarily involve strenuous efforts to remake and reinforce understandings so as to keep them intact in the face of what was changing (Becker, 1986, p.19).

The victim's understanding of the assault and the events that follow affects how the victim will respond to the sexual assault. "Rape as one (victim's) personal trauma is shaped by who she (he) is and by all of the attitudes, judgments, and experiences that surround (them) daily, and these, we contend, are structured by a system of racial-sexual stratification" (Williams, 1981, p. 125).

Understanding Differences in Therapeutic Needs

This stratification has contributed to services being openly available to female victims of sexual

assault, while male victims are left to search for services. "When a male victim of sexual assault is identified, referring him to an appropriate treatment program can greatly reduce the sense of isolation that is typical in these cases and can insure that the (man) receives the therapeutic service he may require" (Isely, 1998, p. 309). When determining what services are required, "differences in types of sexual abuse need to be taken into account when examining the long-term effects of sexual abuse" (Ketring, 1999, p. 111). The authors indicate that there is more force and threat used against men during an assault and that men are far less likely to be acquainted with their assailant than women are. This is one area where men may fare better than woman since one of the additional traumas of acquaintance rape is the loss of trust in one's own judgment about people. With any victim of sexual assault who no longer trusts their ability to recognize danger, work must be done to help them regain trust in themselves. They must value themselves enough to risk being impolite to others when they feel the need to protect themselves from potential danger without becoming so aggressive towards all people that they are isolated from a social life. Another difference that Ketring and Feinauer (1999) noted was that women tend to internalize their symptoms, showing signs of depression, anxiety and disassociation, while men tend to externalize symptoms and act out or abuse substances.

In choosing therapeutic services, the history of the victim as well as the current assault may impact the victim's preference for a therapist of a particular gender.

> While many people in therapy do not seem to care about the sex of their therapist, most sexually abused individuals do state preferences ... The same decision about the sex of the therapist may be made for diametrically opposite reasons by different [victims] ... [A therapist] must therefore explore the reasons for a [person's] preference, and not assume it has an unambiguous, predictable meaning. Explorations of how the [person] arrived at [his or her] decision regarding therapist sex will yield the specific implications of this choice for the treatment and therapeutic relationship (Gartner, 1999, p. 267).

Treatment Approaches

There are several treatment choices available for the therapist and a combination of methods may best meet the victims needs. In designing a treatment plan, Northcut & Heller (1999) warn that

> Whether clinicians today are practicing short-term or long-term treatment, the need for a clear understanding of the defenses is critical for assessing adaptive and maladaptive coping strategies. Without this understanding, clinicians waste time and energy trying to suggest techniques that are beyond the person's ability to perform. Clear understanding and assessment of client functioning allows the clinician to accurately determine when to focus on the therapeutic relationship and/or when there may be a need for a concrete, didactic intervention (p.25).

Empowering the client by mutually generating therapeutic goals and assisting them in dealing with their social, political, legal and interpersonal environments can be effective in facilitating their ability to cope with the assault (Land, 1998). Regardless of the victim's gender, a sense of powerlessness, and the resultant loss of 'machismo' for male victims, is most likely experienced during the assault. Therefore, or as a result, it is important that "in no instance should the therapeutic relationship replicate the inequity experienced by clients" (Land, 1998, p. 245). Therapeutic goals need to be established as a concordance between the victim and the therapist with an understanding of the victim's environment including their family, work, school, medical and legal systems. The therapist may need to serve not only as a clinician, but also as an advocate for the victim throughout these systems in order to protect him from revictimization.

Advocacy may be required because "it unfortunately is a fact that our society is indeed racist, sexist and homophobic, that it is injust and oppressive" (Saari, 1993, p. 20). The oppression may come in the form of culturally implicit messages received from childhood on. "Young children also appear to form implicit rules of behavior for themselves and others. These presumably derive from their analysis of 'the way things are' and are not subjected to testing against alternative rules ... [In] early childhood they equate 'the way it is' with 'the way it should be'" (Nelson, 1985, pp. 16-17).

In order for the victim to create new meaning, these implicit messages and their influence upon self perceptions have to be brought to consciousness, understood, and accepted or rejected.

> Gender is so basic to our assumptions about who we are and how we and

> others should behave that we are seldom aware that gender-related experiences influence and shape the ways we think about others and ourselves. Our beliefs - typically experienced as "oughts" and "shoulds" - nevertheless guide our behavior, establishing the nature of the interaction in intimate relationships without our conscious awareness (White, 1996, p. 51).

The use of narrative techniques could help the client bring into conscious awareness the implicit gender myths that they have incorporated into their schemas. Then they may be able to look at their gender role schemas and the impact they have had on their experience of the assault and reinterpret the meaning of the assault without the negative influence of societal myths.

> Everyone is traumatized when confronted by the facts of his or her abuse, neglect, or addiction. However, when wrapped in a narrative, fashioned into a story, and given new meaning, the trauma becomes detoxified and loses its grip on the person's life ... No activity is more essential to a person's recovery from pain and trauma than the act of naming (i.e. putting words to) one's traumatic experience. It enhances and deepens our connection with ourselves and with others (Diamond, 1998, p. 212).

The narrative is a way to help the victim learn more about themselves and the experience they are now trying to conquer.

This process may be further aided by group therapy. "Groups are excellent sources of information on how others see clients as opposed to how they see themselves. As a result, some of the destructive narratives (experienced by victims from family, significant others or the legal system) might be reworked in group" (Land, 1998, p. 244). Male sexual assault survivors should be in groups of other male survivors in order to help facilitate their understanding that they are not alone in dealing with the issues of male sexual assault.

Conclusion

The experience of sexual assault is not an isolated one, but one whose meaning is created out of the past as it impacts the three components of an event: "the event itself, its mental representation and its public verbal representation" (Nelson, 1986, p. 12). The creation of meaning is a lifelong journey that

> ... starts out with confusion, disorientation, and chaos. This struggle is a never-ceasing process, continuing throughout life: man's objects are always touched with a coefficient of indeterminacy and, as long as he is open to new environments and experiences, they are constantly in the process of transformation, changing in their significance. One may indeed say that man lives constantly in a world of becoming rather than a world of being (Werner, 1963, p. 13).

The goal in working with a survivor of sexual assault is to respect their being with the realization of their potential for becoming. This kind of therapeutic attitude allows for the experience of growth rather than isolation. Services must be available to men that recognize they have needs unique to their gender. Furthermore, children should not be socialized with the idea that men are the perpetrators and women are victims. Men can, and should be, supported in their efforts to heal through appropriate programming and protective legislation. The issue of male rape needs to be brought out from under shrouds of ignorance, stereotyping and misunderstanding. "...[T]he blessings which we associate with a life of refinement and cultivation can be made universal and must be made universal if they are to be permanent; ... [and] the good we secure for ourselves is precarious and uncertain, is floating in mid-air, until it is secured for all of us and incorporated into our common life" (Addams, 1990/1910, p. 69). We must recognize that men and women can be victims of sexual assault and that all victims, regardless of gender, deserve support, respect and a chance to heal.

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References

Addams, J. (1910/1990). The subjective necessity for social settlements, *Twenty years at Hull-House*. Chicago: Prairie State Books.

Amini, F., Lewis, T., Lannon, R., Louie, A., Baumbacher, G., McGuinness, T., & Schiff, E. (1996). Affect, attachment, memory: Contributions toward psychobiologic integration. *Psychiatry, 59*, 213-239.

Bartlett, J. (1945). *Bartlett's quotations*. Garden City, N.Y.: Little Brown Co.

Becker, H. (1986). *Doing things together: Selected papers*. Evanston, IL: Northwestern University Press.

Burgess, A. W., & Holmstrom, L. L. (1979). *Rape crisis and recovery*. Bowie, MD: Robert J. Brady Co.

Cooley, C. (1964). *Human nature and the social order*. New York: Schocken Books.

Diamond, J. (1998). Postmodern family therapy: New voices in clinical social work. In R. Dorfman (Ed.), *Paradigms of Clinical Social Work* (Vol. 2, pp. 185-224). Philadelphia, PA: Brunner/Mazel.

Gartner, R. B. (1999). *Betrayed as boys: Psychodynamic treatment of sexually abused men*. New York: The Guilford Press.

Goyer, P. F., & Eddleman, H. C. (1984). Same-sex rape of nonincarcerated men. *American Journal of Psychiatry*, 141 (806-810). In Struckman-Johnson, C. (1991). Male victims of aquaintance rape. In A. Parrot & L.

Bechhofer (Eds). *Aquaintance rape, the hidden crime*. New York: Wiley.

Gray, J. (1992). *Men are from Mars; Women are from Venus*. New York: Harper Collins.

Groth, N., & Burgess, W. (1980). Male rape: Offenders and victims. *American Journal of Psychiatry, 137*(7), 806-810.

Grubman-Black, S. (1990). *Broken boys/ Mending men: Recovery from childhood sexual abuse*. Bradenton, FL: Human Services Institute, Inc.

Isely, P. J. (1998). Sexual assault of men: College-age victims. NASPA, *35*(4), 305-17.

Ketring, S., & Feinauer, L. (1999). Perpetrator-victim relationship: Long-term effects of sexual abuse for men and women. *The American Journal of Family Therapy, 27*, 109-120.

Land, H. (1998). The feminist approach to clinical social work. In R. Dorfman (Ed.), *Paradigms of Clinical Social Work Vol. 2* (pp. 227-256). Philadelphia, PA: Brunner/Mazel.

Mitchell, D., Hirschman, R., & Hall, G. (1999). Attributions of victim responsibility, pleasure and trauma in male rape. *The Journal of Sex Research, 36(*4), 369-73.

Nelson, K. (1985). *Making sense: The acquisition of shared meaning*. New York: Academic Press.

Northcut, T. B., & Heller, N. R. (1999). *Enhancing psychodynamic therapy with cognitive-behavioral techniques*. Northvale, N.J.: Jason Aronson, Inc.

O'Reilly, S. H., & Rhone, Insp. D. (Undated reprint). *Guidelines for a responding officer in sex-assault cases*. Hamden, CT: Hamden, CT Police Department.

Saari, C. (1991). *The creation of meaning in clinical social work*. New York: Guilford Press.

Saari, C. (1993). Identity complexity as an indicator of health. *Clinical Social Work Journal, 21*(1), 11-24.

Scarce, M. (1997). *Male on male rape: The hidden toll of stigma and shame*. New York: Insight Books.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Struckman-Johnson, C. (1991). Male victims of aquaintance rape. In Parrot, A. & Bechhofer, L. (Ed.), *Aquaintance rape: The hidden crime*. (pp. 192-213). New York: Wiley.

Struckman-Johnson, C., & Struckman-Johnson, D. (1992). Acceptance of male rape myths among college men and women. *Sex Roles, 27*(3/4), 85-100.

Turman, L., & Levine, J. (1967). *The Graduate*. Hollywood, CA: Metro Goldwyn Meyer.

Washington, P. (1999). Second assault of male survivors of sexual violence. *Journal of Interpersonal Violence, 14*(7), 713-730.

Werner, H., & Kaplan, B. (1963). *Symbol formation*. New York: John Wiley.

White, M., & Tyson-Rawson, K. (1996). A peace plan for the gender wars. *Psychology Today 29*(2), 50-59.

Williams, J., & Holmes, Karen A. (1981). *The second assault: Rape and public attitudes*. Westport, CT: Greenwood Press.

Working with Homeless, Mentally Ill Clients: Fieldwork Reflections

by Brenda K. Nelson

Introduction: My First Year Field Placement

I arrived on the first day of my first-year field placement, a residential program for homeless, mentally ill clients, fully anticipating a good experience. Rumor had it that the supervisors at this placement valued and respected students, and that clients received humanizing, helpful care. While I had every reason to believe these positive reports, I had no idea what this would really look like in practice. I have not been disappointed. The reality of my learning experience has far exceeded my anticipation.

My purpose here is to reflect on my experience in light of two things I have been thinking about wanting to form in myself as a budding social worker: I want to enjoy what I do and I want to help the clients I work with to get better, not out of compliance or my need for them to improve, but because I provide a relationship that gives them a greater sense that they can make it in the world. I want strong guiding ideals, and I want to consciously work to articulate what informs my ideals. I will be curious in ten years to see how this has worked and how my perspective has changed and strengthened.

The residential program where I intern consists of three housing programs: a short-term, emergency program (approximately 3-12 months), a transitional program (2 years), and a permanent program. Each client meets criteria for an Axis I diagnosis, and all were either homeless or at risk of homelessness upon admission to the program. Sixty percent of the residents are substance abusers. At least seventy-five percent are male and approximately seventy percent are African-American. In order to protect the confidentiality of the clients discussed in this paper, I have changed identifying characteristics and details.

Although my placement is officially in the short-term, emergency program, the students from the emergency and transitional programs share supervisors. I work with clients in both programs and meet one hour each week with each of the supervisors. Another hour a week we have a "student lunch" at which both supervisors, the other social work student, and myself, get together and talk about our cases and issues in the program. This variety of opportunities for intellectual stimulation and reflection about cases has proved extremely valuable in my experience as a student. I have worked in the mental health field my whole working life, and until now, never experienced helpful clinical supervision. The attention and care the students receive from the supervisors provide a model and experience of relating for how students, in turn, care for clients we work with. This is especially important given the level of support homeless, mentally ill clients need. This experience of supervision has made a tremendous difference in how I think about the clients I work with, how I conceptualize my role in working with them, and the extent to which I am able to grapple with my questions constructively.

Some of my questions are: how do you build rapport with someone who is psychotic? What does a healing, therapeutic relationship entail? Is relating to this population different from relating with other types of clients? What can I generalize to other populations from what I have learned here? Why do clients improve or, conversely, why do they fail to improve or get worse? What is it that makes a person really enjoy their work with clients? How does one maintain this stance over a period of years? All these questions, and more, have often circulated through my mind during the course of my field placement. The great thing about being a student is getting the opportunity to think about these matters in a context where you are considered a learner. You don't have to have it all figured out.

A Brief Word about the Literature

Although the literature regarding homeless, mentally ill individuals and programs is primarily quantitatively based, experts in the field agree that an individualized, flexible approach is important in working with homeless, mentally ill clients (Brown & Wheeler, 1990; Morissey & Levine, 1987; Kanter, 1989; Goldfinger & Chafetz, 1984; Murray & Baier, 1997). In both of the cases I discuss below, the services treatment providers offered them at a nearby community mental health center often have not matched what these clients want for themselves. This negativity about services should not necessarily be viewed by staff as an unwillingness to receive help, or even a resistance to receiving help. Rather, the treatment providers should look for the individual meaning of the rejection of services and, for the

sake of the client, thoughtfully adjust their approach accordingly (Goldfinger & Chafetz, 1984). I have observed that this philosophical stance makes all the difference between whether a client feels forced to comply, and whether she experiences the respect and compassion which, in turn, potentially leads to the increased capacity to treat herself with newfound respect.

What I've Learned from Mark: Approach is Everything

While waiting to meet with my supervisor on my first day, I picked up a client's chart and started to read. When my supervisor asked who I picked, I told her I was reading about a new resident, Mark, an African-American man in his late thirties who recently relocated to Chicago from Detroit. I had my first case. I located this reportedly psychotic resident in his room and introduced myself. If you have never experienced talking to someone whose mental state exemplifies derailment and tangential thinking, one word describes what it is like to hold a conversation: impossible. I quickly learned that my willingness to help this client, at least at first, would get nowhere if I continued attempting pointed, let's-sit-down-and-talk conversation. What amazed me was that despite his utter confusion, Mark still communicated interest in the role I was supposed to play in his tenure in the program, a desire to engage in the dignified activity of going to school, and concern about a very large, unhealed sore on his forehead. I adjusted my approach to talking with him from meeting-style to simply finding him and holding whatever type of conversation seemed possible that day, always greeting him warmly. It worked. His avoidance subsided and we started building a relationship. Mark also began to benefit from medication, a warm living space, three square meals, and a lot of people who cared about his well-being. His ability to hold a logical conversation gradually increased.

Mark has taught me a lot. While a very likable, amiable person, Mark is also highly sensitive to disrespect and I discovered he does not like people "poking their noses where they have no business," as he once put it. He let me know this very forthrightly. I initially found it hard to track him down because he would often leave for long periods of time, frequently changing plans and eluding the possibility for regular contact. I understood this as his way of backing away from the intimacy that our relationship represented to him, and also his understandable fear that I would be nosy and disrespectful.

Realizing the severity of this case and the grave implications of failing to engage him, I poured a lot of thought and care into my relationship with Mark. Our major concern surrounded three life-threatening medical problems, two of which had become known only recently. He began to let me intervene more in his medical care, and either his primary caseworker or I attended appointments with him whenever possible, weathering his paranoia with the knowledge that not pushing him along this path would have been neglectful. I saw first hand the stark contrast between Mark's response to medical doctors who treated him well and his response to those who treated him disrespectfully. He remained paranoid, though less so, with those who treated him well, but visibly suffered when other doctors talked to him like a helpless schizophrenic. Confirming the experience of being treated poorly showed Mark that I wanted the best for him.

Mark grew more related and less paranoid. He took all the steps necessary to arrive at a definitive diagnosis regarding his most immediately threatening medical condition, then agreed to the full course of a very taxing and serious treatment. One week in a community support group that all the residents attend, Mark shared how much it meant to him to live in a place where other people cared about him so much. He regularly expressed nervousness about his upcoming medical treatment, and in great contrast to two months prior, completely shed his paranoia that his doctors were imposters and only wanted to use him as a guinea pig. Rather, he spoke of them as competent, smart professionals. He came a long way in three months.

How much of Mark's psychosis was based in worry about his medical problems, or the medical problems themselves? If we had listened only to his paranoia and allowed him to push us away, he never would have received the medical care he needed. If we had confronted his paranoia head on, he would have dug in his heels even harder. This possibility was all too real, as Mark's psychiatrist considered that guardianship might be necessary If we had demanded compliance, he would not have trusted us. Finding an approach that suited him made all the difference and taught me a great deal about what an "individualized approach" really means. It means keeping safety the foremost priority, but working within the parameters of a relationship that works best for the client, rather than what is convenient for staff. Working with Mark has been a gratifying start to my career as a social worker.

Engaging Conrad: Work in Progress

Work with another of my clients has also given me much food for thought, but in a less dramatic story. Conrad is an imposing-looking Caucasian man in his mid-twenties, but in whose presence you feel as though you are with a six-year-old little boy. He has been in and out of psychiatric facilities since he was a teenager. He began hearing voices at a very young age and has battled them ever since. He is a client who at times I have thought could hold a job with the right kind of support - and he wants this, too. Sometimes. Then he goes through periods where he seems completely unable to muster getting out of bed and imagines he will always be disabled. What is he capable of? How do we find the balance between believing the best for him and not putting unrealistic expectations on him?

Conrad started out in the short-term program, and I began working with him just prior to his moving to the transitional, two-year program. He interacted with me very jovially at first. He looked forward to moving to a new place where he could stay for two years, but said that he needed to be more "mellow" than he had been previously. I wondered about this self-imposed expectation. Was he bracing himself in some way?

Both of my supervisors, as well as other staff, have observed that the transition between these two programs presents difficulties for residents, though one would not necessarily guess this to be the case. On the face of it, one might guess that someone who has lived on the streets would be overwhelmed with joy to know they have two or more years to live in the same place. But the impermanence factor can be even more unsettling to a homeless person: he or she ultimately has to leave and find yet another place to survive. Perhaps the common "settling in" difficulties speak to the fact that many of these clients have had few successes, and getting accepted into this program is indeed a success. It is as though this positive experience takes awhile to sink in. Or maybe all their previous bad experiences have to battle it out with the possibility of something good before the "good" takes hold.

Although not a particularly misbehaving or rule-breaking type, Conrad seemed to work against himself in about every way possible during his first couple of months. He hosted a female in his room one night (no one is allowed visitors in his or her room), and he also precluded his ability to pay rent by giving away all his cash to a drug-dealing relative. After each incident, Conrad cried with genuine remorse and expressed how he did not know how these things had happened, fully realizing that he had jeopardized his place in the program. With help and support, he recognized his inclination for getting involved with people who put him up to doing things he would not likely do on his own. But how do you protect an adult from harming himself in this way? How do you help someone begin to see and actually change such obvious self-destructive behavior?

I feel like I remain in the engagement phase with Conrad, even after four months of work. He sleeps constantly and mostly smokes during his waking hours. We meet twice a week, and nine times out of ten, I have to wake him up to meet with me. Recently, I was unable to keep one of our appointments due to an illness. When I returned, he was sick and couldn't meet with me. I considered the possibility that he wanted me to know, though probably not consciously, that my absence had been difficult for him. I wanted to acknowledge to him that I recognized the loss he likely felt from not being able to meet, but in a way that would have concrete meaning for him. I also wanted him to know that I took his sickness seriously, rather than viewing it as an excuse to avoid meeting with me. So I took him a cup of hot tea and encouraged him to drink fluids and get lots of rest. He seemed surprised that someone would care about him in this way, and I had the impression that this kind of care and attention was very new to Conrad. I mentioned that it must have been disappointing to miss our regular meeting time. He looked at the floor and nodded in agreement. Two days later we were able to meet, and he said he still felt congested. When we talked about specific ways he could help himself feel better, Conrad looked me right in the eye and said, "Man, that tea you brought me was the best." I think we made some headway.

Perhaps an individualized approach in Conrad's case might include lots of concrete acts of demonstrating care and involvement, such as bringing him hot tea, much more than a higher-functioning adult might ever need. "To be meaningful to those we serve, our services must offer not only what we deem useful but what [the clients] deem necessary ... The advice and interventions we offer must be relevant to the world they inhabit ... In order to engage the difficult-to-treat population of the homeless mentally ill, we must begin seeing what we offer through their eyes" (Goldfinger & Chafetz, 1984, p. 104). What is relevant for Conrad? How can he best be helped? I do know that as one of ten children Conrad never got the attention he desperately needed. Perhaps continuing to give him atten-

tion, even in little ways, will help him recognize his need for ongoing care, help him make better use of his treatment, and help him begin to realize that he deserves attentive care.

Support Group: Inspiration in Unexpected Places

Every Saturday morning, all the residents from the short-term program (roughly 20 people) are required to attend what the program calls Support Group. It is one of three mandatory weekly groups, with the purpose of giving the residents the opportunity to come together to talk about how their week went and, ideally, to support each other. This is my one chance during the week to observe all of the residents together and witness how they function as a group. Large group meetings are not exactly my forte, so I have been pleasantly surprised at how much I enjoy this particular group. The reason for this occurred to me recently. Here are two dozen people who have been about as beaten down by life as they come. They have suffered severely from abuse, neglect, and racism, not to mention mental illness, homelessness, and substance abuse. Yet they come to this program because they want something better for themselves. This desire gets convoluted in so many ways, but every week I come away inspired in some way by these clients' efforts. I am lucky to be a part of their experience.

Conclusion

I knew I would learn a great deal from my field placement, but I did not anticipate how much I would learn from the clients themselves. And I especially didn't expect that I would enjoy working with this population as much as I do. I know that had I landed in a program where staff did not take the needs of the clients seriously, or treated the clients disrespectfully, I would have had a much more difficult time maintaining clarity and commitment to my ideals. I feel fortunate to have landed in a place that provides a good philosophical match, and know that I can use my field placement experience as a beacon for orienting myself from this point forward. I will let you know how things are going ten years from now.

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References

Brown, M.A., & Wheeler, T. (1990). Supported housing for the most disabled: suggestions for providers. *Psychosocial Rehabilitation Journal, 13*, 58-68.

Goldfinger, S., & Chafetz, L. (1984). Developing a better service delivery system for the homeless mentally ill. In Lamb, H.R. (Ed.), *The Homeless Mentally Ill, A Task Force of the American Psychiatric Association*. Washington, D.C.: American Psychiatric Association.

Kanter, J. (1989). Clinical case management: Definition, principles, components. *Hospital and Community Psychiatry, 40*, 361-368.

Morrissey, J.P., & Levine, I.S. (1987). Researchers discuss latest findings, examine needs of homeless mentally ill persons. *Hospital and Community Psychiatry, 38*, 811-812.

Murray, R., Baier, M., North, C., Lato, M., & Eskew, C. (1997). One-year status of homeless mentally ill clients who completed a transitional residential program. *Community Mental Health Journal, 33*, 43-50.

The Policy Behind the Indian Child Welfare Act

by Justine van Straaten and Wendi Liss

Introduction

The Indian Child Welfare Act of 1978 (ICWA) is a unique and important legal document impacting the rights of Native American communities. The Act ought to be understood both historically and legally in an effort to secure optimal compliance with the Act on behalf of Native American children and families. While the political and social significance of the Act is more widely known, its history remains relatively unknown throughout the child welfare system in the United States, and thus enforceable rights for Native Americans may be neglected. In addition, the lack of compliance with the ICWA runs the risk of interfering with cultural preservation of tribal communities. This risk prompted legislators to implement the Act. In order for the ICWA to be successful as a public policy measure, there must be a more widespread understanding throughout the child welfare community of the legal significance of the Act, the historical background of the Act, and the cultural and social consequences of not complying fully with the Act.

Historical Background

Throughout the history of the United States, relationships between the Native American community and the federal government have been wrought with tension. Upon the arrival of the European settlers, competition for resources and cultural differences led to intense hostilities. Formal difficulties between the two groups commenced with the creation of the federal government in the 1700's, as the Native American community viewed themselves as a separate and distinct nation from the emerging United States federal government (Feagin & Feagin, 1996). In an effort to address this conflict, the government acknowledged that Native Americans were a self-governing nation through the policy set forth in the Northwest Ordinance, but this policy considered the separate Native American government as a hostile nation (Feagin & Feagin, 1996). Despite this viewpoint, the federal government significantly recognized Indian tribes as having distinct governments in Article I of the United States Constitution; however, subsequent legislation suppressed the self-governing rights and cultural needs of the Native American community.

In the nineteenth century, the federal government passed a series of laws aimed at disrupting the existing Indian tribes and ultimately designed to force the assimilation of Native Americans into the developing American culture (Churchill, 1993). The most significant of these policies were the Indian Removal Act of 1830 and the Dawes Act of 1887 (Spicer, 1980). The Indian Removal Act of 1830 extinguished the rights of Indians to own land east of the Mississippi River and forced marches of Native Americans. Relocation created new challenges and posed survival risks for Native Americans where unfamiliar agricultural skills were required and different game was to be hunted (Feagin & Feagin, 1996). Of the nearly 50,000 individuals affected by this removal, over half died in the process of relocation (Morales & Sheafor, 1998).

While the Indian Removal Act decreased the land base of the Native American population, the Dawes Act attempted to force the assimilation of Native people into U.S. culture through creating a dependency of Native people on the American economic structure (Morales & Sheafor, 1998). The passage of the Dawes Act specifically generated this dependency by allowing Native Americans to become citizens of the United States, provided that they show themselves to be "competent" in managing land allotments provided by the U.S. government (Adams, 1995). Inherent in this policy was compliance with the dictates of the U.S. federal government, although it was masked as an act of good-natured paternalism.

A statement issued by the Commissioner of Indian Affairs in 1886 embodied the attitude toward Native Americans prevalent at that time. The Commissioner said, "If you want to solve the Indian problem you can do it in one generation. You can take all of the children of school age and move them bodily out of the Indian country and transport them to some other part of the United States where there are civilized people ... If you take these kids away and educate them to make their own lives, they wouldn't come back here" (Feagin & Feagin, 1996). From this statement and the political forces behind it, a movement flowed known as the "boarding school era."

The rules and regulations which governed the boarding schools created for Native American children were designed to suppress the cultural identities of the Native American children by indoctrinating the children with the norms of "white" society. In order to achieve this objective, the children were denied contact with their families, forced to cut their hair, taught Christian doctrine, and forbidden to speak their native language (Churchill, 1993).

Failure to follow these rules was punishable by such measures as grade failure and physical assault (Churchill, 1993). The removal of Native American children during this era received strong non-Indian support. While it was viewed as a compassionate movement, the reality was that the boarding schools eroded the foundation upon which the tribal communities were built (Feagin & Feagin, 1996).

The boarding schools continued to operate well into the 1930's when the Indian Reorganization Act was signed (Spicer, 1980). This Act, passed under the New Deal, intended to establish Native American civil and cultural rights, to allow for semi-autonomous tribal governments, and to foster the economic development of Native American reservations (Feagin & Feagin, 1996). Due to the greater level of control granted to tribal governments under this Act, the boarding schools started to close in the mid-1930's (Churchill, 1993). These restorative efforts led to subsequent policy aimed at returning Indian communities to the status of sovereign nations. The policies enacted during this time sought to terminate federal responsibility toward Indian tribes. Legislation was passed that reversed the trust relationship between the federal and tribal governments and attempted to eradicate the federal government's responsibility to protect these so-called "dependent sovereigns."

Between 1954 and 1966, approximately one hundred tribes were stripped of official recognition from the federal government resulting in tribal loss of funding, claim to land bases and accesses to social services on a broad level. Due to the dissolution of many Native American nations, the influx into urban areas of Native Americans with no "home" and confused identities increased dramatically. As current estimates suggest, approximately two-thirds of the two million Native Americans in the United States today live off of reservation areas (Morales & Sheafor, 1998).

The newly independent Native tribes were forced to negotiate U.S. systems with little assistance, experience or desire. The child welfare system in particular was unfriendly to the unique circumstances of the Native community. The non-Native American social workers and judges facilitated the removal of many Native children from their families due to adjudications that Native American parents were unfit to care for their children due to allegations of neglect. It was common, however, for such allegations to be based upon a Native parent's decision to leave a child with an extended relative for long periods of time. Non-Native American social workers' lack of understanding of Native American cultural values is reflected in such interventions. In addition, the poverty of Native American families was seen as justification for removal and led to high levels of interstate placement of Native American children. While poverty was the justification, the increasing popularization of adoption in the U.S. put Native American babies in high demand in the adoption market as fewer Caucasian babies were available to prospective adoptive parents (Jones, 1995). These trends along with other cultural biases against the Native American community led to a situation in which an average of 25-30% of all Native American children were placed in foster or adoptive homes with a non-Native family (Jones, 1995).

The Indian Child Welfare Act

The American Indian Policy Review Commission, which was created in the 1970s, was formed by the United States Congress to review the current status of federal policy designed to govern the relationship between Native American people and the federal government. The report submitted to the United States Congress included recommendations for legislation regarding child custody issues involving Indian children (Feagin & Feagin, 1996). The statistics gathered for the study demonstrated that Indian families were at a greater risk of unwarranted separation than any other population in the United States. The specific findings of the committee, such as the discovery of high rates of unwarranted separation of Indian children from their families, led to the enactment of the Indian Child Welfare Act of 1978. This Act allowed tribes and Native organizations to assume greater responsibility for protecting the best interests of their children and families (Morales & Sheafor, 1998).

ICWA established minimum federal standards in guiding the removal of Indian children from their families (H.R. 104-808, 1996). It set forth guidelines regarding the possible placement of these children. The stated purpose of the Act set forth in Section 307.1 is "to protect the Indian child as a resource for Indian communities throughout the nation" (Indian Child Welfare Act, 1978). In keeping with this stated purpose, the Act recognizes the Indian child as the guiding force behind the preservation of Indian tribal culture, traditions, and values. The Act also assures additional safeguards to protect the integrity of the Native American family and the unity of the Indian nations (H.R. 104-808, 1996).

The Act was passed as a result of congressional recognition of the importance of the preservation of Native American heritage, culture, and communities

(Indian Child Welfare Act, 1978). ICWA sets minimum federal standards that apply in child custody proceedings involving a child that is either enrolled or eligible for enrollment in a federally recognized Native American tribe. These procedures attempt to control the imposition of an "Americanized" standard of child welfare that is culturally insensitive to understanding cultural differences within the Native American community. It has been estimated that Indian children are being placed in substitute care 3.6 times more often than non-Native children (Bending, 1997). Prior to the enactment of the ICWA, Native American children were placed in non-Native homes at an even more alarmingly high rate (Feagin & Feagin, 1996). The provisions of the ICWA attempt to reverse this phenomenon by keeping Native American children within their communities and thus preserving their cultural ties.

The primary authority over an Indian child's relationship with his or her tribe was granted jointly to the child's tribe and to the child's parents through the implementation of the ICWA (Indian Child Welfare Act, 1978). This policy perspective flowed from the resentment about historical practices which interfered with the cultural integrity of the Native American family system. Returning the locus of control to the tribes and tribal members themselves was a congressional effort to rectify past atrocities committed against Native people (S. Rep. 104-335, 1996). These atrocities had profoundly negative consequences in Native communities which occurred on many levels.

The trend of removing Native American children and placing them in a culturally foreign world created developmental difficulties for the child as well as psychological trauma to the disrupted Native families. Various studies conducted on such children reveal that "Native American children brought up in non-Native homes suffer from a variety of adjustment disorders once they discover their unique racial ancestry" (Jones, 1995). The denial of cultural beliefs and traditions which took place through this involuntary conformity created internal conflict for many of these children. A particular source of conflict was the mainstream American value of rugged individualism versus the Native American tradition of community-based family structure (Jones, 1995).

The ICWA was intended, in part, to address the best interests of Native American children and their families by preserving the fundamental generational and tribal ties so vital to individual development and the strength of the Native American community. This broad-based policy was particularly significant in that it ensured the right of cultural identification to Native Americans residing on or off tribal reservations. The recognition of the cultural heritage rights of all Native Americans regardless of their domicile represented a dramatic shift in federal policy in that prior policies limited tribal jurisdiction to matters that fell within the physical boundaries of the specific reservation (Spicer, 1980). The federal government took an important step toward recognizing its own role in the deterioration of the Native American family by granting tribal jurisdiction to matters involving all Native American children irrespective of physical location. The federal government also communicated a newfound dedication to Indian tribes by empowering them to govern themselves.

The main objective of the Indian Child Welfare Act is to grant tribal courts, rather than state courts, exclusive jurisdiction over custody proceedings involving Indian children. In order to comprehend the manner in which this is accomplished, it is imperative to understand what is meant by the terms "child custody proceedings" and "Indian child" for purposes of the Act. Section 1903(1) of the ICWA outlines the procedural criteria necessary to invoke the protections of the Act (Indian Child Welfare Act, 1978). Child custody proceedings for purposes of the ICWA include foster care placements, voluntary or involuntary termination of parental rights, preadoptive placement, adoptive placement, and status offenses. The ICWA specifically exempts delinquency proceedings other than status offenses and custody determinations in divorce proceedings (Indian Child Welfare Act, 1978). Guidelines formulated by the Bureau of Indian Affairs (BIA), created to assist in the uniform interpretation of the Act, clarify that the Act was intended to apply in situations in which the placement of a Native American child in a non-Native home was a likely result (Fed. Reg. 44-228, 1979).

In addition to the contextual threshold requirement of the ICWA that there must be a child custody proceeding at issue, there is the eligibility requirement for application of the Act that the subject of the child custody proceeding be an "Indian child." Section 1903(4) of the Act defines an Indian child as an unmarried person under eighteen years of age who is a member of a tribe or eligible for membership of a tribe, and the biological child of a tribal member (Indian Child Welfare Act, 1978). Caselaw has routinely held that tribes are endowed with the authority to determine their own membership and eligibility requirements, and that the party asserting the applicability of the ICWA is responsible for proving through sufficient evidence that the child

meets the threshold requirements outlined in the Act (*In the Matter of Shawboose*, 1989; *In the Matter of Tracy Angus and Cyrus M. Waters*, 1982; *In the Interest of H.D., C.D., and C.D.*, 1986).

Once both of these threshold requirements are met, the tribal court system is granted the power of either exclusive or concurrent jurisdiction. This legislatively driven deferment to the tribal courts is highly significant as a federal policy in that it recognizes that the individual tribal courts are better situated and more appropriate institutions for the determination of the best interests of Native American children. Tribes have exclusive jurisdiction over child welfare matters if the child resides or is domiciled on the reservation or when the child is a ward of the tribal court (Indian Child Welfare Act, 1978; Fed. Reg. 44-28, 1979). The Act further states that the domicile of the child is generally that of the parent (*In re Adoption of S.S. and R.S.*, 1995). This exclusive jurisdiction, however, does not divest the State courts of the authority to remove a child from his or her home in order to prevent any imminent physical damage or harm to the child (*In re Adoption of S.S. and R. S.*, 1995).

State courts have concurrent jurisdiction with tribal courts over child custody proceedings involving Indian children domiciled off the reservation (Indian Child Welfare Act, 1978; Fed. Reg. 44-28, 1979). While there is a preference for transferring these cases to the relevant tribal court, objection by either parent to the transfer, a declination by the tribal court to accept jurisdiction or a determination of good cause not to transfer the case to the tribal system serve as justifications for State retention of the case (Indian Child Welfare Act, 1978; Fed. Reg. 44-28, 1979). Because the State courts are entitled to concurrent jurisdiction regarding many child custody proceedings involving Native American children, the ICWA includes various additional protections to guard against the continuation of arbitrary separation and dissolution of Indian families. These additional protections include higher burdens of proof for the termination of parental rights of Native parents and for the removal of Native American children; strict notification requirements to ensure that tribes are aware of any proceeding involving a member of their tribe and are offered an opportunity to intervene; active efforts on the part of social services to keep the Indian family intact must be demonstrated prior to measures directed toward placement outside the home; qualified expert witness testimony is required before there can be an out of home placement or a termination of parental rights; and specific attention in the Act is paid toward placement preferences should removal of Indian children become necessary (Indian Child Welfare Act, 1978).

The placement preferences enumerated by the Act further highlight the commitment of the federal government to the preservation of the Native American cultural community. Absent a showing of good cause not to follow the placement preferences, the preferences for adoptive placements shall be selected in the following order. First priority is granted to a member of the Indian child's extended family, second priority is granted to other members of the Indian child's tribe, and last priority is given to other Indian families (Indian Child Welfare Act, 1978). In the case of foster care or preadoptive placements, first priority should be given to a member of the Indian child's extended family and second priority should be given to a foster home licensed, approved or specified by the Indian child's tribe. Third priority is given to an Indian foster home licensed or approved by an authorized non-Indian licensing authority and fourth priority goes to an institution for children, approved by an Indian tribe or operated by an Indian organization (Indian Child Welfare Act, 1978).

Social Work and the Indian Child Welfare Act

Proper adherence to the ICWA is crucial for child welfare practitioners as the invalidation of proceedings, the possible return of custody to the Indian parent, and the vacation of an adoption decree and malpractice actions are all potential consequences of not following the provisions of the Act (Indian Child Welfare Act, 1978). The responsibility for the implementation of this piece of legislation falls into the hands of many different players in the child welfare system. Social workers have a unique role in relation to the ICWA in that their advocacy on behalf of Native American families, in part, led to the passage of the Act. Social workers are obliged to ensure that the provisions of the Act are appropriately followed. Because social workers usually have the initial contact with children and families potentially entitled to the protections of the Act, workers' prompt identification of Native American heritage in the lives of their clients is crucial.

A social worker's failure to identify a Native American child prior to removal can result in court intervention. Such failures may be caused by ignorance of the law, cultural bias, or less than thorough casework. In the event that social workers err and do not properly identify Native American heritage,

the onus of carrying out the provisions of the federal policy lie with the judicial system. Even when social workers properly execute their duties regarding adherence to the ICWA, nuances and the manner in which the provisions are applied to distinct cases are often left to state court interpretation. To prevent the state court discretion from rising to a level of unintended authority, many states have witnessed the establishment of child welfare agencies specifically designed to advocate for the Native American population (Wagner, 1998). These organizations, such as the Native American Foster Parent Association (NAFPA) in Chicago, Illinois, work to enforce the provisions of the Act and ensure that the goals of the policy are met.

The goal of the ICWA to preserve Native American heritage is in keeping with the values of the social work profession in that it respects individual cultural practices and entrusts the Indian community with autonomous functioning. This objective directly contributes to a better quality of life for Native Americans because it seeks to remedy years of culturally insensitive practices. Furthermore, it affords protection of Native American families and prevents the systematic destruction of their tribal customs, cultural identity, and familial structures. The policy is unique in that the criteria for inclusion in the Act is not based on need but rather on individual heritage. The broad applicability of the Act promotes cohesiveness among the Native American population instead of dividing the community into separate factions with conflicting interests. As a result, community-wide interests, as well as interests shared by the hundreds of different Indian tribes throughout the nation, may be promoted as one united effort.

Problems of the Indian Child Welfare Act

While the general applicability of the ICWA effectuates the cohesiveness of the Native American community as a whole, other disenfranchised minority groups in the United States take issue with the unique protections offered to the Native American community exclusively. Such a challenge has a basis within the guarantees of the United States Constitution, which mandates Equal Protection of the law under the Fourteenth Amendment (U.S. Const. amend. XIV, § 1). Despite the pervasive feeling of inequity on the part of other minority groups, several courts, including the U.S. Supreme Court, have held that the ICWA is not unconstitutional because it is based on the special classification of Native people as members of quasi-sovereign nations and is therefore not based upon an impermissible racial classification (*U.S. v. Antelope*, 1977; *Morton v. Mancari*, 1974; *Delaware v. Weeks*, 1977).

While the United States Supreme Court is clear in its interpretation of the constitutionality of the ICWA, strong opposition to the policy cannot be ignored. This opposition, which even exists in the minds of child welfare professionals, can thwart the successful implementation of the Act. Social workers, lawyers, and judges who disapprove of the mandates set forth in the Act are in a position to circumvent the accomplishment of the Act through withholding pertinent information or abusing the discretion available to them. As such, cultural sensitivity training and education on the historical context unique to the plight of Native Americans should be incorporated into the job training of all child welfare practitioners.

The main obstacles to achievement of full implementation of the ICWA are the discretion given to State courts in interpreting the dictates of the Act and the lack of knowledge about the Act itself common throughout the child welfare system. The lack of understanding regarding the purpose and procedures of the Act leads to an after-the-fact appraisal of cases involving Native Americans. Problems such as tardy or insufficient notification of tribes and the failure to identify court involved families as Native American early in the proceedings can lead to further disruption in the Native child's life. Such procedural delay in the child custody decision due to a violation of the ICWA provisions is detrimental to the well-being of a child left to linger throughout the duration of lengthy litigation. Educational programs for child welfare workers, therefore, are a necessary future step to eradicate complications that currently arise in the application of the ICWA.

Another difficulty that prevents the goals of the ICWA from being achieved is the discretion given to state courts in resolving ambiguities in applying the ICWA to complex realities. An example of this discretion can be seen in the existing Indian Family Doctrine, which is an addition to the ICWA accepted by many states (Jones, 1995). The existing Indian Family Doctrine is a judicially created exception to the provision in the ICWA which governs the removal of Indian children, although it is mentioned in neither the BIA guidelines nor the ICWA. This doctrine allows courts to use its discretion to not apply the ICWA when there is no "intact existing Indian family" prior to removal (*In the Matter of T.R.M.*, 1988). Although not all jurisdictions follow this exception (*In re Tyler James Elliot*,

1996), it serves as a substantial threat to the goals of the Act and further frustrates uniform application of the federal protections afforded to the Native American community. The existing Indian Family Doctrine is but one example of the multiple interpretations of the ICWA provisions made possible through the state courts' part in the administration of the ICWA policy.

Future Trends

While current disagreement continues in the administration of the ICWA, some issues which may need to be addressed in the future stem from the social changes occurring in U.S. society. One such change is the increasing social acceptibility of cross-cultural marriages. Child custody disputes which involve children with one Native American parent and one non-Native American parent cause confusion and disagreement with regard to the applicability of the ICWA. While some courts have ruled on cases in which this was an issue, there is no consensus as to how these cases should be handled and more specific legislation focused on this issue is suggested.

The Federal government has committed itself to the protections of Native American families and tribes through the provisions of ICWA regardless of cost. Despite the fact that the ICWA is not an economically-based policy, additional resources would be helpful in increasing compliance with the Act. Underfunded child welfare agencies do not have the economic resources nor the time to adequately train their employees about a policy that impacts a relatively small percentage of their caseload. This predicament leaves educational efforts and the obtainment of necessary funding to grassroots organizations, such as NAFPA, to advocate on behalf of the Native American community. The creation of specialized agencies responsible for cases involving Native American children, education about the Act throughout the child welfare system, and advocacy for this under-represented population would greatly enhance compliance with the Act and the general quality of life in the Native American community.

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References

Adams, W.E. (1995). *Education for Extinction.* Kansas: University Press of Kansas.

In the Matter of Tracy Angus and Cyrus M. Waters, 655 P.2d 208 (OR App., 1982).

Churchill, W. (1993). Crimes against humanity. In M.L. Andersen & P.H. Collins (Eds.), *Race, class, and gender: An anthology, (2nd ed.).* California: Wadsworth Publishing.

Delaware v. Weeks, 430 U.S. 73 (1977).

Department of the Interior, Bureau of Indian Affairs: Guidelines for State Courts; Indian Child Custody Proceedings, Fed. Reg., Vol. 44, No. 228 (1979).

In the Interest of H.D., C.D., and C.D., 729 P.2d 1234 (Kan. App., 1986).

Feagin, J.R., & Feagin, C.B. (1996). *Racial and ethnic relations.* Upper Saddle River, NJ: Prentice Hall.

H.R. Rep. 104-808, 1996.

Indian Child Welfare Act of 1978, 25 U.S.C. § 1901, *et. seq.* (1978).

Jones, B.J. (1995). *The Indian Child Welfare Act handbook: A legal guide to the custody and adoption of Native American children.* United States of America: American Bar Association.

Karger, H.J., & Stoesz, D. (1998). *American social welfare policy: A pluralist approach* (3rd ed.). New York: Longman.

Olsen, J.S., & Wilson, R. (1984). *Native Americans in the Twentieth Century.* Chicago, IL:University of Illinois Press.

Morales, A.T., & Sheafor, B.W. (1998). *Social Work: A profession of many faces* (8th Ed.). Boston, MA: Allyn and Bacon.

Morton v. Mancari, 417 U.S. 535 (1974).

In the Matter of Shawboose, 438 N.W.2d 272 (Mich. App., 1989).

S. Rep. No. 335, 104th Cong., 2nd Sess. (1996).

Spicer, E.H. (1980). *The American Indians.* Boston, MA: Belknap Press.

In re Adoption of S.S. and R.S., 167 Ill.2d 250 (1995).

U.S. v. Antelope, 430 U.S. 641 (1977).

Wagner, I.V. (1998). The new urban Indian politics: A case study of the Indian Child Welfare Act. *High Plains Applied Anthropologist, 1*(18), 47-61.

Codependency Through a Feminist Lens

by Helen Montgomery

Introduction

The concept of codependency inevitably arises when working with chemically addicted clients. This concept has permeated both popular literature and professional settings for over a quarter of a century. For example, any self-help section in a bookstore offers several books on codependency, mostly aimed at women, and 12-step programs, such as Alcoholics Anonymous and Al-Anon, incorporate the concept into their literature. Treatment programs that are based on the 12-step model also teach this concept in treatment groups.

Currently, I am interning on an inpatient chemical dependency unit that is based on the 12-step model. Part of my internship includes facilitating family sessions that usually include making recommendations that family members attend Al-Anon meetings as a form of support and education. As I began reading the literature from Alcoholics Anonymous and Al-Anon, I came across the term "codependency" several times, and found myself disturbed by the concept. I instinctively felt that the term was pejorative and victim blaming, specifically towards women. I therefore decided to review the literature on codependency that has been written from a feminist perspective.

The Development of the Concept of Codependency

The concept of codependency grew out of earlier research on addiction, which largely focused on white, male alcoholics and their wives. Women's addictions and the addictions of people of color were generally ignored (Babcock, 1995). The views of wives of alcoholics were rarely based on empirical research, but rather on "anecdotal, biased speculations ... (Indeed), the consistent theme for wives of alcoholics was to portray them as pathological women who were seeking to fulfill their own disordered needs ..." (Babcock, 1995, p. 6). This theme was built on a consistent pattern of sexism in western psychotherapy, such as Freud's idea of the masochistic woman, which held that women were inherently seekers of pain (Babcock, 1995). Additional descriptions of these wives included actual typologies of character types:

> (a) 'the sufferer' ... an unnecessary martyr who symbolically asks for crucifixion; (2) 'the wavering wife' ... who never followed through with attempts to cope with the problem ... (3) 'the controller' ... with a desperate need of her own, apart from any realistic connection to the alcoholism situation; and (4) 'the punisher' who needed an emasculated husband to punish ... while denying the intrapsychic origins of her anger (Harper & Capdevila, 1995, p. 38).

Additionally, beginning in the 1930's, alcoholism itself was beginning to be viewed from the medical model, and became defined as a physical disease (Krestan & Bepko, 1991). As alcoholism began to be seen as a diagnosis, the view of the alcoholic wife's behavior as pathological also began to be defined as a diagnosis. Babcock (1995) discusses the "disturbed personality hypothesis":

> This was a formalization of the notion that these women were emotionally disturbed themselves, so that they not only selected impaired partners but also were invested in the continuation of the partners' addiction. Accompanying this belief was the 'decompensation hypothesis,' which proposed that these women would supposedly deteriorate further if their spouses became sober - a supposed confirmation of their pathological investment in keeping the addiction alive (p. 6).

Later in the 1950's, however, researchers began debunking the 'disturbed personality hypothesis' and the 'decompensation hypothesis' (Asher, 1994; Babcock, 1995). Despite this research, ideas about the investment of family members in maintaining addiction continued.

The development of family systems theory also contributed to the continued pathologizing of alcoholics' wives' behaviors (Babcock, 1995; Haaken, 1995; Krestan & Bepko, 1991). Along the same lines as the disturbed personality hypothesis, family systems theory also proposed that family members have an investment in maintaining homeostasis (Babcock, 1995). "It was not a difficult leap to decide that if the alcoholic had a disease, then so must the other people in the family" (Krestan & Bepko, 1991, p. 52). The pathology of these family members came to be called codependency.

Definitions of Codependency

Codependency is used both to describe spouses of alcoholics and adult children of alcoholics (ACA). As such, definitions of codependency abound in the literature. Many authors agree that there is no one universally accepted definition of codependency (Babcock, 1995; Beattie, 1989; Granello & Beamish, 1998; Krestan & Bepko, 1991). Krestan & Bepko (1991) list several definitions of codependency and conclude that, "These definitions are irresponsible and so vague as to be meaningless" (p. 53).

Granello & Beamish (1998) suggest that "most definitions include the theme of dependence on someone or something else for emotional fulfillment to the point of living vicariously through that other person or object" (p. 345). Cermak (1988) describes a codependent as "... a person who is dependent on and controlled by others who are themselves dependent on or controlled by forces such as alcoholism ..." (p. 112). Beattie (1989) defines the term as "... a person who has let someone else's behavior affect him or her, and is obsessed with controlling other people's behavior" (p. 12). Potter-Efron (1988) describes codependents as "... those individuals whose lives have been significantly affected by another's use of alcohol or mood altering chemicals" (p. 81). Despite the lack of a common definition, the term continued to be used widely.

With no concise definition, it is important to focus on what authors define as the "symptoms" of codependency. Cermak (1988) gave one of the earliest sets of "diagnostic criteria" for codependency, viewing it as a possible personality disorder:

> A) Continued investment of self-esteem in the ability to control both oneself and others in the face of serious adverse consequences; B) assumption of responsibility for meeting others' needs to the exclusion of acknowledging one's own; C) anxiety and boundary distortions around intimacy and separation; D) enmeshment in relationships with personality disordered, chemically dependent, other codependent, and/or impulse disordered individuals; E) three or more of the following: excessive reliance on denial, constriction of emotions (with or without dramatic outbursts), depression, hypervigilance, compulsions, anxiety, substance abuse, has been (or is) the victim of recurrent physical or sexual abuse, stress related medical illnesses, has remained in a primary relationship with an active substance abuser for at least two years without seeking outside help (p. 223).

Cermak (1988) also lists common signs of codependence, such as "excessive pride in self-control, basing self esteem on getting others to be in a relationship with you, changing who you are to please others, low self-worth, and sacrificing your true self to keep the facade of your false self intact" (p. 113).

Ruben (1993) describes codependency as "... a desperate need to have a spouse at any price. Self-esteem is so low, self-identity is so absent, that the dependent spouse feels totally invisible and an imposter unless he or she can assume a role or personality by obsessively overachieving for the addicted spouse" (p. 69). This need for another person in order to achieve a sense of social identity leaves the codependent spouse in constant fear of being left alone. The codependent spouse also engages in a battle with the addicted spouse, demanding order in the household and following a rigid regimen of caretaking (Ruben, 1993).

Barnard (1990) also provides an extensive list of behaviors associated with codependency, including external referenting, caretaking, development of physical illness, self-centeredness, control issues, avoidance of feelings, emotional dishonesty, gullibility, fear, rigidity, and judgmentalism. Of particular note is Barnard's (1990) discussion of what external referenting means:

> Almost all the co-dependent's mean ing comes from the outside. They are relationship addicts as a result, and believe that involvement in a relationship is tantamount to abandoning one's self. There are not clear boundaries between themselves and others, resulting in phenomena such as being depressed, frustrated, or whatever other experience those in their environment are manifesting (p. 141).

The author also suggests that the term codependence is a way of identifying "... the syndrome of predictable behaviors observed among those who live with an alcoholic" (p. 140).

O'Gorman (1991) views codependency as a form of learned helplessness. She says codependency consists of family traditions and rituals about intimacy and bonding that lead to a view that not only is codependency a learned set of behaviors, but also a relationship disorder. This is characterized by an enmeshed quality of the relationship, and "compulsive dependence" on another, as opposed to "interdependency," or the healthy give and take of relationships (O'Gorman, 1991).

Brown (1992) notes that a codependent person "... cannot regulate closeness and distance toward

others or develop strong relationships with them" (p. 55). In looking specifically at codependency that develops in adult children of alcoholics, she says that codependents have a false self characterized by an emphasis on denial, an inappropriate assumption of responsibility, all-or-none thinking, and a focus on control. Brown (1992) also feels that both codependence and dependence have negative connotations, and suggests either adding a category of "interdependence" or broadening the categories to include healthy and unhealthy codependence and dependence.

Beattie (1989) notes that with the recognition of codependency as a problem, codependents finally have hope. "The word codependency may label a problem, but to many of us, it also labels the solution: recovery" (p. 7). Beattie's writings on codependency focus a great deal on the concept of recovery, which is similar to recovery for substance abusers. Like recovery for addicts, Beattie (1989;1999) focuses on the use of the 12-step method, with recovery for codependency being an ongoing, life-long process, with the possibility of relapse.

12-Step Programs

The first 12-step program was Alcoholics Anonymous (AA), which was founded in 1935 (Harper & Capdevila, 1995). As discussed above, initial focus was on male alcoholics. Approximately 20 years later, the wives of these alcoholics formed Al-Anon, a program for family members of alcoholics where the family members follow the same 12-steps of recovery as AA (Harper & Capdevila, 1995). At this time, the 'disturbed personality hypothesis' was incorporated into the Al-Anon literature:

> ... a moralistic and negative theme appeared early... introduced there by Reverend Kellerman ... who described wives as 'the Provocatrix ... who never gives in, never gives up, never lets go, but never forgets.' Kellerman also introduced Whelan's types verbatim into the Al-Anon literature ... Refashioned only slightly, they appear as 'Controlling Catherine, Suffering Susan, Wavering Winnie, and Punitive Polly.' The tone and theme endure as these works continue to be reissued verbatim ... (Harper & Capdevila, 1995, p. 39).

Al-Anon also introduced the idea that wives are partly to blame for their husbands' alcoholism. "The same Al-Anon pamphlet that introduced the Provocatrix contains the explanation that 'a person must have the help of at least one other person to become an alcoholic ...'" (Harper & Capdevila, 1995, p. 39). Literature such as this also helped incorporate the idea of codependency as a disease, developing along a similar track as alcoholism.

Currently, much of the codependency recovery movement is centered on 12-step groups such as Al-Anon or Codependents Anonymous. The focus of these programs is on developing the role of spirituality in the codependents' life and changing behaviors around decision making and boundary setting (Beattie, 1989).

Feminist Critiques of Codependency

With the beginning of the feminist paradigm shift, numerous psychological constructs and diagnoses were revisited and critiqued using a feminist lens. Codependency is one label that has come under a great deal of scrutiny. Early in feminist therapy theory, codependency was originally viewed as potentially being compatible with the new feminist paradigm. Concepts such as codependency and learned helplessness were discussed in the context of using feminist empowerment to disengage women from enmeshed relationships (O'Gorman, 1991). Other authors called for a redefinition of codependency, where some codependency behaviors could be viewed as healthy, or interdependent. Gradually though, feminist therapy theory came to consider the concept as both undermining of women's psychological health and antifeminist (Brown, 1994).

Two of the major criticisms of the concept of codependency are the lack of a clear definition and a paucity of empirical research (Babcock, 1995; Granello & Beamish, 1998; Harper & Capdivila, 1995; Krestan & Bepko, 1991). "In the absence of any well-thought-out, validated, and professionally accepted definition of codependency, self-appointed experts on this alleged syndrome have felt free to come up with many variants of the profile..." (Babcock, 1995, p. 12). Additionally, studies that have attempted to validate the existence of codependency through empirical research rather than anecdotal evidence "... have been marked by major flaws in research design ... and by interpretations that ignore obvious sex-role phenomena in research findings ... Perhaps the most glaring error is that these researchers usually do not try to demonstrate that codependency exists, but they assume that it does (as a pathology) and pursue analysis of the results from

there" (Babcock, 1995, p. 13).

With the lack of a concise, empirically valid definition, some authors "... estimate that up to 96% of the female population may suffer from codependency" (Kaminer, 1995, p. 71). It is also important to recognize that the anecdotal evidence comes largely from studying the behavior of white, heterosexual women in relationships with white, heterosexual men, which therefore ignores any cultural or racial differences (Babcock, 1995; Brown, 1994; Krestan & Bepko, 1991).

Additionally, feminist critiques point out that codependency has become big business. The financial profits that come from books, seminars, and treatment of codependency are certainly an incentive to continue pushing the term in popular culture (Babcock, 1995; Kaminer, 1995; Krestan & Bepko, 1991). This may have been part of the incentive to pathologize codependency and turn it into a disease. "If one is dealing with a disease, there is justification for establishing high-cost programs to treat it" (Krestan & Bepko, 1991, p. 52). The financial profits may also contribute to the continued proliferation of the term despite its datedness.

A major concern about codependency theory is that it pathologizes behavior that has traditionally been associated with the feminine role (Babcock, 1995; Granello & Beamish, 1998; Krestan & Bepko, 1991). Viewing codependency through a feminist lens, it is clear that the original theorists did not take into consideration the economic, political, and social realities of women's lives (Granello & Beamish, 1998). Economically, women have largely been financially dependent upon men. The construct of codependency came about in the era before feminism, when women rarely worked outside the home and were almost completely dependent upon their husbands or fathers for financial support. Even today, women continue to earn less than men in the workplace, and married women typically take on the responsibility of staying at home to raise children, leaving them again dependent upon their husbands. The behaviors described as codependent, such as when a woman tries to maintain control of the household and hold on to the relationship with her husband, can be reframed through the feminist lens as being coping mechanisms and survival tactics in an oppressive situation (Granello & Beamish, 1998; Mason, 1991).

There are political implications of the codependency construct as well. Feminism assumes that women are oppressed under a patriarchal system (Babcock & McKay, 1995). It can be argued that codependent behavior is actually an adaptation to oppression and subservience (Miller, 1986). It can also be argued that codependency was created as a way of continuing to maintain the balance of power within the family.

> Since many families ... were affected by the behavior of the male alcoholic, describing the female spouse and children as also sick helped to detour responsibility away from the male alcoholic. Since defining the alcoholic husband as sick implies that the wife is somehow stronger or 'better' or more healthy threatens the balance of power in traditional families; the notion of 'codependency' became a useful way of ... maintaining a cultural status-quo (Krestan & Bepko, 1991, p. 52).

Codependency also supports the oppression of women by continuing to stigmatize them as having a mental illness (Brown, 1994). The 12-step program movement also perpetuates the myth of codependency as a life-long mental illness through what Asher (1992) calls the 'no-exit model': if a woman stops attending her 12-step program, it is viewed as a sign that she is 'sicker' and needs the group even more than she realizes (i.e., she is once again in denial about the severity of her codependency).

Codependency is also viewed from a feminist perspective as being particularly victim-blaming. When clinicians label a woman as codependent, for example, they are leading her to believe that she is responsible in some way for her husband's alcoholism, which in turn can exacerbate feelings of shame and guilt (Babcock, 1995; Granello & Beamish, 1998; Kokin & Walker, 1995). Asher (1994) notes that blaming the woman for the man's alcoholism, which codependency does, has an inherent flaw: "After all, men who are single nonetheless manage to maintain and intensify their alcoholism" (p. 186). Victim-blaming is also particularly dangerous for women who are living in abusive situations, which are common in alcoholic homes. In these cases, victim-blaming can extend to blaming the woman for the abuse by connecting the abuse to the addiction, which is partially the woman's fault (Babcock, 1995; Fabunmi, Frederick, & Jarvis Bicknese, 1995; Frank & Golden, 1995). As noted above, the codependency construct also serves to maintain the current inequities of power within the family structure, which are exacerbated by domestic violence.

The feminist paradigm also sees codependency as pathologizing the behavior that women are socialized to accept as feminine (Babcock, 1995;

Brown, 1994; Granello & Beamish, 1998; Haaken, 1995). Babcock (1995) states, "The similarity between 'codependency' and the traditional feminine role has been so obvious that most, if not all of us, making the feminist critique have come to this conclusion independently of each other" (p. 20). Women, therefore, are 'damned if they do, damned if they don't' when it comes to their relationship with the alcoholic. If they perform the roles they have been socialized for, they are viewed as codependent, but if they do not, they are seen as cold and uncaring. This is sometimes called the 'codependency trap' (Fabunmi, Frederick, & Jarvis Bicknese, 1995).

Self-in-Relation Theory

An important theory that came out of the feminist movement and is highly applicable to reframing issues of codependency is the self-in-relation theory. Definitions of codependency usually have a reference to a problem of relationship. Self-in-relation theory emphasizes the importance of relationship and connection, particularly for women (Jordan, 1997a). "We are suggesting that the deepest sense of one's being is continuously formed in connection with others ... The primary feature, rather than structure marked by separateness and autonomy, is increasing empathic responsiveness in the context of interpersonal mutuality" (Jordan, 1997a, p. 15). For women, healthy development occurs in relation to others (Jordan, 1997a; Sloven, 1991). Instead of placing the blame for symptoms on an internal pathology, self-in-relation theory emphasizes the lack of mutuality in the relationship as the cause of symptoms (Miller & Stiver, 1997). Self-in-relation theory notes that disconnection can lead to "... depression, anger, isolation, confusion, increased striving for connection, a diminished sense of well-being, and ultimately efforts to make oneself into what one believes is necessary to be allowed into a connecting relationship" (Miller, 1988, cited in Granello & Beamish, 1998, p. 353). This description sounds a great deal like the symptoms of codependency. Self-in-relation theory, then, sees this striving for connection as normal, and describes codependency as "... another form of blaming women for wanting relationships ..." (Miller & Stiver, 1997, p. 221).

Another key concept in relational theory is the importance of shame. Jordan (1997b) describes shame as "... a felt sense of unworthiness to be in connection, a deep sense of unlovability, with the ongoing awareness of how very much one wants to connect with others" (p. 147). Research unrelated to the self-in-relation theorists has emphasized the importance of shame within alcoholic families, albeit with the use of the codependency label (Potter-Efron, 1989). Codependents, says Potter-Efron (1989), experience different types of shame: "'borrowed' shame, critical self-judgment, intimacy blocks, feeling estranged from the world, the caretaker role, and self-defeating behavior" (p. 81). These forms of shame found within "codependents" mirror the symptoms experienced by a sense of disconnection, according to self-in-relation theory.

For the self-in-relation model, it is the emphasis on relationship that explains the impact of 12-step programs. "We believe that it is the mutual empathy and mutual empowerment that these groups foster that make them effective" (Miller & Stiver, 1997, p. 182). Additionally, Jordan (1997b) notes that the 12-step programs also lead to a "... loosening of the grip of shame and secrecy," which is therapeutic (p. 150).

A Case Analysis of "Codependence" from a Feminist Perspective

Brown (1992) presented the case of Tom and Marcy as an example of codependence. Using a feminist paradigm and self-in-relation theory can provide a new way of thinking about this case.

> Let's move through the typical phases ... with one couple - Tom, the alcoholic, and Marcy, the codependent. Marcy adjusts her view of herself and the world to fit Tom's distorted logic. She and the family may hear from Tom that her nagging and overcontrol are the real problems, that he would not have to drink if it weren't for her. So she tries harder to alter her behavior and her thinking, in an effort to please Tom and solve the drinking problem. To no avail. Marcy's self-esteem plummets. She denies for a long time that she feels helpless, depressed, and victimized, because she believes it is her own fault. To counter her sense of self-blame, she bolsters her denial. She tries an outward pose of superiority and pride that announces 'nothing is wrong here.' She begins to feel more shame and increased isolation because her unconscious recognition of the real problem is deepening. She becomes more obsessed with the need to control Tom, to protect him and maintain the nothing-wrong denial at the same time. Her futile struggle for control of Tom

> results in chronic tension, anxiety, depression, underlying resentment, and rage. She worries when Tom drinks and when he does not. Will he come home, lose his job, get killed on the highway, or kill someone else with the car? She denies that she worries. For Marcy, now fully an unhealthy codependent, obsession and preoccupation take over (Brown, 1992, p. 57).

In analyzing this case study from a feminist perspective, several points stand out. First, while there is no mention of Marcy holding a job outside of the home, she is concerned that Tom could lose his job. A feminist lens would propose that Marcy is an apparent victim of economic oppression, which would explain why she is focused on controlling Tom's drinking - the potential cause of his job loss. Additionally, Tom blames Marcy for his drinking, which could be considered a form of verbal and emotional abuse. The codependency model, however, would see Marcy's "nagging" as codependent behavior, and would place some of the blame for Tom's drinking on Marcy.

Self-in-relation theory would identify that there is a lack of interpersonal mutuality between Tom and Marcy. This sense of disconnection is leading to Marcy's symptoms of anxiety and depression. Kaplan (1991) notes that "... to the extent that women seek mutuality of understanding with others, they are often disappointed, especially but not only in relationships with men. This can leave women in a constant state of self loss" which is a key component of women's depression (p. 211). Additionally, Tom's blaming of Marcy is leading to a deep sense of shame for her, and the isolation mentioned is coming from that sense of shame - the feeling that she is unworthy to be in connection with anyone. Her internal rage is due to her inability to own and express her anger, which may be due to her sense of unworthiness. In other words, her shame has made her feel unworthy of connection, and also unworthy of the right to be angry at another person.

This interpretation provides us with a very different picture of Marcy. She becomes a woman experiencing emotional abuse and economic oppression. Her behavior is viewed as an attempt to maintain and improve a connection with Tom, by trying to stop the behavior that she sees as damaging to their connection - Tom's drinking. No longer is she viewed as a woman with a disease that needs life-long recovery. She can now be seen as a woman who needs help in rebuilding a connection with her husband.

Conclusion

Viewed through a feminist lens, it is clear that codependency is a construct with great potential to be damaging to women. While the codependency movement did help to identify a potential area of difficulty for women in their relationships with men, it also created a victim-blaming dynamic that places the blame for relationship problems on women. In essence, codependency is treated in the popular literature as if it were a new personality disorder, with the need for life-long treatment in order to recover from this disease. Instead, it seems that a healthier alternative for women is to view the problems that occur in a relationship with a substance abuser from the self-in-relation perspective. This allows the woman to view herself without blame for her partner's addiction, and to seek new ways of forming mutually empathic relationships with others -- a much more empowering perspective.

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References

Asher, R. (1994). *Women with alcoholic husbands: Ambivalence and the trap of codependency*. Chapel Hill, NC: The University of North Carolina Press.

Babcock, M. (1995). Critiques of codependency: History and background issues. In M. Babcock & C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. 3-34). Toronto: University of Toronto Press.

Babcock, M., & McKay, C. (1995). Introduction. In M. Babcock & C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. xv-xix). Toronto: University of Toronto Press.

Barnard, C. P. (1990). *Families with an alcoholic member: The invisible patient*. New York: Human Sciences Press, Inc.

Beattie, M. (1989). *Beyond codependency*. Center City, MN: Hazelden.

Beattie, M. (1999). *Playing it by heart*. Center

City, MN: Hazelden.
Brown, L. (1994). *Subversive dialogues: Theory in feminist theory*. New York: Basic Books.
Brown, S. (1992). *Safe passage: Recovery for adult children of alcoholics*. New York: Wiley and Sons.
Cermak, T. (1988). *A time to heal*. Los Angeles, CA: Jeremy P. Tarcher, Inc.
Fabunmi, C., Frederick, L., & Jarvis Bicknese, M. (1995). The codependency trap. In Babcock M., & McKay C. (Eds.), *Challenging codependency: Feminist critiques* (pp. 88-92). Toronto: University of Toronto Press.
Frank, P. B., & Golden, G. K. (1995). Blaming by naming: Battered women and the epidemic of codependency. In M. Babcock and C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. 111-114). Toronto: University of Toronto Press.
Granello, D. H., & Beamish, P. M. (1998). Reconceptualizing codependency in women: A sense of connectedness, not pathology. *Journal of Mental Health Counseling, 20*(4), 344-358.
Haaken, J. (1995). A critical analysis of the codependency construct. In M. Babcock & C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. 53-69). Toronto: University of Toronto Press.
Harper, J., & Capdevila, C. (1995). Codependency: A critique. In M. Babcock & C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. 35-52). Toronto: University of Toronto Press.
Jordan, J. V. (1997a). A relational perspective for understanding women's development. In J. V. Jordan (Ed.), *Women's growth in diversity* (pp. 9-24). New York: The Guilford Press.
Jordan, J. V. (1997b). Relational development: Therapeutic implications of empathy and shame. In J. V. Jordan (Ed.), *Women's growth in diversity* (pp. 138-161). New York: The Guilford Press.
Kaminer, W. (1995). Chances are you're codependent too. In M. Babcock & C. McKay (Eds.), *Challenging codependency: Feminist critiques* (pp. 70-78). Toronto: University of Toronto Press.
Kaplan, A. G. (1991). The 'self-in-relation': Implications for depression in women. In Jordan, J.V., Kaplan, A.G., Miller, J.B., Stiver, I.P. & Surrey, J.L. (Eds.), *Women's growth in connection* (pp. 206-222). New York: The Guilford Press.
Kokin, M., & Walker, I. (1995). Codependency is a misleading concept. In Babcock, M. & McKay, C. (Eds.), *Challenging codependency: Feminist critiques* (pp. 81 87). Toronto: University of Toronto Press.
Krestan, J., & Bepko, C. (1991). Codependency: The social reconstruction of female experience. In Bepko, C. (Ed.), *Feminism and addiction* (pp. 49-66). Binghamton, NY: The Haworth Press.
Mason, M. (1991). Women and shame: Kin and culture. In Bepko, C. (Ed), *Feminism and addiction* (pp. 175-194). Binghamton, NY: The Haworth Press.
Miller, J. B. (1986). *Toward a new psychology of women* (2nd ed.). Boston: Beacon Press.
Miller, J. B., & Stiver, I. P. (1997). *The healing connection: How women form relationships in therapy and in life*. Boston: Beacon Press.
O'Gorman, P. (1991). Codependency and women: Unraveling the power behind learned helplessness. In Van Den Burgh, N. (Ed.), *Feminist perspectives on addiction* (pp. 153-166). New York: Springer Publishing Company.
Potter-Efron, R. T. (1988). *Shame, guilt and alcoholism: Treatment issues in clinical practice*. New York: The Haworth Press.
Ruben, D. H. (1993). *Family addiction: An analytical guide*. New York: Garland Publishing
Sloven, J. (1991). Codependent or empathically responsive? Two views of Betty. In Bepko, C. (Ed.), *Feminism and addiction* (pp. 195-210). Binghamton, NY: TheHaworth Press.

Dissertation Abstracts

Successful Family Reunification: The Contribution of Clinical Social Work

Elizabeth Peffer Talbot, Ph.D., LCSW

This qualitative research explores how experienced M.S.W.'s in child welfare practice use the clinical knowledge base of the profession when working with successfully reunified families who had been separated as a result of child abuse and neglect. It also explores how the clinical knowledge base of the profession contributed to the decision to recommend family reunification to the courts. Twelve M.S.W. child welfare practitioners throughout the State of Illinois were interviewed. Each social worker presented the case of a successfully reunified family with whom he/she had worked. The families presented had been separated for a minimum of 12 months and successfully reunified for 12 months. The child sample was bounded by ages 0-12. The data reveals that experienced M.S.W.'s draw from the clinical knowledge base of the profession when working with families and when seeking to justify their decision to recommend family reunification. The study also revealed a list of clinical interventions that contributed to the successful work with the families presented and a constellation of successful variables that demonstrated change and supported the recommendation for reunification.

Social Workers' Countertransference Issues with Spiritually-Similar Clients

James Curtis Raines, M.A., M.Div., Ph.D.

This is a qualitative study of social workers' countertransference issues when providing psychotherapy to spiritually-similar clients. It examined five pairs of social workers and their respective clients and conducted in-depth interviews with each member of the pair as to the nature of the therapeutic relationship, covering four broad areas: similarities, assessment, transference and countertransference, and evaluation of progress. Data analysis was conducted through the use of Nud*ist Nvivo to code transcripts of the interviews into themes. Four themes that appeared across multiple social workers were: 1) the "halo" effect, 2) narcissism of minor differences, 3) sinful feelings, and 4) the usefulness of spiritual literature. Two themes which appeared across multiple clients were: 1) value conflicts regarding homosexuality and 2) mixed feelings regarding medication. Finally, the one methodological theme was the importance of the unasked question. Each of these is discussed for social work practice and education.