Perspectives on Social Work

The Journal of the Doctoral Students of the
University of Houston
Graduate College of Social Work

Volume Nine, Issue One
Fall 2011 and Spring 2012

Perspectives on Social Work

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From The Editor

We are pleased to present the Fall 2011/Spring 2012 Issue of *Perspectives on Social Work.* Submissions represented a wide range of topics from a diverse array of doctoral students. We have seen the quality of submissions rise and our job has become more difficult as we have had to select the few articles to be published from among so many interesting and worthy choices. We appreciate the efforts of all doctoral students who have submitted manuscripts, as well as those who have contributed to our peer review process by reading and commenting on the submissions. This journal would not be possible without the contributions of the writers and reviewers as well as the members of the Editorial Board.

We would like to extend a special thanks to those who responded to our call for outside reviewers. This issue marks the first time we've made an open call for outside reviewers. We believe this decision has greatly influenced the quality of PSW and offered social work PhD students all over the country the experience to participate as peer reviewers. With your numerous personal commitments and deadlines, we appreciate your efforts in reviewing articles during a busy semester.

We thank you all for your dedication and hard work in making *Perspectives on Social Work* a success!

Best regards,
Traber Giardina

Editorial Policy:
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Health Information Portability and Accountability Act of 1996: An Analysis of its Implication Using an Adapted Model

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Abstract

The HIPA Act of 1996 is analyzed using an adapted model: Approach, Need, Assessment, and Logistics. The adaptation comes from McInnis-Dittrich (1994). McInnis-Dittrich uses the word ANALYSIS as a model structure to analyze proposed/enacted policies or programs. The structure was modified to better fit general policies and to flow from element to element by only utilizing the first three components of the structure and by adding a new element, Logistics, which facilitates an outcome and implementation analysis. In addition, the model has been enriched with assessment of values and consequences (intended and unintended). As illustrated through this paper, the adapted model seems to fit well with analyzing the HIPA Act of 1996, a macro level policy.

Introduction

There are many policy models that can be used to analyze proposed and enacted policies. However, most of these focus on the purpose of the policy, and they are more descriptive. Rare are broad policy structure models that can be applied to any policy (micro, mezzo, macro) for an overall analysis, to include descriptive and evaluative components. The attempt in this paper is to test an adapted micro level model on a macro level policy.

A twofold approach is used to illustrate and test the modified model. First, the structure of the adapted model is presented and discussed. Second, the new model structure is applied to the Health Information Portability and Accountability Act of 1996 (HIPA Act of 1996; PL. 104-191). This analysis of the HIPA Act of 1996 primarily focuses on Title II—Preventing Health Care Fraud and Abuse; Administrative Simplification; Medical Liability Reform. This Act is analyzed using an adaptation of McInnis-Dittrich's (1994) model for policy analysis. McInnis-Dittrich uses the letters of *ANALYSIS* for the eight elements of the model: *A* is *Approach* used to the policy*; N* is the *Need* the policy is addressing*; A* is *Assessment* of strengths and weaknesses of the policy; *L* is the *Logic* within the policy; *Y* is *Your Reaction*, which refers to the professional's response to the policy; *S* is the financial *Support* for the program or policy*; I* is *Innovation* to change the policy or program if necessary*;* and *S* is *Social Justice* assessing to what degree is the policy addressing societal and social work values of social justice.

The elements utilized from McInnis-Dittrich's (1994) model are *Approach*, *Need*, and *Assessment*. This author has added a fourth element to the model, *Logistics*—the effects of implementing the policy and its implications (cost, efficiency, adequacy, and goal attainment*)*. In addition to strengths and weaknesses, which is part of the *Assessment* element of the original model, values and intended and unintended consequences are also assessed. The values component was adapted from Prigmore and Atherton's (1986) and Chamber and Wedel's (2009) model; the stakeholder component imbedded in the values section was adapted from Flynn's (1992) and Moroney's (1981) models (see appendix A for more details of model structure). A demonstration of the adapted model is given by analyzing the HIPA Act of 1996. That is, the modified model is tested to determine how well it fits with a macro level policy.

McInnis-Dittrich's (1994) model was chosen because it was designed to analyze the effect that proposed and enacted policies might have in an agency. The focus of the model is to determine if the proposed or enacted policy addresses the targeted need effectively, which includes a professional response to the policy. Simmons and Wright (2008) used this policy model to compare national practices of mental health in the US and the UK. Their analysis seemed adequate for structure. However, the adapted model was strengthened by eliminating *Your Reaction*, *Support*, *Innovation*, *Logic*, and *Social Justice* components and streamlining *Approach, Need, Assessment,* and *Logistics*. Modifications were made to facilitate dynamic fluidity and to allow analysis beyond micro to macro policy levels.

The model has been changed to be interactive between elements—recognizing and discovering how the elements influence one another facilitates greater scrutiny and deeper insight into the intent and the consequence of a policy. Thus, components were removed (*Your Reaction, Innovation, Support, Social Justice, and Logic*) because they were inadequate to guide the analyst into such discernment and understanding of a policy. Furthermore, the model was adjusted to allow the analyst to evaluate policies without restriction on the type or level of policy. For example, McInnis-Dittrich's (1994) component of *Your Reaction* asks for the analyst's reaction. The analyst's goal is not to be reactive but objective and critical—the analyst's emotions and values might interfere with the analysis and inadvertently superimpose his/her values rather than the values within the policy. Although it is understood that one cannot remove oneself completely, minimizing self-imposed values and maintaining a neutral stance to effectively analyzing a policy is necessary. *Support* was excluded because it had limitations in assessing outcome in that *Support* only looks at the finances of the policy. Cost, efficiency, adequacy, and goal attainment are necessary factors in outcome analysis. *Innovation* was not conceptually removed from the adapted model; rather, it was redefined within the *Assessment* and *Logistics* components. *Logic* was not included because each component presumes to follow a logical order. For example, as *Approach* and *Need* of the policy are assessed, the analyst can determine the logic of the policy within each element. Finally, *Social Justice* was the only value examined in McInnis-Dittrich's (1994) model. This limited the assessment of values. Thus, the values section within the *Assessment* component was expanded not to just include social justice but other values as well.

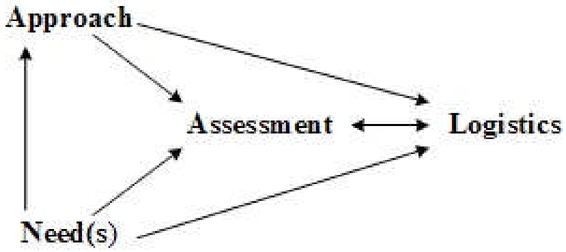
HIPA ACT of 1996

The stated purpose of the HIPA Act of 1996 is "to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets…" (PL 104-191, p.1). This purpose changes the policies of insurance companies, providers, and how individuals receive medical care. Furthermore, it goes on to state, "to combat waste, fraud, and abuse in health insurance and health care delivery…" (PL 104-191, p.1). The prevention of waste, fraud, and abuse in health insurance and health care delivery is the primary area of analysis. This prevention component influences dynamics in practice and research (Arnold, 2008; Fisher, 2008; Fisher & Oransky, 2008; Greenberg, Ridgely, & Hillestad, 2009; Lawrence, 2007).The protection of consumer/patient information, for example, limits researchers' recruiting process. Nevertheless, the overarching goal of the policy is prevention and protection.

Understanding this Act is critical for two reasons. First, the consequences of violating this Act carry penal code sentences. However, it has been debated how and whether prosecution will be enforced (Wielawski, 2009). Second, the Act's aim at prevention and protection is to help the consumer receive high quality service delivery and information regarding services provided to the consumer to be protected (McDonald, 2009; Moore, Snyder, et al. 2007; Walfish & Ducey, 2007). Prevention and protection are present at the macro, mezzo, and micro level of this policy. At the macro level, the policy attempts to prevent fraud and abuse of government and consumer resources (Bodenheimer & Grumbach, 2002). According to Bodenheimer and Grumbach (2002), in the 1990s, managed care was about capitation. Bodenheimer and Grumbach state, "…capitation was expected to slow rising costs, reduce unnecessary medical services, and correct the imbalance between specialty and primary care" (p. 44; Karger & Stoesz, 2002). At the mezzo level, the policy aims to prevent information pertaining to services delivered to become public domain. At the micro level, the policy focuses on basic privacy protection which aligns with statements Ginsberg and Miller-Cribbs (2005) made regarding professional responsibility (Gilbert & Terrel, 2005; Karger & Stoesz, 2002; Lightfoot, 2003). According to Ginsberg and Miller-Cribbs "Human services professionals should think and act beyond their daily tasks to the larger concepts of social change and human services delivery planning" (p. 207). Thus, the provider's task is to protect patient information at all levels.

Policy Analytic Framework

The next section of this paper uses the modified model to analyze the HIPA Act of 1996. Below is a diagram to place the model in perspective (see Figure 1 for model outline):



1. **Approach**—How the policy is organized and methods used
2. **Need**—The needs the policy attempts to address
3. **Assessment**—what is at stake (feasibility; quality; effectiveness)? Is the policy meeting the need? Are their conflicts in values? How likely will there be for misinterpretations and misapplications?
   Values (efficiency, adequacy, and equity)
      Stakeholder Values at micro, mezzo, and macro level (first identify who the stakeholders are before and after the policy was enacted) (fraternity, equality, liberty)
      Social Work Values
   Strengths
   Weaknesses
   Intended Consequences
   Unintended Consequences
4. **Logistics**—the effects of implementing the policy and its implications (cost, efficiency, adequacy and goal attainment)

Figure 1. ANAL Policy Model[1]

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[1] The model was adapted from: McInnis-Dittrich (1994)—Approach, Need, Assessment; Prigmore and Atherton (1986), Chamber and Wedel (2009), Flynn (1992) , Moroney (1981)—Values; and Jose Carbajal—Logistics.

As shown in the diagram above, the elements are dynamic and intertwined. First, *Approach*, which looks at the structure of the policy, is influenced by *Need*(s). Second, *Approach* and *Need(s)* influence *Assessment*. *Assessment* in essence is the core of analyzing the policy. Third, *Assessment* is influenced by *Approach*, *Need(s)*, and *Logistics*. Finally, *Logistics* is influenced by *Approach*, *Needs*, and *Assessment*. Note that this model is used with an active policy. However, to analyze a proposed policy, the sequence of analyzing the policy would be *Need(s)*, *Approach*, *Assessment*, and *Logistics*. The sequence changes because the need, which is identified and determined first, will influence the approach to the policy. Therefore, for a proposed policy, the arrow changes direction.

Analysis of HIPA Act Using the Adapted Model

Approach

In this section, the policy is analyzed regarding organization. The HIPA Act has four titles. Title I is Health Care Access, Portability, and Renewability. Under Title I, the main issues addressed are: 1) access and portability for those with pre-existing conditions; 2) regulation regarding the protection of patient health information; and 3) the availability of health care insurance. Title II, the section of policy under analysis, deals with Preventing Health Care Fraud and Abuse; Administrative Simplification (electronic exchange standards and security of health care information); and Medical Liability Reform. Additionally, Title II provides regulations establishing, monitoring, and reporting standards for fraud and abuse of health care services. Furthermore, sanctions and penalties are established for fraud and abuse of health care services. Finally, the national healthcare clearinghouse was established. Title III is the Tax-Related Health Provisions. Under Title III, higher tax deduction provisions are made to self-employed individuals; deduction for medical savings account is allowed; regulation regarding long-term health care services and contracts and state insurance pools receive exemptions from income tax. Title IV is Application and Enforcement of Group Health Plan Requirements. This Title addresses group health care plan requirements and continuation of care coverage. Finally, Title V is Revenue Offsets. Under Title V, company owned life insurance is regulated; regulation on individuals who lose US citizenship and tax compliance reports on those living abroad is established.

Need

In this section, the policy is analyzed on the needs the policy attempts to address. The need the policy addresses, as stated above, is “to combat waste, fraud, and abuse in health insurance and health care delivery…” (PL 104-191). The need to control fraud and abuse is met by establishing federal, state, and local law enforcement. Furthermore, current sanctions are revised for fraud and abuse, and a national data collection is established to report final adverse actions against practitioners and suppliers. The sanctions include civil monetary and imprisonment penalties for various violations in which criminal law is revised to protect confidential information disclosed in court proceedings that are not part of the investigation. The revised sanctions are intended for those that are fraudulent and that abuse the health care system via “fraud, theft, embezzlement [coding or unnecessary medical claims on item or service in order to receive greater payment], breach of fiduciary responsibility, or other financial misconduct” (PL 104-191).

Finally, the need to combat waste is achieved through the establishment of national electronic transmission which establishes uniformity and reduces duplication and coordination of Medicare related plans. The duplication and coordination of Medicare related plans is to facilitate exchange of information amongst practitioners and suppliers. Furthermore, under this section, disclosure of protected information for coordination of services is permitted without patient authorization. The consent of the consumer is optional for these purposes except the disclosure of psychotherapy notes. Thus, waste is reduced through this process of streamlining information, communication, and coordination of services.

Assessment

Values. Values are ingrained in social welfare policies (Moroney, 1981). These values often compete or are dimensionally juxtaposed. According to Moroney (1981):

> Values influence the selection of a specific policy issue and how it will be defined. Values are the basis for setting policy goals and objectives, for selecting criteria, for comparing policy options to achieve these goals and objectives, and for evaluating policies once they are implemented. (p. 85)

Furthermore, values are often more subtle than obvious. Therefore, scrutiny is required to unmask hidden values that sometimes mask purposes. The HIPA Act does not escape this reality. The traditional value perspectives of *efficiency*, *adequacy*, and *equity* by economists are helpful here (Chambers & Wedel, 2009; Moroney, 1981). *Efficiency*, which has to do with cost-effectiveness, is used in this policy. One of the purposes of the policy is to reduce health care cost.

The question of whether this is accomplished is answered by *adequacy*, which has to do with the magnitude of the policy to create sufficient changes. In this policy, in terms of cost reduction as an overall goal, adequacy is not accomplished (Banks, 2006; Bodenheimer & Grumbach, 2002). However, in terms of fraud and abuse, the policy is effective in capturing those already prosecuted. Furthermore, the coordination of services among providers and health care clearinghouses meet the goal of cost reduction. The establishment of uniformity code sets for treatment and billing seems to reduce cost as well.

Equity, which has to do with fairness and equalization of service provision, seems to be prominent in this policy. *Equity* is most prevalent in Title I and throughout the rest of the Titles. Specifically, on Title I, the portability and access of health care regulates insurance policies for individual and group markets to help the consumer. *Equity* is also seen through the other Titles via cost reduction, fraud and abuse of health care services. Therefore, the prevention of fraud and abuse, specifically in Title II, is to decrease the overall expenditure for public health care services.

Stakeholder values. Within this policy, the stakeholders are insurance companies, healthcare providers, consumers, and the federal, state, and local government. Each individual entity has its values. The insurance companies focus on profit and delivery of services at a high profit margin with low cost to providing those services. The provider's focus is two-fold. First, the provider focuses on providing services. Second, which is most important from a billing perspective, is reimbursement for services provided. The consumer's perspective is the quality of services provided and efficiency. In addition to efficiency, the underlined value is equity and liberty, and to have services available and to choose from whomever the consumer decides. The federal, state, and local government focuses in reduction of cost (*efficiency*) to the government in all the levels, and to prevent fraud and abuse (*adequacy*). In terms of equity, the government regulates how these services should be provided. The establishment of national data code sets provides equity for all regardless of gender or race. Therefore, "based on the recognition of common human needs," the government has placed (within this policy) a residual approach to repair a health care system that is broken and in need of assistance in which universal provisions for services and prevention of health care fraud and abuse are established (Moroney, 1981, p.94).

Insurance companies. As the government established universal regulation on health care services, insurance companies ensured that the profit margin would remain high. According to Bodenheimer and Grumbach (2002), "…the force that began to erode professionalism dominance was not the government but the large private managed care corporations that forcefully asserted their influence in the 1990s" (p.65). This was done by creating health maintenance organizations (HMOs) and preferred provider organizations (PPOs) best known as In-Network providers. The implication was that although a greater freedom of services is supposed to exist in health care, it does not due to HMOs and the creation of Network providers. In other words, individuals are discouraged to seek out-of-network providers due to higher out-of-pocket expenses. In effect, the insurance companies use the same approach of efficiency the government uses in uniform fee schedules to reduce cost (Gilbert & Terrell, 2005); consequently, insurance companies use selective contracting (network providers) as a mechanism to reduce costs (Brodenheimer & Grumbach, 2002)

Providers. For providers, efficiency through the national clearinghouse was achieved. However, equity was decreased. In order for providers to provide services, they have to be paneled by insurance companies; otherwise, the consumer would have to pay privately or pay higher fees for the services that someone else who is contracted with an insurance company could provide and thus pay less for the services. Also, this means that providers are more willing to provide services to those that are privately funded rather than through HMOs or Managed Care companies. Thus, not everyone has access to all the providers but only to selected providers within the medical plan. Furthermore, providers are limited to whom they are able to provide services because consumers are less likely to seek out providers who are not within their network.

Consumer. The policy is supposed to provide liberty to the individual to choose among health care providers or services. However, it limits freedom based on HMOs and participating providers within the medical plan of the person. The question of equity is also addressed through providing services to everyone. However, as stated above, consumers do not have a choice based on their plan. Thus, equity of services for consumers is limited to within network providers.

The federal, state, and local government. Fraud and abuse of the health care system has been prevalent. Therefore, the residual model of Moroney's (1981) second step as discussed above is applied here (Moroney, 1981, p.92). The second area is the incremental social change (Moroney, 1981). The radical reform is seen through sanctions and penalties of those that violate the policy (Moroney, 1981, p. 93).

Social work values. The values ingrained in the profession of social work are addressed in this policy. Specifically, the values addressed are *service*, *social justice*, *dignity and worth of the person*, *integrity*, and *competence*. Some of the values are more direct, whereas others are indirect.

Service. The manner in which *Service* is addressed is by the purpose of the policy: to reduce cost and prevent fraud and abuse in healthcare.

Social justice. As stated above, one of the government's values within this policy is fraternity. Fraternity is seen through the equity of service provision. However, due to the nature of stakeholder's responses to the policy implementation, this might not be accomplished as desired.

Dignity and worth of the person. The privacy rule seeks to protect the dignity of the person by ensuring patient health information is protected from misuse or inappropriate disclosure (Gostin & Nass, 2010).

Integrity. The value of integrity is throughout this policy, as a significant purpose is to ensure no fraud and abuse exists among those providing the services (insurance companies and providers). Therefore, the policy overtly demands integrity.

Competence. Although competence is more of an indirect value, the HIPAA Privacy Rule establishes guidelines for providers to ensure consumers are fully aware of their treatment and use of their information. This is accomplished in two ways. First, the consumer must acknowledge that he or she understands the informed consent and office practice policies. Second, the provider is supposed to explain to the consumer the extent of confidentiality and how laws apply to their protected information.

Weaknesses. The weakest aspect of the HIPAA policy might be the use of an information disclosure for billing purposes and information held by noncovered entities. Under this policy, disclosure of patient information is authorized for processing, clearing, settling, billing, transferring, reconciling, or collecting a payment for, or related to, health plan premiums. While the Privacy Rule protects patient health information held by covered entities (insurance companies, providers, and health care clearinghouses), Gostin and Nass (2010) point out, "…personal data held by numerous noncovered [sic] entities remain unregulated, such as data management or data warehousing companies, pharmaceutical companies, and public health agencies" (p. 1373). In addition, though patients can give consent to release their information, many patients do not understand the consent they are giving (Gostin & Nass, 2010).

The use of technology increases the risk of protected information to be breached. Technology might cause an unintended disclosure. For example, electronic documents might be sent to the wrong place or someone might break into the server where the patient protected information is kept (Gostin & Nass, 2010). In the study conducted by Cooper, Collman, and Neidermeier (2008), they explored how breach of confidential information occurs. They discussed the technical glitch Kaiser Internet Patient Portal (Kaiser Permanente Online [KP online]) experienced whereby confidential and member's personal health information was emailed to unintended member queries. This breach, due to server malfunction and not to human error, exposed confidential information to people without authorization to receive such information.

Strengths. The strengths of the policy are based on the attempt to prevent fraud and abuse of the health care system. The national data collection of adverse actions against practitioners and suppliers allows the public to feel safe and protected. The sharing of data with representatives of health plans reduces cost. Furthermore, the access to documentation in respect to fraudulent activities facilitates the monitoring and prosecution process.

The establishment of safe harbors aims at protecting the public. The intent is to increase patient protection and reduce cost. The safe harbors are in place through the access to health care services that provide freedom of choice among health care providers, the ability of health care facilities to provide services in medically underserved areas, the cost to federal health care programs is reduced through monitoring potential over and under-utilization of health care services; and, the ability to contract with health care providers to provide services that are in existence or nonexistence. In addition, practitioners are allowed to waive coinsurance and deductible amounts in order for the patient to continue receiving the service if the practitioner determines the patient is in financial need. However, the practitioner cannot advertise or solicit patients by stating that the practitioner will waive the coinsurance and deductible amounts.

The policy also includes sanctions for violation of healthcare fraud and abuse. This includes “unlawful manufacturing, distribution, prescription, or dispensing of a controlled substance” and false certification of services (PL 104-191). The penalties vary from license revocation, suspension, or termination to life imprisonment. This also includes loss of contract. However, depending on the severity of the violation, practitioners receive an opportunity of a corrective action plan to complete. Nevertheless, once the adverse action is finalized, the practitioner’s name and fraudulent act is reported to a national data bank.

The consumer is also protected in the process of prosecuting a provider for fraud and abuse. Thus, obstruction of criminal investigations of health care offenses is a provision to protect the public. In this provision, there is a limitation clause that states:

> Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health. (PL 104-191, sec. 248.3486.4[e])

This provision clause protects the consumer from information disclosed to the practitioner in confidence.

In addition, the Privacy Rule in section 261 to 264 was modified by the Department of Human Health Services (DHHS) in 2002 to strengthen this clause even further (65 FR 82462). DHHS increased security measures for protecting individual’s information and gave significant rights to consumers such as the use and disclosure of their information. Thus, the privacy section becomes the strongest section of the HIPA Act.

Finally, the strongest aspect in terms of reducing cost to health care is through the establishment of health care clearinghouses. The administrative cost reduction is to all the stakeholders through the electronic exchange of information. The electronic exchange includes health claim attachments, plan enrollment and disenrollment, eligibility for a health plan, health care payment and remittance advice, health plan premium payments, first report of injury, health claim status, and referral certification and authorization. The electronic exchange process also accommodates the needs of specific providers. The establishment of code sets to uniquely identify a person and treatment diagnostic allows for standardized allowable payments for specific codes. The unique identifiable code is for both patient and provider or supplier. The patient has the identification number on their medical card and the provider or supplier has the national provider identifier (NPI) number.

Intended consequences. Intended purposes of the policy are more obvious and overt. For example, the establishment of uniformity for treatment and payment shows how the purpose of the policy is meeting this goal. Moreover, the electronic exchange of information to electronically standardized documents is to reduce cost and medical errors (K. Chung, D. Chung, & Joo, 2006). Consequently, however, a great increase in technology use and creation of new markets was expanded (K. Chung, D. Chung, & Joo, 2006). Furthermore, the Privacy Rule is geared to protect the privacy of individual Patient Health Information (PHI) (Committee on Child Abuse and Neglect, 2010; Ness, 2010). In accordance to the purpose of the policy, the Privacy Rule was modified in 2002 by DHHS to ensure that consumers are protected, especially with the use of electronic transactions.

Unintended consequences. In policy, interpretation is not consistent. Therefore, unintended consequences result from the policy. For example, for billing purposes, providers are supposed to use the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) codes. In addition, the policy states that only medically necessary treatments are reimbursable (section 231e). The problem lies in the misuse or over use of diagnostic codes for reimbursement purposes. Codes such as V61.20 (Parent-Child Relational Problem) or V61.10 (Partner Relational Problem) are not reimbursable because they are not considered medically necessary. Therefore, providers use codes such as 309.3 (Adjustment disorder with disturbance of conduct) or 309.28 (Adjustment disorder with mixed anxiety and depressed mood). The overuse or misuse of these codes is fraud and abuse, to an extent, according to the policy. However, to prosecute someone for misusing a diagnostic code is more difficult and costly. According to section 231e of the HIPA Act, a person is not supposed to use code sets in order to receive “greater payments.” Consumers often seek services for issues not considered medically necessary. Under the HIPA Act, only medically necessary services are reimbursed; thus, the HIPA Act is violated.

The creation of multiple Electronic Data Interchanges (EDI) and the increase of formats that sometimes do not meet specific entity requirements has been a challenge (K. Chung, D. Chung, & Joo, 2006). This has also required providers to increase maintenance of technological software to ensure security, which was purposefully designed to protect consumer’s information. In addition, this has increased cost to stakeholders to keep up with developing technologies and improvements (K. Chung, D. Chung, & Joo, 2006).

Another unforeseen consequence is the effect the policy has had on researchers. In a study conducted by Ness (2010) to determine whether the privacy rule has affected researchers, she found “a majority of respondents reported that the degree to which the rule made research easier was low,” and “that the degree to which the rule made research more difficult was high” (p. 2166; Campbell, Sosa, Rabinovici, & Frankel, 2006; Damschroder et al., 2007; Gostin & Nass, 2010). In addition, in terms of randomization for research studies, the Privacy Rule limits the researcher’s ability to conduct promising studies in which valid conclusions could be made (Damschroder et al., 2007).

A complete juxtaposed consequence has been the increased risk of inappropriate accessing of PHI (K. Chung, D. Chung, & Joo, 2006). This consequence is due to the easy accessibility of information. For example, agencies usually keep files in a central location that is available to all those that have access. Technically, agencies are supposed to safeguard this information with security measures that decrease the disclosure of information to other staff members of the agency that are not involved in the case. However, it is a common practice in agencies to debrief about cases. This is not an issue if the PHI is de-identified; in the process of debriefing however, partially due to the nature of the case and Freudian slips, PHI information is disclosed to someone that is not supposed to have access to that information. This also leads to other consequences of electronic use. More is discussed on this in the *Logistics* section.

Logistics

In this section, the policy is analyzed concerning the effects of the implementation of the policy. There is no immediate effect on cost reduction, and uncertainty exists on how much has been saved (Banks, 2006; Bodenheimer & Grumbach, 2002). However, there is agreement on the efficiency created through the electronic transaction, which is expected to reduce cost in the long run. According to Chung, Chung, and Joo (2006), “although the initial startup cost is estimated to be considerable, most agree that long-term savings will be greater” (p. 55). Furthermore, the execution of uniformity for exchange of information has been problematic in terms of the type of software and technology used (K. Chung, D. Chung, & Joo, 2006; Huang, Chu, Lien, Hsiao, & Kao, 2009). Gaps might exist in technology across stakeholders. For example, in order to reduce expenditures, providers might not have access to the most updated software. Therefore, this policy, in terms of efficiency is setup to have long-term savings while increase of cost is upfront (Banks, 2006).

In addition, PHI delays consumers from receiving services. For a seamless process to occur and no interruption of services, it requires providers to be in collaboration or associated to different entities; otherwise, the process of releasing information becomes cumbersome and tedious (Huang et al., 2009). Huang, Chu, Lien, Hsiao, and Kao (2009) suggest using software that will de-identify the patient’s information and create pseudonymity. In this way, information could be provided to others without needing authorization from the patient. This seems to help in cases where immediate medical decisions need to be made and in decreasing duplication of services. For example, if a consumer had been receiving services somewhere else for a problem that has already been determined, the same procedure that another provider might have performed due to an initial visit, the procedure might be eliminated and thus reduce cost.

Discussion/Conclusion

The HIPA Act of 1996 is a comprehensive policy. However, this policy is rarely viewed for the total effect it has in society. Most people focus on the PHI section and neglect the national uniformity it has created on health care services. Another policy that is neglected is continued health insurance coverage known as COBRA, which is intended to ensure that consumers do not lose health care benefits in between employments. COBRA was established under the purpose of the HIPA Act of 1996, “to improve portability and continuity of health insurance coverage…” (p. 1). The current policy signed by President Obama, *Patient Protection and Affordable Care Act* (PPACA) appears to be an extension of the HIPA Act of 1996. Therefore, in terms of changes to the health care system, PPACA only appears to make revisions to other policies already in place in addition to eliminating and adding other programs.

In terms of the model, the modifications were beneficial to analyzing this policy. The element *Approach* was redefined as how the policy is organized and the methods used. There were no changes to the *Need* element, which was defined as the need the policy is addressing. The *Assessment* element was redefined as: 1) what is at stake (feasibility, quality, effectiveness)? Is the policy meeting the need, and are their conflicts in values? How likely will there be for misinterpretations and misapplication? 2) Values (efficiency, adequacy, and equity), stakeholder values at micro, mezzo, and macro level (first identify who the stakeholders are fraternity, equality, and liberty), social work values, strengths and weaknesses (intended and unintended consequences). The *Logistics* element was defined as the effects of implementing the policy and its implications (cost, efficiency, adequacy and goal attainment).

The structure of the modified model is easy to follow. The discussion within each element provides a comprehensive understanding of the policy. Furthermore, the *Logistics* element is helpful in analyzing the implementation and its implications. Often models do not include an evaluative component. Thus, this new model expanded the analysis. This allowed for a breadth and depth evaluation of the policy. Furthermore, as policies have values ingrained, it was necessary to add a value component to the *Assessment.* Additional elements to *Assessment* of feasibility, quality, effectiveness, strengths, and weaknesses provided framework to include the intended and unintended. In McInnis-Dittrich (1994), *Social Justice* is one of the elements to assess values; however, there is only a broad level focus and it does not flow from element to element.

Regarding the discussion within each component, an explanation is needed. Although some of the sections had greater discussion than others and might seem imbalanced, the purpose of policy analysis is to ensure comprehensive scrutiny. One must consider the reality of policies which are inherent to misinterpretations. That is, policies address a need which is carried out with an intended consequence in mind based on a goal. However, once a policy is enacted, it is open to interpretation and thus unintended consequences ensue. Therefore, the discussion should not be weighed on the balance of each section but rather on comprehensiveness. Moreover, the modified model accomplishes the purpose of analyzing a policy at a macro level seamlessly.

A limitation within this policy analysis is the stakeholders' section. A suggestion for improving this area is to look at who influences the policymaker. The pharmaceutical companies, for example, were not included. They play a strong role in policymaking and therefore they must be considered as well. This limitation highlights a reality of policy analysis—stakeholders are within complex systems in which lobbying often obfuscates each individual's role. There are two aspects to consider when analyzing stakeholders: the lobbyists' influence on the policymakers and the population (groups) affected once the policy is enacted. This dual approach of pre and post policy enactment analysis would illuminate who are the stakeholders.

Finally, a limitation of the adapted model is based on the fact that it has only been tested on a macro level policy. In order to determine suitability with other policies it needs to be tested with micro and mezzo policies. It is also encouraged to retest this adapted model with another macro policy to corroborate the validity of its claim.

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Strength and Resilience of Homeless, Single Mothers: A Focus Group Analysis

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Abstract

A qualitative research design was used to explore the views of homeless, single mothers. The research was guided by a phenomenological perspective by collecting data on the lived experiences of the research participants. Eight women participated in a focus group. Analysis of the statements given by the research participants resulted in the identification of two themes: 1) connectedness; and 2) sources of strengths. This article describes each theme and discusses implications for social work practice and research.

Introduction

On any given day, it is estimated that between 664, 000 to 800,000 persons are without shelter or are sheltered homeless in the United States (National Association of Social Workers [NASW], 2009), and 30% to 60% of this population experience problems related to substance abuse (Thompson, Barczyk, Gomez, Dreyer, & Popham, 2010; Zlotnick, Tam, & Robertson, 2003). The greatest increase in prevalence of homelessness in the United States is with single women who have children (NASW, 2009). Exiting homelessness has been a challenge for this population because few resources are available for homeless women with children; as a result, they often find themselves in situations that compromise their safety and health (Brown & Ziefert, 1990). It has been suggested that women are more likely than men to find themselves homeless due to being victims of financial crisis, trauma, domestic violence, and rape (Brown & Ziefert, 1990; NASW, 2009).

Literature Review

Research in the area of exiting homelessness has explored many topics, such as the perceptions held by homeless individuals towards the quality of services they receive and the role of self-determination in the process of exiting homelessness (Brown & Ziefert, 1990; Pollio, McDonald, & North, 1996). The topics most often cited as significant challenges for people exiting homelessness are untreated substance abuse and mental health symptoms (Thompson et al., 2010; Zlotnick et al., 2003). A qualitative study by Thompson, Pollio, Eyrich, Bradbury, and North (2004), for example, found that individuals who were homeless and had substance abuse and mental health disorders were more likely to maintain their exit from homelessness if they had personal relationships with family and friends, active involvement in community resources, and intrinsic motivation to change.

Cohen and Burt (1990) suggests that those who provide services to individuals who are homeless with substance abuse and mental health symptoms make exceptional efforts to not only provide the basic needs, such as shelter and food, but also offer interventions that support recovery from substance abuse and mental health symptoms. In a recent study, Sutherland, Cook, Stetina, and Hernandez (2009) suggests that more knowledge is needed to identify interventions that effectively support and strengthen women's existing protective factors, which may promote substance abuse and mental health recovery, as well as an exit from homelessness. This study, following the suggestion by Sutherland et al. (2009), contributes to the current body of literature related to women's protective factors by asking women who are homeless and have a history of substance abuse about their perceived strengths, resiliency, and motivations that contributed to their exit from homelessness. The purpose of this exploratory research is to answer the following two research questions.

1. What are the views held by participants of Hopeful Solutions, Inc. that promote their exit from homelessness and encourage their continued improvement of quality of life?
2. Do the views held by the participants of Hopeful Solutions, Inc. have practice and research implications related to homeless mothers who are in the process of exiting homelessness?

Methodology

Focus groups were facilitated to collect data to answer the study's two research questions. Hopeful Solutions Inc. (HS Inc.) was selected to recruit participants for the research because HS Inc. provides services to homeless mothers who are in the process of exiting homelessness. A focus group methodology was selected because focus groups are recommended for research samples that have similar characteristics (Padgett, 2008). For this study, all research participants were homeless mothers who had a history of substance abuse. Focus groups that enroll participants with similar characteristics can have a synergistic effect, which may result in a comprehensive understanding to a single question or idea (Padgett, 2008). An additional rationale for the use of a focus group methodology is that focus groups have been used in other research topics to successfully explore and develop a thorough understanding of concepts such as strengths (Bender, Thompson, McManus, Lantry, & Flynn, 2007), resiliency (Singh, Hays, Chung, & Watson, 2010), and protective factors (Okamoto, Mayeda, Ushiroda, Rehuher, Lauilefue, & Ongalibang, 2008). The focus group design was embedded in a phenomenological perspective. A phenomenological perspective is structured in a manner that captures the lived experiences of research participants, with an understanding that the sharing of lived experiences can provide an in-depth answer to the research questions (Padgett, 2008).

Prior to beginning the recruitment process, written permission to facilitate the research was received from both the Executive Director of HS Inc. and the Institutional Review Board at the University of Texas at Arlington. Informed consent was received from all individuals who chose to participate in the research. Following the informed consent process, each of the eight research participants completed an 8-question demographic survey. Participants of HS Inc. were offered two dates to participant in a focus group. Four participants attended the first focus group and another four participants attended the second focus group. The focus groups were facilitated primarily by one researcher, while the other researcher audio recorded the sessions and documented nonverbal communications, such as body language and posture, from the research participants. Each focus group was 60-minutes in length, and the discussion centered around five open-ended questions related to the participants' views regarding their life experiences. The focus group questions are included in Table 1.

Table 1

Focus Group Questions

1) What are your motivations for participating in Hopeful Solutions Inc.?
2) What advice do you have for women in your situation who are considering participating in Hopeful Solutions Inc.?
3) What are those supports in your life that encourage you to continue to improve the quality of your life?
4) What strengths do you possess that assist you in meeting your life goals?
5) What do you want your life experience to look like in the future?

Data Analysis

The quantitative findings are associated with the information received from the 8-question demographic survey. The demographic survey provided a detailed summary of the research participants' demographics, substance abuse and mental health history, length of time participating in HS Inc., and referral source to HS Inc. The qualitative data analysis involved content analysis and constructivist grounded theory. To further enhance the validity and reliability of the data analysis, Drake and Jonson-Reid (2008) suggest that the researchers doing the coding be trained in similar methods of coding, and independently create coding schemes and compare the results in order to decide on the code that is most consistent with the theoretical orientation of the research. The researchers for this study have been trained in similar methods of coding and have analyzed qualitative data together in past studies.

NVivo was used to organize the qualitative data and assist with the analysis. The qualitative analysis followed a three-step process, as suggested by Miles and Huberman (1994). First, a verbatim transcription of the focus groups was developed. Each line of the verbatim transcription was independently reviewed by each researcher, and the data were initially reduced by developing various codes. Second, each code was displayed on a matrix. During this process, the researchers' independent analyses were compared, and codes that lacked a significant relationship among variables and demonstrated a lack of consistent responses from the research participants were excluded. Third, conclusions were drawn by extracting two themes from the data; verification of each theme was done by assigning direct quotes from the focus groups to each theme. Last, an external audit of the themes was completed by an academic who has expertise in qualitative data analysis. The external audit provided a critique of the analysis and further validation of the themes that emerged from the data.

Findings

One focus group consisted of four individuals who have been participating in HS Inc. for less than 6 month and the other focus group consisted of four individuals who have been participating in HS Inc. for six months or more. A descriptive summary of the research participants was provided through the 8-question demographic survey. The results of the 8-question demographic survey are noted in Table 2.

Table 2
Demographic Survey (n=8)

1) How long have you been at Hopeful Solutions Inc.?	1 – 2 months = 4 (50.00%) 12 – 18 months = 4 (50.00%)
2) How old are you?	Range = 24 - 40 years Mean = 32.25 years
3) What is your ethnicity?	African American = 3 (37.50%) Caucasian = 3 (37.50%) Latina = 2 (25.00%)
4) How old were you when you first started using illicit drugs/alcohol?	Range = 12 - 20 years Mean = 16.00 years
5) What illicit drugs/alcohol have you used in the past? (identify all the apply)	Cocaine = 7 (87.50%) Methamphetamine = 4 (50.00%) Ecstasy = 6 (75.00%) Hallucinogens = 4 (50.00%) Opiates (prescription) = 3 (37.50%) Marijuana = 7 (87.50%) Heroin = 1 (12.50%) Alcohol = 5 (62.50%) Benzodiazepines = 5 (62.50%)
6) How long has it been since your last use of any illicit drug/alcohol?	Less than a month = 1 (12.50%) 7 – 8 months = 1 (12.50%) 12 – 18 months = 3 (37.50%) 18 – 24 months = 3 (37.50%)
7) Have you ever been diagnosed with a mental illness? (if yes, identify all diagnoses that apply)	Yes = 6 (75.00%), No = 2 (25.00%) Major Depression = 4 (66.67%) Post Traumatic Stress Disorder = 2 (33.33%) Bipolar Disorder = 3 (50.00%) Anxiety = 4 (66.67%)
8) Who referred you to Hopeful Solutions Inc.?	Drug Treatment Center = 5 (62.50%) Counselor = 1 (12.50%) Self = 2 (25.00%)

The qualitative analysis resulted in the emergence of two themes. Throughout the focus groups, a number of major thoughts and ideas were expressed consistently by the research participants. The two themes that emerged from the data were: connectedness and sources of strengths.

Connectedness

The first theme drawn from the data was connectedness. The research participants expressed their desire to feel a sense of connectedness to self, family, and community. The research participants also explained how being involved in a nurturing, nonjudgmental environment contributes towards reaching their aspirations.

> When people do not understand you and judge you, it makes it a lot more difficult, a lot harder for you to get anywhere.
>
> When you have people who understand you, it helps you build your self-esteem and get stronger.
>
> I am definitely not getting any younger, and there are definitely things that I want in my life and in the life of my children…how I was living there is no way I would be able to obtain it. I am just grateful for having a support system that does understand; it motivates me to be here.

The women discussed the sense of connection that removes them from the isolation of addiction and homelessness.

> …you have to be comfortable enough to open your mouth and speak, just speak. Just to say, you know what, today I feel like I ain't shit. And, someone can look at you and be like I had that feeling the other day too. So, it removes you from that isolation of thinking that you are the only one.

In addition to being involved in a nonjudgmental environment and feeling removed from the isolation of addiction and homelessness, the women also discussed how having a positive belief in self connected them to their personal strengths which resulted in them developing a stronger bond with their children.

> I had to redefine my belief in myself because when I got to treatment I had nothing. I had no belief in me. I was dead inside. I'm finding out that I do have a lot of strengths, a lot of assets, and a lot of really good things that can carry me a long way…it's a process for me to learn how to believe in myself because I didn't have that when I got here (HS Inc.) …I know that I can look at my kids' faces and I can see my progress, I must be doing something right.
>
> I definitely believe in myself now because before I got to Hopeful Solutions I had a plan in my mind when I was graduating my drug program that I wanted to be in Texas with my children because without that I know I probably wouldn't be sober today. I probably wouldn't be sober at all…I just knew I needed to be here.

In summary, the women felt that living in a nonjudgmental environment assisted them in feeling connected to self, family, and community. This sense of connectedness helped the women feel less isolated which enhanced their parenting relationships with their children.

Sources of Strengths

The second theme which emerged from the data was sources of strengths. The research participants primarily mentioned intrinsic sources of strengths in their lives. While the women did discuss extrinsic strengths, such as family, the mention of extrinsic strengths was not as significant as the focus they placed on intrinsic strengths, such as spirituality.

> I am aware of what my faults are, what my wrongs are, and I just face it, pray about it… sometimes I forget to pray and I just slip right in and God helps carry me, helps me go through the rest of the way, and the day will be good.
>
> My strengths are my God. I talk to Him on a daily basis to keep me going.
>
> I believe that I can do anything that's possible through the strength of God's hands.
>
> I've placed myself in through God's help because I know that I would not be here without His help. I know He was doing for me what I could not do for myself.

Additionally, experiencing a personal sense of independence contributed towards the women feeling empowered to parent and make positive choices that impact both their and their children's lives.

> My future for me is to have all three of my kids together with me…just to have them back with me and to live, all of us live in the same house together, that's my future…to be supporting them, for me to be supporting them and to do for them what they need and give what they need.

> I have been here a few months now and I feel good about myself; that I can be able to grow up, be a mom, be independent, and be somebody that I thought I never could be… there's no way I am going back, my independence and my child mean more to me than anything, I am tired of living off of other people.
>
> …today I have a choice, I do have a choice to make a difference. I have a choice to make a difference in my life and my kid's life and maybe someone else's.

The use of affirmations was continuously referred to throughout the focus groups. Affirmations, in the view of the women, are a daily source of strength that assists them in maintaining motivation to continue the process of improving the quality of their lives.

> …determination, my God, my affirmations. I always have to tell myself everyday that you are a beautiful, strong, important woman…that's what I tell myself every day.
>
> One of the first things that I learned in recovery was affirmations and how to use affirmations. Whenever I got here (HS Inc.), I did not believe a lot in myself because my past history has shown me that I did not do very well. You know, so, I had to use a lot of affirmations to keep myself going because my own thinking will tell me that I'm not good enough or I'm not smart enough…so, I start off in the morning with I'm beautiful, I'm grateful, and I'm clean.

In summary, the women shared that the use of spirituality and affirmations assisted them in feeling more independent and empowered to make positive choices that impact both their and their children's lives.

Discussion and Social Work Implications

Participants of HS Inc. reported most frequently spirituality, competence, and affirmations as intrinsic sources of strength. Spirituality is an intrinsic protective mechanism that gave participants a sense of protection, motivation in their lives, assistance with the recognition of their own values and worth, and positive attitudes about change. Competence is exemplified with the participants experiencing a sense of motivation to parent and desire to make positive choices that impact their lives, as well as their children's lives. Participants also noted the use of affirmations on a daily basis to motivate them to meet their goals, to maintain change, and to improve their lives.

Extrinsic supports commonly identified by the research participants include family support and community support. Participants expressed their desire to feel a sense of connectedness by being engaged in a nurturing, nonjudgmental environment. Participants discussed that as a result of being in a safe, structured environment like HS Inc., they have experienced an increase in positive self-belief and a stronger bond with their children. Surprisingly, participants emphasized more intrinsic supports, as compared to extrinsic supports. A possible explanation is that the resources offered by HS Inc. are designed to meet the immediate needs of the participants, such as housing, food, and safety; therefore, more individual attention can be dedicated to the awareness of intrinsic strengths.

From the sharing of their own lived experiences, the research participants were able to contribute to the existing knowledge base, as well as help guide the direction of future research in this specialized area. It is important to mention that many unanswered questions arose throughout the research, and future social work research may assist in answering these questions. Future research can be used to answer questions related to how homeless mothers believe intrinsic strengths are developed and the challenges that children experience while exiting homelessness. While the results of this research study are not meant to be generalized beyond the research sample, the findings of the research have lead to the development of several implications that can be considered in the advancement of social work practice and research.

The most noticeable finding for this study was the value that the women placed on intrinsic strengths as compared to extrinsic strengths. Many of the participants report increased feelings of safety, security, and connectedness. Once those basic needs are met, participants are able to recognize other intrinsic strengths that enable them to sustain their exit from homelessness and aspirations for an improved quality of life. It is important at the social work practice level that agencies that work with homeless mothers incorporate interventions that promote the development, identification, and utilization of intrinsic strengths. Based on the findings from this study, interventions that may promote intrinsic strengths include teaching about affirmations, allowing mothers an opportunity to parent, and providing an environment where spirituality can be discussed.

In regard to social work research, it is recommended that future research explore the value placed in intrinsic strengths. Specifically, further research exploring the development of intrinsic strengths can contribute to a more comprehensive understanding of the cognitive process in strength development. This research was able to identify specific intrinsic strengths such as affirmations and spirituality; however, the research did not explore how these strengths are believed to be developed. Having a better understanding of the factors that contribute to the development of intrinsic strengths can help guide program design and treatment interventions for homeless mothers. The participants of HS Inc. have their children live with them while they are in the process of exiting homelessness. The presence of children alone is a valuable strength for the women that contributed to increased levels of motivation to parent. Future research is needed to explore the views held by the children of homeless mothers. It is suspected that these children hold valuable experiences that are important to be heard. Providing these children with a "voice" can offer an alternative perspective related to the challenges of exiting homelessness, as well as the strengths and protective factors of children in this unique situation.

Limitations

It is important to mention the limitations associated with this study. First, the research sample participated in a single focus group. The use of multiple focus groups and individual interviews would have provided more data, and possibly additional themes and implications. Second, the findings may have been influenced by social desirability bias. All research participants were members of HS Inc. and there is a risk that the participants may have been more selective in what they chose to share because they have had prior associations with the other members of the focus group. The researchers attempted to minimize the risk for social desirability bias by designing the study in a manner that encouraged the research participants to share their views related to their protective factors and strengths, as compared to exploring high-risk behaviors from the past.

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A Systematic Review: The Effectiveness of Cultural Competence Trainings among Health Professions

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Abstract

Cultural competence trainings are cited as improving providers' interactions with culturally diverse clients. Yet, little is known about the methodological rigor of such studies. To date, a systematic review of the effectiveness of cultural competence trainings by target population, intervention duration, and intervention intensity has not been conducted. An electronic systematic search was conducted to identify recent empirical evaluations of cultural competence trainings. Studies meeting the inclusion criteria were critically appraised using the Methodological Quality Rating Scale and the Outcome Attainment Index. Thirteen studies were included. Trainings targeting professionals were more rigorous than those targeting students. Accounting for methodological rigor, trainings targeting professionals, those longer in duration, and of higher intensity, achieved higher outcome attainment indices. Given the lack of rigor among these studies, it is difficult to assess their overall effectiveness. Considering the ever-growing diversification of this county, cultural competence trainings need to be both effective and rigorous.

Cultural competence trainings among health professions such as social work, pharmacy, nursing, and the medical field have been the focus of a growing body of literature due to our country's continued diversification. By 2025, it is estimated that minority populations will dramatically increase (i.e., African American by 27%, American Indian/Alaska Native by 48%, Asian by 69%, and Hispanic by 97%) compared to 18% by Caucasian Americans (US Census Bureau, 2009). Yet increased client diversity has not been equally mirrored by health professionals, with minority populations being more likely to receive care from non-minority professionals (Assemi, Cullader, & Hudmon, 2004) who may not fully understand the cultural nuances of domestic and international minorities.

To address cultural and racial/ethnic disparities often experienced by minority clients, professional mental health and health care agencies, hospitals and academic institutions have begun offering cultural competence interventions to current and future mental health and health care providers. The goal of these trainings has been to provide relevant and culturally specific information to health professionals and produce increased cultural competence as evidenced by improved measurable outcomes in attitude, knowledge, and skills/behavior. While the results of these studies often indicate increased improvement in cultural competence among their targeted audience, there has been limited systematic exploration of the effectiveness of cultural competence interventions across health professions (Beach et al., 2005). For example, in a review of 34 studies addressing cultural competence training of health professionals, Beach et al. (2005) found that 82% of interventions demonstrated beneficial effects on provider knowledge, attitudes, and skills.

However, a subsequent evaluation of the effectiveness of cultural competence models of professional education among mental health professionals found limited evidence of the effectiveness of cultural competency training to mental health professionals working with culturally diverse patient groups (Bhui, Warfa, Edonya, McKenzie & Bhugra, 2007). In a review of nine studies, the authors found that few studies (33%) included teaching and learning methods or quantitative outcomes, and only one provided information about staff follow-up after training completion. Consequently, they asserted that these limitations hindered the ability to accurately ascertain the effectiveness of cultural competence trainings.

Additionally, Price and colleagues (2005) conducted a critical appraisal of the methodological rigor of cultural competence trainings and found that the quality of evidence from these interventions was generally poor. This conclusion was based, in part, on results from a sample of 64 studies where only 34% used pretest-posttest study designs and less than 16% of the studies used randomized or concurrent controlled trials. Furthermore, while a third of the studies provided enough detail to replicate the intervention, only eight of them used adequate comparison groups. Based on their findings, the authors concluded that most of the studies lacked the methodological rigor to wholly determine the effectiveness of the training on improved cultural competence and encouraged greater attention be given to study design and intervention evaluation.

Given the importance of cultural competence trainings among social workers and other health professionals, it is essential that trainings be effective in improving the cultural competence among its intended audience. As indicated by previous systematic reviews of cultural competence training among health and mental health professions, fully gauging the effectiveness of these trainings is limited by poor study quality. When assessing the effectiveness of any intervention, and particularly one that impacts so many professions and client populations, it is imperative that the training is of the highest quality. Evaluating the methodological rigor or quality of cultural competence training studies allows for comparison of studies by certain pre-determined characteristics to assess the reliability of the stated outcomes. Incorporating the results and their statistical significance, if any, further assists in evaluating the studies in an objective manner. Critiquing the methodological rigor of studies can help inform whether or not the study is, in fact, effective and its outcomes applicable to other health professionals.

Thus, the purpose of this study was to (1) evaluate the methodological rigor of cultural competence training studies by target population and (2) assess the effectiveness of the trainings on participants' cultural competence by three intervention characteristics. This study furthers the literature by including recent studies of cultural competence trainings not previously examined, expanding the target population to include students in addition to health professionals, and considering three intervention characteristics – target population, intervention duration, and intervention intensity – when evaluating training effectiveness on cultural competence. The hypotheses were: (1) studies targeting students will be more rigorous than those targeting professionals; and (2) studies targeting students, those of longer duration, and of higher intensity will be more effective in improving cultural competence.

Methods

Selection of Studies

The search objective was to identify cultural competence training studies, written in English, and published between 2004 and 2011 in peer-reviewed journals. Studies had to target students or professionals in health professions (i.e., social work, nursing, or the medical field), identify a cultural competence intervention and an evaluation of the intervention (i.e., pre/post-test results), and include statistical analyses of these results. Studies were identified through a search of electronic databases including CINAHL Plus, ERIC, Family and Society Studies Worldwide, MEDLINE via PubMed, PsycINFO, Race Relation Abstracts, SocINDEX, Social Work Abstracts, and Urban Studies Abstracts. Keywords used to in this search included "cultural competence," "training or intervention," and "evaluate". Total search results of the inclusion criteria yielded 366 citations. Following duplicate citation removal and an article screening and filtering method identified by Bhui et al. (2007), 84 articles remained. Full-text articles were retrieved and reviewed for relevance. Thirteen peer-reviewed studies met the above criteria and were included in this review.

Assessing Methodological Rigor

An adapted version of the Methodological Quality Rating Scale (MQRS) was used to evaluate the methodological characteristics of each study. Miller and colleagues (1995) developed this instrument to assess the methodological quality of studies across multiple dimensions (e.g., study design, baseline, follow-up length, and analyses) with point values ranging from 0-3. It has been used in other systematic reviews with inter-rater reliability scores of 95-97% and adapted to address specific dimensions relevant to the studies of interest (e.g., Cabassa & Hansen, 2007; Vaughn & Howard, 2004). For this review, nine dimensions specific to cultural competence training studies were used to assess the methodological rigor of included studies. Each dimension was allotted a point value (possible values ranged from 0-3; see Table 1) and these scores were summed to produce a total MQRS score ranging from 1 (low quality) to 16 (high quality). Once all studies were scored, the median split of the scores was used to delineate between above average and below average methodological rigor (Vaughn & Howard, 2004). Studies with a score above the median split were considered above average rigor while studies with a score equal to or lower than the median split were considered below average rigor.

Assessing Intervention Effectiveness

Cultural competence training effectiveness was evaluated by three intervention characteristics: target population, intervention duration, and intervention intensity. *Target population* was based on whether the study targeted students or professionals. *Intervention duration* referred to the total number of training hours and was calculated after determining the mean number of total training hours across studies. Long duration was defined as eight training hours or more while short duration was defined as less than eight hours of training. *Intervention intensity* referred to the amount of participant involvement required in the training. Low intensity trainings were defined as trainings that included lecture only, written materials or audio/video components while high intensity trainings were those trainings that added a participant practice component such as role-playing or actual interactions with clients. This distinction was based on criteria used in previous systematic reviews of cultural competence trainings (see Price et al., 2005).

Table 1
Adapted Methodological Quality Rating Scale

Methodological Criteria	**Points Awarded**
1. Study design	1 = Single group pretest-posttest 2 = Quasi-experimental (nonequivalent control) 3 = Randomization of groups
2. Intervention curriculum	0 = Curriculum not included in study 1 = Curriculum included in study
3. Measure reliability	0 = No information on measure reliability 1 = Reliability implied from previous studies and/or reported in current study 2 = Reliability reported and adequate
4. Intervention duration	0 = ≤ 5 hours 1 = 6-10 hours 2 = ≥ 11 hours
5. Intervention intensity	0 = Lecture and written materials only 1 = Lecture/written materials plus audio/video component 2 = Lecture/written materials & audio/video plus participant practice component
6. Follow-up length	0 = No follow-up 1 = 1-6 months 2 = > 6 months
7. Dropouts	0 = No discussion or enumeration of dropouts 1 = Dropouts enumerated 2 = No dropouts from the study
8. Statistical power	0 = Inadequate power due to small sample size/dropout or not discussed 1 = Adequate power with adequate sample size
9. Analyses	0 = No statistical analyses or clearly inappropriate analyses 1 = Appropriate statistical analyses

Note: Adapted from Miller et al. (1995). Scores could range from 1 (low) and 16 (high).

In order to compare intervention effectiveness across studies by these three characteristics, an Outcome Attainment Index (OAI; Rhee & Auslander, 2002) was created to ascertain the degree to which statistically significant improvement (p<.05 or better) occurred in participants' level of cultural competence. Table 2 shows how the index combined the study's MQRS score with the study's reported findings of significant or non-significant results, and generated a pre-established rating system of 1 to 4.

Table 2
Outcome Attainment Index categories by MQRS score and Statistical Significance

	Above Average MQRS score	Below Average MQRS score
Statistically Significant Results	OAI = 4	OAI = 3
Non-statistically Significant Results	OAI = 1	OAI = 2

The assumptions of this index were that studies with a *rating of 4* will exhibit the strongest evidence of intervention effectiveness as they achieved statistically significant results while attaining above average or more stringent methodological rigor. A *rating of 1* indicated the weakest evidence of effectiveness as the study was deemed rigorous but did not achieve statistically significant results. A *rating of 3* indicated a potentially good intervention due to its statistically significant results; however, due to its below average rigor, it was unclear if the intervention was effective and additional testing of the intervention would be required. Lastly, a *rating of 2* indicated a poor test of the intervention as the study's methodology was deemed below average along with a study report of non-significant results (Auslander, Bowland, Carter, Tracey, & Vaughn, 2004; Auslander, Tracey, Ollie, & Yu, 2004).

Results

Electronic Search

A total of 366 articles were identified through the electronic search. An article screening method using title and abstract review, followed by an article review, yielded 13 studies that met the inclusion criteria. About 38% of the studies targeted professionals and included health professionals in the fields of social work, pharmacy, nursing, and medicine. The majority of student studies (75%) targeted medical students, while nursing and pharmacy students were the focus of one study each.

Methodological Rigor

Using the adapted MQRS criteria, scores of the studies ranged from 2 to 13 with a median split of 7, which was then used to delineate between above average or below average methodological rigor. Studies with scores of 8 or higher were considered to have above average rigor, while those with scores equal to or below 7 constituted below average rigor. Four out of five studies targeting professionals and two out of eight studies targeting students achieved above average rigor. A higher percentage of studies targeting professionals achieved the maximum number of points for *intervention intensity* (60% vs. 50%), and *measure reliability* and *dropouts* (60% vs. 13%, respectively). In addition, professional-targeted studies were more likely to have *adequate power* and provide *follow-up* than student-targeted studies. Studies targeting students were more likely to receive the minimum number of points on methodological criterion including *power* (0/8), *follow-up* (1/8), and *measure reliability* and *intervention duration* (3/8, respectively). This combination of lower scores impacted the overall score of these studies; thus, student-targeted studies were more likely to achieve below average methodological rigor (see Table 3).

Regarding the methodological rigor of all the eligible studies, this review found that, overall, most studies failed to achieve consistent scores for methodological rigor across the criteria. For example, all the studies used appropriate statistical analyses and the majority (85%) included the intervention curriculum. However, slightly less than half (46%) of the interventions received the maximum number of points for intervention intensity. Only 31% of the studies included interventions that were longer in duration, used reliable measures of cultural competence to evaluate training effectiveness, or reported no dropouts. Additional areas of weakness included failure to address statistical power (15%), use a randomized control study design (7%), and conduct follow-up beyond six months (0%).

Table 3

Methodological Quality of Cultural Competence Trainings among Health Professions

MQRS Criterion	**Maximum Points Possible**	**# of Studies Achieving Maximum Points**	**% of All Studies**	**% Professional (n=5)**	**% Student (n=8)**
Statistical analyses	1	13	100	100	100
Curriculum included	1	10	85	100	63
Intervention intensity	2	7	54	60	50
Use of reliable measurement tools	2	4	31	60	13
Dropouts	2	4	31	60	13
Intervention duration	2	4	31	40	20
Statistical power	2	3	23	40	25
Study design	3	1	8	0	0
Length of follow-up	2	0	0	0	0

Intervention Effectiveness

Target Population. Eighty percent (4/5) of the trainings targeting professionals received an OAI rating of 4, indicating they reported statistically significant results while achieving above average methodological rigor compared to 25% (2/8) of the interventions targeting students. Six studies targeting students received a rating of 3, denoting that while they reported statistically significant results, the study lacked rigor.

Intervention Duration. Two student studies were excluded from this category as they did not include the amount of training time in hours (see Crosson et al., 2004 and Paul et al., 2008). Sixty-six percent (4/6) of the interventions with longer durations received an OAI rating of 4 compared to 40% (2/5) of those with shorter durations. The remaining studies (2 with longer durations and 3 with shorter durations) received a rating of 3.

Intervention Intensity. About 71% (5/7) of the high intensity trainings received an OAI rating of 4 and were considered effective in improving cultural competence, compared to 17% (1/6) of the low intensity trainings. Two high intensity studies and five low intensity studies reported statistically significant results but due to their below average rigor were given a rating of 3. Table 4 summarizes the study characteristics.

Table 4

Description of 13 Studies Evaluating the Effectiveness of Cultural Competence Trainings among Health Professions

Author, Year	**Target Pop**	**Intervention Duration**	**Intervention Intensity**	**Summary of Findings**	**MQRS Score**	**OAI Rating**
Armour et al., 2004	Social Work Field Instructors (n=52)	Long	High	18-hour training resulted in statistically significant improvement between pre-test, post-test and follow-up in comfort with diversity, attention to issues of power and control, and knowledge about oppressed groups.	11	4
Assemi et al., 2004	Pharmacy Students (n=58)	Long	Low	Scores from pre- to post- tests after an 8-hour elective course indicated significant change in students' perceived awareness, knowledge, and communication skills related to cultural competence.	7	3
Brathwaite, 2005	Registered Nurses (n=76)	Long	High	Voluntary participation in a 10-hour workshop resulted in statistically significant results at post-test and follow-up, indicating that participants' overall cultural competence increased over time.	11	4
Carter et al., 2006	Medical Students (n=196)	Short	High	3-hour training, as part of a required clerkship, resulted in significant improvement in cultural awareness in 8 out of 11 items.	8	4
Crosson et al., 2004	Medical Students (n=175)	N/A	High	A cultural competence curriculum was incorporated into two existing required courses. Results of pre- and post-test indicated significant improvement in assessing patients' opinion and determining patients' beliefs.	7	3
Krajewski et al., 2008	Medical Students (n=43)	Short	Low	Approximately 3-4 hour lecture showed significant improvement in health care cultural competency, cultural skill and clinical scenarios.	2	3
Lee et al., 2006	Registered Nurses (n=7)	Short	Low	Participation in a 90-minute education program resulted in significant difference in pre- and post-test scores on test of cultural sensitivity.	7	3
Lim et al.,	Medical	Short	Low	Pre- and post- test results indicated a required 2-	4	3

2008	Students (n=95)			hour presentation significantly improved cultural competence.		
Melamed et al., 2008	Medical Students (n=27)	Long	High	Voluntary participation in a 40-hour course plus hospital volunteering resulted in significant improvement on pre- and post-tests of cultural awareness and knowledge.	8	4
Nokes et al., 2005	Nursing Students (n=14)	Long	Low	Voluntary participation in a 15-hour intervention resulted in significantly lower cultural competence scores from pre- to post-test.	7	3
Paul et al., 2008	Medical Students (n=91)	N/A	High	6-week curriculum was incorporated into a required clerkship and resulted in significant improvement in cultural knowledge and attitude among intervention group versus control group.	7	3
Schim et al., 2006	Hospice Providers (n=130)	Short	Low	Participation in a voluntary 1-hour educational session resulted in significantly higher scores on post-test of intervention group compared to control group.	8	4
Williams, 2006	Social Workers (n=47)	Long	High	Voluntary participation in a12-hour educational intervention demonstrated significantly greater improvement in cultural awareness among intervention group compared to control group.	13	4

Discussion

This systematic review evaluated the effectiveness of cultural competence trainings by target population, intervention duration, and intervention intensity, while considering methodological rigor. This review revealed that while 80% professional-targeted studies and 25% of the student-targeted studies achieved above average rigor, overall the quality of studies was lacking. Contrary to the initial hypothesis, studies targeting students were less likely to achieve above average rigor when compared to those targeting professionals. This could be due to the fact that many of the student-targeted studies failed to achieve the maximum number of points on the MQRS.

As hypothesized, studies with longer duration and of higher intensity were more likely to be effective in improving cultural competence. Three studies that targeted professionals, were longer in duration and of higher intensity (see Armour et al., 2004, Brathwaite, 2005, and Williams, 2006), achieved statistically significant results and above average methodological rigor, and represent studies that may demonstrate more effective cultural competence interventions. However, one study that also targeted professionals (Schim et al., 2006) reported statistically significant results and achieved above average methodological rigor with an intervention of shorter duration and low intensity which suggests that longer duration and/or high intensity may not necessarily be more effective in improving cultural knowledge.

Limitations

There are two major limitations of this systematic review: the rating scale used for the MQRS and the use of the median split. Although the methodological criteria for the adapted MQRS were selected based on the original MQRS, previous systematic reviews, and the studies themselves, the opportunity for problematic categories remain. For example, the majority of studies did not receive the maximum number of points for study design, follow-up length, or statistical power; however those criteria were deemed important in determining the methodological rigor of the study. In the future, it will be important to review how those criteria are rated to better delineate between above and below average methodological rigor.

Moreover, while using the median split as a determinant for above or below average methodological rigor is systematic, it is also somewhat subjective. Based on the MQRS scores, there were five studies that received a score of 7 in this systematic review. If studies with a MQRS score of 7 had been included in the above average methodological rigor category, the intervention effectiveness by intervention characteristic results would have been very different. In fact, if multiple studies receive below average MQRS scores, it may appear that the median split is not a meaningful method for determining methodological rigor. However, consistent below average scores may be indicative of the need to improve methodological rigor among studies as well as the need for further testing of the MQRS with cultural competence interventions.

Implications for Social Work

Considering the ever-growing diversification of our nation’s population, it is imperative that social work and other health professions alike improve their ability to provide cultural competent services through the development and implementation of effective and rigorous cultural competence trainings. As the field of social work strives to accomplish the mandates set forth in *Standards for Cultural Competence in Social Work Practice* (NASW, 2001), it is anticipated that such trainings will further improve one’s ability to deliver care that is based on a working knowledge and understanding of a population’s diverse culture and background.

Therefore, to ensure that social work professionals and students are well equipped to provide culturally competent care, social work programs and agencies are encouraged to require cultural competence trainings. Yet, social work educators must bear in mind that not all intervention types lead to the desired outcome of increasing cultural competence as measured by improved service provision. When developing curriculum for students and professionals, it was found that training characteristics including longer duration (i.e., 8-10 hours) and higher intensity (i.e., include a participant practice component) led to more desirable outcomes. While this review highlights the need for methodologically rigorous cultural competence studies, further research is needed to fully evaluate the benefits of using effective cultural competence trainings.

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Acknowledgements
This manuscript was supported by a grant from the National Institute of Mental Health (MH019960-15).

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Title X, Family Planning, and the Affordable Care Act: A Strengths Perspective Policy Analysis

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Abstract

This paper analyzes Title X of the 1970 Public Health Service Act using a strengths perspective framework. Title X was the country's first federal policy to provide public funding for family planning programs and it was implemented during a time when overpopulation was a great concern. The goals of Title X align with the strengths perspective's focus on self-determination and empowerment. While Title X has made a great contribution by preventing unplanned pregnancies for low-income women, there are several limitations in regards to beneficiaries, service delivery, and funding. This paper explores both the strengths and limitations of the policy and makes recommendations for improvements that are crucial as implementation plans of the Patient Protection and Affordable Care Act of 2010 are developed.

The Title X Population Research and Voluntary Family Planning Programs (Title X) provide public funding to family planning programs for low-income women. Title X was enacted shortly after the birth control pill was approved for contraception and during a time when overpopulation concerns occupied center stage. The growing population worldwide raised anxiety about meeting people's basic needs as well as concerns about poverty, shrinking natural resources, and education (May, 2010). In fact, "The pill promised to be a stealth weapon that would defuse the 'population bomb' by limiting the size of 'nuclear' families across the globe (May, 2010, p. 37). Theoretically, Title X in many ways reflects empowerment and self-determination values of Social Work's strengths perspective. Today, Title X provides funding for family planning services and exists to serve the original goal, "to assist in making comprehensive voluntary family planning services readily available to all persons desiring such services" (The Family Planning Services and Population Research Act [FPSPRA], 1970, p. 1504) by providing an array of reproductive health care services.

Using a strengths perspective to analyze Title X is useful to understand what changes are needed and how to best serve low-income women seeking Title X services. As cited by Chapin (2011), "the strengths perspective is a philosophical approach to social work that posits that the goals, strengths, and resources of people and their environment, rather than their problems and pathologies should be the central focus on the helping process" (p. 2). The purpose of this paper is to utilize the strengths of Title X to make recommendations for changes that ultimately impact women.

Overview

In light of increasing concerns about overpopulation, Nixon signed Title X into law as a part of the Public Health Service Act in 1970. Title X provided funding for low-income women to access contraceptives and information. This marked success for the women's rights movement because it directly aligned with the theoretical underpinnings of the movement that focused on gender equality. Birth control gives women the option to plan and space their families and, therefore, affords women self-determination in their families and beyond to their educations and careers.

Policy Analysis: Strengths and Limitations

Insights gained by examining who benefits from Title X, how services are delivered, and how the policy is funded help document the strengths and limitations of Title X (Chapin, 2011). Furthermore, the strengths and limitations inform and provide a foundation for recommendations and policy change.

Beneficiaries

Demographics of Title X patients in 2009 are summarized in Table 1 (US Department of Health and Human Services [HHS], 2010). Traditionally marginalized racial/ethnic minorities are over-represented as patients of Title X. Americans in poverty are similarly over-represented (Census, 2011).

Table 1

Demographics of 2009 Title X Patients

Gender	**%**
Female	93
Male	7
Age	**%**
19 and younger	24
20-29	50
30 and older	26
Race/Ethnicity*	**%**
White	59
Hispanic/Latino	28
Black/African-American	20
Asian	3
Native American or Other Pacific Islander	1
American Indian or Alaska Native	1
Federal Poverty Level	**%**
At or Below the Poverty Level	70
Between 101% and 250% of the Poverty Level	23
Greater than 250% of the Poverty Level	4

* These numbers do not add up to 100% because one could record both Hispanic/Latino for ethnicity and another category for race. US Department of Health and Human Services HHS, 2010

Title X has a positive impact on families, future families, and sexual partners of Title X patients. Families and future families are improved by better birth outcomes associated with planned pregnancies. When controlling for socio-demographic factors, Cheng, Schwarz, Douglas, and Horon (2009) found that women who experience unintended pregnancies are less likely to have adequate prenatal care, less likely to breastfeed, and more likely to have babies with low-birth weight than their counterparts who experience planned pregnancies. Conversely, Kost, Landry, and Darroch (1998) found that women who planned their pregnancies were more likely to recognize their pregnancy in the first six weeks, seek prenatal care in the first eight weeks, and adhere to medical advice to stop smoking.

Families and sexual partners of Title X patients are also healthier because of cancer prevention and sexually transmitted infection (STI) screening and treatment. Early detection and treatment of cervical and breast cancer can lead to better health outcomes for women (Centers for Disease Control and Prevention, n.d.). The same can be said for STIs, potentially resulting in a positive impact for both the patient and his/her family (Tripp & Viner, 2005). Further, if one's partner is diagnosed with an STI, he/she may be more likely to get tested and/or use barrier protection in future sexual encounters.

Finally, taxpayers and the government benefit from Title X. In fact, Frost, Sonfield, Benson Gold, and Ahmed (2006) estimate that every dollar spent on Title X saves state and federal governments three dollars due to the Medicaid-covered pregnancy care averted by preventing unplanned pregnancies. Furthermore, another child could push more women and families below the poverty level and raise government costs (Forrest & Samara, 1996).

Services provided by Title X have had a profound impact. It is estimated that between 1980 and 1999, Title X-funded clinics helped prevent 19 million unintended pregnancies (Frost et al., 2006). However, Title X providers are only reaching approximately one million black women and 1.4 million Hispanic women. Yet, black women have the highest rate of unplanned pregnancy (Finer & Zolna, 2011;Mosher, Martinez, Chandra, Abma, & Willson, 2004). Additionally, Hispanic adolescents are more likely than black and white teens to forgo birth control (as cited in National Latina Institute for Reproductive Health [NLIRH], 2010). Another study found that black and Hispanic women are less likely than white women to use hormonal birth control pills (Krings, Matteson, Allsworth, Mathias, & Peipert, 2008) and of those who do use it, black and Hispanic women have a higher rate of contraceptive failure than white women (Frost & Darroch, 2008; Ranjit, Bankole, Darroch, & Singh, 2001).

Service Delivery

Eligibility for services provided by Title X-funded clinics around the country is determined through an income-based means test. Families who live at or below the Federal Poverty Level (i.e., $23,050 gross income for a family of four) receive all services Title X grant recipients are required to offer at no charge unless a third party is obligated or authorized to pay (HHS, 2010). Families between 101% and 250% of the Federal Poverty Level receive services on a sliding scale (as cited in HHS, 2010). For these women, choice of contraceptive method is limited because their preferred method may be cost prohibitive. Limiting women's contraceptive choices can result in an increase in unintended pregnancy (Freeman, 2004).

Accessibility is an issue of social justice. While nearly 75% of the counties in the United States have at least one Title X-funded clinic, four states have publicly funded family planning clinics in fewer than 50% of their counties (Frost, Frohwirth, & Purcell, 2004), demonstrating a lack of accessibility. In fact, difficulty obtaining contraceptives is one of the top three (along with believing that she would not get pregnant and a fear of side effects of contraceptives) reasons women report not using contraceptives (Singh, Darroch, Ashford, & Vlassoff, 2009). Furthermore, in a study of family planning accessibility among local health departments, Planned Parenthood clinics, and federally qualified health centers, Title X-funded clinics were reported to be less likely than non-Title X clinics "to be open full-time, in the evening or on weekends" (Ramashwar, 2007, p. 124). In addition, Title X providers are not always accessible to minority women. In a 2007 study, Title X-funded clinics were less likely than other reproductive health clinics to "have services tailored for minorities" and to provide materials in other languages and identify staff as culturally competent (Ramashwar, 2007, p. 124).

Funding

In 2009, the Office of Population Affairs (OPA) awarded Title X grants to 89 public and private grantees. The 2009 grantees used these funds in their own clinics and distributed the rest to 1,157 subcontractors, extending public funding to 4,515 service sites (HHS, 2010). While funding for Title X has remained stagnant for many years, costs continue to increase. According to Lindberg, Frost, Sten, and Dailard (2006), new contraceptive methods give women more options to achieve contraceptive adherence, yet the cost of these new methods is higher. Further, "two-thirds of the agencies that operate Title X-supported clinics reported in 2003 that they did not stock certain methods because of their high cost" (Frost et al., 2006, p. 12). Not offering these contraceptive methods impacts clients' outcomes and undermines the goals upon which Title X was founded. Without options, women are more likely to experience contraceptive failure (Freeman, 2004). Furthermore, women are not likely to have all of their options when clinics cope with funding that runs out before the end of the grant cycle by cutting hours, reducing staff, and limiting the array of contraceptives offered.

Recommendations

The Patient Protection and Affordable Care Act of 2010 (ACA) will bring the United States closer than we have ever been to universal health care coverage by expanding insurance coverage to 32 million people by 2019, leaving 23 million uninsured residents (Chapin, 2011). According to The Henry J. Kaiser Family Foundation, the ACA (as it currently stands) will provide contraception, well-woman visits, STI screenings, and STI and HIV counseling with no cost sharing (co-pay) requirement. However, according to Sonfield and Benson Gold (2010), "all of this progress—much of it not yet crystallized—is beset by serious threats" (p. 287). Though the Supreme Court ruled that the ACA is constitutional, lawmakers continue to attack reproductive health benefits in the ACA, and states are struggling to fund Medicaid *before* the drastic expansion of the program to extend coverage.

Building on the Strengths Perspective Foundation

Providing services under Title X through a strengths lens will likely address many limitations. The goal of Title X is strengths-based, as it focuses on patients' family planning goals. Title X goals provide a strong foundation for inclusion of the strengths perspective throughout the services provided under Title X. The following demonstrates how the strengths approach can be infused to resolve some of Title X's limitations.

Beneficiaries. Title X services need to be revamped to reach more women in need. This cannot be achieved without addressing cultural competence, defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 7). One simple way to institutionalize cultural competency is to recruit staff on all levels who reflect the diversity of Title X patients. Furthermore, the strengths perspective views the patient receiving services as the expert and Title X administrators need to purposely incorporate patient feedback and involvement into goal planning and service delivery. Implementation of these two components is the first step toward cultural competency.

Services provided to Hispanic women under Title X also require an improvement in cultural competence. This is especially important since "95% of Title X clinics report having clients that are not native English speakers" (Frost et al., 2006, p. 11). Special attention should also be paid to reaching Hispanic adolescents, as their use of birth control has declined significantly in recent years and they gave birth at more than twice the rate of white adolescents in 2007 (as cited in NLIRH, 2010). In addition to recruiting staff that reflect their patients and engaging patients in the process, Title X providers need to offer materials in other languages, provide translation services, and engage staff in cultural competency training. Certainly cultural competence is not this simple, though these recommendations provide first steps.

Service Delivery. Ideally, eligibility and the current fee for service model for Title X services would to be reconsidered so a woman's choice in contraceptive method would not be limited by affordability. However, given the current funding and political climate this is not feasible. It is therefore recommended that each Title X clinic engage patients in a community needs assessment to determine which methods to offer. Prioritizing the methods based on community needs will allow the Title X provider to offer fewer methods (decrease costs) while maximizing the number of patients they see while staying within the Title X budget. Giving women as many affordable choices as possible is empowering, reflective of a strengths approach, and can have a direct impact on contraceptive adherence.

One way to address lack of accessibility is to change the grant application to require extended accessibility by grantees. Grant applicants should be encouraged to collaborate with other agencies to establish services in underserved areas. One Title X clinic recently expanded into an underserved area in Appalachia by collaborating with an existing women's center for space. While only open one day each week, this is a beginning step to reach more women in need of affordable family planning services (S. Emmert, personal communication, July 25, 2012) (Note: This agency is no longer a Title X recipient). Furthermore, the grant application process should assess who is able to provide services with greatest accessibility in terms of location, hours of operation, and days open during the week. Awards should be granted accordingly.

Funding. It is quite possible that the ACA will resolve some of the funding limitations on Title X as, in theory, there will be fewer women in need of Title X services because they will be receiving them through expanded insurance coverage. If this happens and Title X is kept intact, grantees may be provided with enough funding to get through the grant cycle. However, ACA's moving parts and uncertain future cannot guarantee this, thus requiring action to address the issue now. Title X administrators need to creatively solve this funding issue. A community needs assessment is one place to start to reduce the array of options provided in a client-centered, strengths perspective way. Another option may be to encourage collaboration with other agencies providing similar services. However it is accomplished, Title X administrators need to be engaged in a creative thinking process (with patient involvement and input).

Conclusion

Title X has a strong foundation in self-determination and empowerment and has been given credit for a reduction of unplanned pregnancies among low-income women. However, there are many ways in which Title X providers can more effectively meet the needs of the populations they serve. Viewing services through a strengths lens can allow Title X administrators to begin thinking about an array of options, especially ways to engage their greatest strengths: their patients. If the promise of Title X is to be fulfilled, programs must more clearly reflect the needs of women of color. This can be achieved in the following three ways: to involve them more integrally, make options and services more affordable and culturally competent, and develop the programs in a way that will fit into major health care transformations to come. This paper outlines beginning strategies to make all three of these happen. Timing is critical and we now have a rare window of opportunity for Title X administrators to collaborate with service providers and patients to improve the limitations identified and prepare to better serve those left behind by the ACA.

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ISSUES IN SOCIAL WORK EDUCATION

From diapers to dissertations: Students' experiences of new motherhood while enrolled in social work doctoral programs

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Abstract

Approximately 13% of doctoral students have children during their studies, and the mothers among them may face particular challenges. These can include time constraints, unsupportive faculty, and a tenure system that often favors women without children and men. As a result, a disproportionate number of young mothers may be leaving doctoral programs prior to completion. The unique perspectives and potential that is lost each time one of these students drops out represents a significant loss to the social work community. The leadership of social work doctoral programs has a responsibility to understand and address experiences and needs of women who are balancing studies and motherhood. This article will use ecological theory and role theory to explore the challenges faced by this group of students. The authors share their own stories, including our struggles and successes in juggling motherhood and our doctoral studies. Suggestions for ways in which social work doctoral programs can become more family-friendly will be offered.

We had conference calls with our dissertation committees while caring for sick babies at home. We pumped breast milk between classes in professors' offices. We worked on our dissertations during nap time, fighting through the fatigue of new motherhood just to put a sentence a together. We struggled to balance the demands of doctoral education, our work as clinical social workers, and the adjustment to life with new babies. We are among the 13% of doctoral students who become parents by the time they graduate (Mason, 2009).

In the United States, the average age of a mother is 27.4 years (National Center for Health Statistics, 2010). This figure roughly overlaps with data about applicants and enrolled students in social work doctoral programs; most applicants are women between 26 and 30 years old, and most enrolled students are also women between 31 and 40 years old (Council on Social Work Education, 2011). While statistics on gender and age are available, few other characteristics about social work doctoral students are known (Anastas & Kuerbis, 2009), such as whether or not they identify as parents.

Two studies have explored how long social work doctoral students took to complete their degrees (Crayton, 2005; Liechty, Liao, & Schull, 2009). Both found that family needs and constraints cause a shift in students' priorities and necessitate more time to completion. Nearly 50% of social work doctoral students never graduate (Liechty et al., 2009). While data is not available regarding why students leave, it is plausible that new motherhood may be a reason for some individuals. In addition to retention and completion time, there are a variety of ways in which family-related factors may have an impact on students' experiences in doctoral programs.

The challenges facing mothers who are pursuing their doctorates in social work remains largely unexplored, although much has been written about the broader issue of mothers in academia.

Mothers in Academia

Timing Matters

Family formation can have a powerful impact on the career trajectory of women in academia. Mason and Goulden (2002) shared findings from their ongoing longitudinal study of academics in the sciences, social sciences, and humanities. They found a large and persistent "baby gap." Women who do not have children tend to achieve tenured faculty positions, while those with children "make choices that force them to leave the academy or put them into the second tier of faculty: the lecturers, adjuncts, and part-time faculty" (para. 5).

The timing of babies also plays a role. Mason & Goulden (2004) used the term "early baby" (p.89) to describe one who is born within five years of the academic parent earning a doctorate. Women who have "early babies" do not advance as far as men who have early babies or women who do not have children or who have later babies. Those years, which represent a crucial step on the path to career establishment, may include the completion of graduate studies, assistant professorships, or postdoctoral positions. Such opportunities are generally characterized by long work hours, high productivity demands, and limited job security (Mason & Goulden, 2002, 2004), which often makes these coveted positions unsustainable for new mothers. The current system is not supportive of women who simultaneously have children and pursue a doctorate.

Impact on the Field of Social Work Education

Individual mothers are not the only ones who are affected when their social work careers stall out. While many disciplines are experiencing an abundance of doctoral graduates, social work does not have enough to meet current faculty needs, despite the rapid growth of social work doctoral programs over the past 25 years (Karger & Stoesz, 2003). The number of women with doctorates has increased in all fields over the past fifty years, and social work has conferred more doctorates to women than all other professional fields combined (Anastas & Kuerbis, 2009); nevertheless, a gender disparity persists. Five percent of male social workers and only three percent of female social workers have acquired a doctorate, despite the fact that men represent only a quarter to one-third of all social workers (Whitaker, Weismiller, & Clark, 2006). Furthermore, male social workers also earn more than their female counterparts and hold more administrative positions (Britton & Stoller, 1998). Addressing the loss of female faculty members from the career pipeline is a serious concern, as our leadership should be reflective of the overall social work community as well as social work values.

Social Work Values and Ethics

The National Association of Social Workers' (2008) *Code of Ethics* outlines several core values and ethical principles that directly relate to new mothers pursuing doctorates. By upholding the value of "dignity and worth of the person," social workers support individual differences and the right to self-determination (Ethical Principles section, para. 4). Similarly, by valuing the "importance of human relationships," workers enhance the wellbeing of individuals and families (Ethical Principles section, para. 5). When following the *Code,* workers consider the individual contexts of their clients and colleagues and tailor their professional behavior accordingly.

Doctoral programs can be guided by the *Code* as well by creating a culture that supports the many and varied relationships in students' lives, both personally and professionally. Differences among students should be acknowledged with dignity and respect, and every effort should be made to support the growth and wellbeing of students who are parents and their families, while still maintaining the standards of the doctoral program. The alternatives—addressing students' needs selectively, considering personal relationships irrelevant, or compartmentalizing parts of a student's self—would not reflect the profession's ethical principles or address the documented gender gap in social work education.

Mothers: An Important Source of Diversity

The importance of valuing and respecting diversity is emphasized throughout the *Code of Ethics* (NASW, 2008). Family status needs to be among the forms of diversity that are acknowledged, welcomed, valued, and supported in schools of social work. It is not difficult to imagine the ways in which our profession would suffer if our leadership were composed of individuals of just one gender, race, or sexual orientation; family structure is no different. Having children is a life experiences that changes one's worldview. Who we are affects our scholarship and teaching; faculty with children will approach their work differently from those who have never had children. No perspective is more valuable than the other; we need all of them in order to most deeply and accurately explore and address the needs of our clients, research participants, and students. New mothers hold meaningful perspectives by virtue of their current life stage, as well as their other life experiences and social locations. Each time a young mother must leave an unsupportive doctoral program, the potential of her entire career is lost.

Understanding the Challenges: Ecological Theory and Role Theory

Although each mother will face different challenges in her pursuit of a social work doctoral education, the overall experience of balancing two demanding roles in an intense environment can be more fully understood through the lenses of ecological theory and role theory.

The Environment Matters

Doctoral programs provide a rich environment of resources and opportunities for their students. Ecological theory tells us that people and the environment are in a reciprocal relationship in which each acts on and influences the other in order to achieve the best possible fit. When the relationship has a good fit, an individual is able to make a positive impact on the environment while being sustained by available resources (Germain & Gitterman, 1980). This begs the question of whether academic culture is supportive to mothers such that they will be able to succeed. Rosen (1999) offered this critique of the environment for women in academia:

> What kind of tenure cycle would a group of female professors create to insure a balance among childbearing, child-rearing, intellectual life, and university responsibilities? Does anyone think that they would come up with the crackpot idea of seven years right in the middle of a woman's prime childbearing years? (p. A48).

Although most tenure-track mothers are equally invested in their careers and their families (Fothergill & Feltey, 2003), doctoral students with new babies may encounter a range of environmental challenges. These include the scheduling of classes and events in the evenings, non-existent or minimal leave policies, and financial constraints (Mason, 2009; Young & Wright, 2001). Full-time programs may be too demanding, while part-time programs may not offer enough support. Perhaps most concerning, however, is the literature regarding negative attitudes from administrators, faculty, and colleagues (Williams, 2004). New mothers report feeling as though they cannot talk about their children or the challenges of motherhood at school, and that they have to prove themselves to faculty, even if they were exemplary students prior to having children (Mason, 2009).

The challenges facing new mothers in doctoral programs are not unique to social work, nor are they a new problem. In her 1983 memoir, Michelle Harrison, a divorced mother of a young daughter, described her training to become an obstetrician-gynecologist. Despite securing a rare part-time residency, she was still expected to complete 60-hour weeks and was subjected to colleagues' resentment of her "maternal preoccupations" and part-time status (for which she was given half the pay for two-thirds time). Several decades later, the availability of part-time residencies remains the exception, not the norm. Less than 4% of accredited residency programs offer part-time options, despite an increasing demand from medical students and residents for more flexible options (Croasdale, 2006). Part-time residencies tend to be offered at large institutions with supportive hospital administrators who know that attracting and retaining top candidates requires being more accommodating scheduling.

Some training programs have established informal ways of offering support to students. At the University of Wisconsin School of Medicine and Public Health, a student-run group called Families and Non-Traditional Medical Students provides a sense of community to students and their partners who are trying to juggle multiple demanding responsibilities. The group even provides tangible help, such as cooking meals or running errands, to fellow students after the arrival of a new baby (Smith, 2011).

Using their own experiences as research data, Grenier and Burke (2008) explored how new mothers completed their doctoral studies in the field of adult education. They found a discrepancy between individual and institutional support: "although individuals within our university supported our choices, the institution often times expects family responsibilities to be taken care of without interrupting studies and with very little need for institutional adaptation" (p. 597). They attributed the encouragement and assistance that they received to faculty members' deep understanding of adults' needs and their commitment to "practice what they preach" (p. 598). Given our professional values, social work doctoral students should be able to count on a similar supportive and welcoming environment. Faculty members can help set the tone, especially if they can relate to the dilemmas firsthand. Grenier and Burke noted the particular importance of female faculty members who had lived the dual roles of mother and scholar and could provide reassurance that being "squeezed out" of academia was not inevitable. Within male-dominated environments, female mentors are critically important to female students (Maher, Ford, & Thompson, 2004).

Adjusting to New Roles

In addition to environmental factors, these women must adjust to the duties and expectations of two new roles: doctoral student and new mother, each of which requires specific knowledge and skills to be successful. Some of the necessary behaviors may come intuitively or may approximate the knowledge and skills of other roles. Writing a doctoral-level paper may be similar in many ways to writing papers in a Master's program; being attuned to a baby may echo the ways in which clinicians are present and empathic to partners, friends, or clients. Other behaviors may be new to a doctoral student and mother, and thus require a steep learning curve. How does one analyze data using multivariate statistics? How does one trim the fingernails on a newborn?

There also are behaviors that involve the intersection both roles, such as the challenge of completing dense readings and writing cogent papers after staying up all night with a fussy baby. These challenges can be described as "role discontinuity," which refers to the lack of integration between roles that arise in sequential—or in this case, simultaneous—stages (Biddle, 1979). By adjusting to more than one new role at once, these students may experience disequilibrium, stress, and confusion. They lack the benefit of having at least one consistent, familiar role to rely on during the all-consuming time of transition into doctoral education and motherhood.

Despite the difficulties, multiple roles can also prove beneficial for one's mental, physical, and relational health (Barnett & Hyde, 2001). Part-time doctoral students, regardless of whether or not they have children, may experience these benefits as they pursue their degrees while engaging in clinical practice, among other meaningful activities and relationships in their lives. For example, academic studies are often enriched by clinical work, and vice versa. Barnett and Hyde (2001) identified several processes that can contribute to the beneficial outcomes and may relate to the dual roles of doctoral student and mother, including buffering effects, opportunities to build self-efficacy, increased self-complexity, and an expanded frame of reference. For example, after being at home all day with a baby, there can be relief and stimulation in putting on professional clothes and teaching an evening course. Conversations with students and colleagues may buffer against the isolation of caring for a newborn. Simultaneously, being a parent can enhance one's worldview in unexpected ways, such as by providing an expanded frame of reference for relating to students, thinking about social problems, listening to research data, and figuring out one's place in the field and career trajectory. The demands of work and family can be seen as compatible, not conflicting, and thus, doctoral students need not be forced to choose between the two (Halpern, 2008).

Our Stories

Theories are important for broad understandings of a phenomenon, but as social workers know so well, deep, resonant understanding often lies in the specific details of personal story. Both of the authors became mothers during our doctoral studies. Although we both ultimately completed our degrees, it was not without struggles and ambivalence, as our stories attest.

Carla's Story

My first daughter was born after I had completed about a year of doctoral coursework, and my second daughter arrived weeks before I passed my comprehensive exams. I took a semester off after the birth of my first child, and I seriously questioned whether or not to return to my studies. As I wanted to remain intimately and consistently involved in the care of my children, I never seriously considered a nanny or full-time childcare. Staying at home full-time or finding a part-time clinical position seemed like viable options. I fantasized about a job that would allow me to leave my work at work, about never again having a paper hanging over my head. I wanted to be fully present with my daughters, but I was also deeply committed to my career as a social worker and academic. I was torn.

Two factors ultimately brought me back to my degree, and sustained me through the challenges of comprehensive examinations and my dissertation: the part-time structure of my program and the support of the faculty. The flexibility of a part-time schedule was crucial as I balanced my research and writing with trips to the pediatrician and planning toddler birthday parties. When my daughters' ear infections happened to fall on the one day each week I had classes, my faculty members were kind and understanding. Many of my professors and committee members (but not all) were parents themselves, and remembered the sleepless nights, the paralyzing fatigue, and the unpredictability and inconsistency of life with new babies and toddlers. They saw me not just as a doctoral candidate, but as a whole person: a mother, a wife, a social worker, and a student, and they were willing to accept all of my roles, as well as my struggles to balance them. Although I was ultimately able to finish my degree, I am not currently pursuing a tenure-track position. I do not believe it would be possible for me to meet the demands of the work while also remaining fully engaged in the work of raising my daughters.

Ashley's Story

I had it all planned out. I would get pregnant in September of my third—and final—year of doctoral courses. I would give birth in May, take the summer off, and begin my dissertation the following fall. My studies could be planned in a linear fashion, but fertility does not work that way, and parenting most certainly does not either. I ended up taking two semesters off from the program: the first due to all-day "morning" sickness, the second due to infatuation with my newborn. My dissertation committee supported my choice and waited patiently while I was on leave.

When I returned, I powered through my dissertation; I would put my baby to sleep in the evening, brew a pot of coffee, and write until the wee hours. I taught courses on an adjunct basis and opted for the sections that were offered on the weekends. My partner could be home with our son, and the added expense of childcare would not be necessary. Several members of my cohort were not parents or had grown children. I watched with envy as they traveled to national conferences before I was ready to leave my baby and go. They put in extra hours to have publications on their CVs, while I focused solely on maintaining momentum with my dissertation. By the time I defended my dissertation, my partner was pregnant with our second child.

I am now on the tenure track; I accepted a position that was too good to pass up. As I remain in academia, these tensions have not gone away. Being a mother and a faculty member are both intense roles with many responsibilities and few boundaries. I find myself creating lines in the sand, which help me to be more present wherever I am, such as limiting my late nights at work so I do not miss family dinners or the kids' bedtimes more than twice a week. I am the only full-time faculty member in my department with young children, but I am fortunate to work with colleagues and administrators who have not forgotten how consuming motherhood can be. When I go up for tenure, my younger child (who now is a baby) will be able to read. As I marvel at her developmental milestones, I try to have patience and celebrate my own incremental progress.

Recommendations for Social Work Doctoral Programs

Although funding is tight for institutions of higher education across the country, there are several straightforward, inexpensive, and valuable changes which can be implemented in order to make doctoral programs more supportive to new mothers. Our proposed recommendations address both the academic environment and the role discontinuity faced by these students.

Change the Culture, Explicitly and Implicitly

The Council on Social Work Education's (2008) core competency 2.1.4 requires schools of social work to engage diversity and difference in practice, and includes many dimensions of diversity: "age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation" (p.5). Schools of social work can think expansively and add "family status" to the forms of diversity that recognized in their student body and beyond. In their admissions materials and policy manuals, schools can be explicit about their goals to be family-friendly. Furthermore, a zero-tolerance policy for discriminatory and disparaging comments should be adopted. Faculty members should be encouraged to initiate conversations with their students about the challenges inherent in balancing doctoral studies and motherhood.

Create Opportunities for Flexibility in Scheduling

Whenever possible, doctoral programs should offer part-time options. In addition, new mothers need to be given an adequate amount of maternity leave from coursework as well as teaching and research responsibilities, ideally an entire semester. The timing of courses and meetings should take into account that most mothers have greater access to a variety of childcare options during the day. The availability of technology would provide greater convenience and flexibility; whether planned or in a pinch, some meetings could take place via conference call or over Skype. Such technology is already being used in teaching online or hybrid courses, and could be extended to other ways of staying connected and progressing work. Employees who have access to family-friendly practices are late or absent less often, exhibit fewer stress symptoms, and are more committed to their employer (Halpern, 2008); it is likely that the same findings would be true for doctoral students in family-friendly academic programs.

Offer Support in a Variety of Formats

Support is crucial to the educational success of new mothers (Liechty et al., 2009). Interested students could be offered a mentor relationship with faculty members and alumnae who have successfully navigated doctoral studies and child-rearing. Workshops could coach students on how to manage campus interviews, and a support group for new mothers pursuing their doctorates could be created and open to students from a number of disciplines within one school or a variety schools in the area.

Listen to the Voices of New Mothers

Students who are new mothers may have a variety of needs, some significant, others less so. Values from the *Code of Ethics* (NASW, 2008) mentioned earlier, including respect for colleagues and the dignity and worth of the individual, require everyone to have a voice in the conversation. Faculty members should have informal conversations with their students, and formal questionnaires about scheduling, financial issues, and formal and informal supports should be conducted.

Maintain Appropriate Expectations

Most doctoral students will need additional support for a variety of reasons during the course of their studies, including new mothers. Just as professors should not expect more of new mothers than other students, they should not lower their standards, either. It is possible to offer flexibility and support while still maintaining appropriate expectations.

Conclusion

Pursuing doctoral studies and embarking on motherhood are intentional choices that many women make. Engaging on both paths simultaneously can be incredibly gratifying, but can also lead to a variety of challenges and stressors that are difficult to anticipate beforehand. As a result, many new mothers are choosing to leave school or drop out of the tenure track career path. The social work profession has an obligation to address, whenever possible, the needs of this group of students. A commitment to family-friendly policies based on a strong understanding of the ways in which the environment can support new mothers as they attempt to integrate two different roles would undoubtedly help more new mothers successfully complete their doctoral studies and go on to make important contributions to the social work profession.

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SOCIAL WORK HISTORY

Remembering Francis Perkins: The Past, Present, and Future of Social Work

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Abstract

As one of the founders of social work, Francis Perkins worked as an educator, union organizer as well as with the Settlement Houses and the Charity Organization Society. Her spirit, passion, and commitment to social justice were not without challenge throughout her life, yet unfazed she worked on behalf of the oppressed to create many of the social programs that are still in existence today. As part of the Labor Movement, Women's Suffrage Movement and co-author of the Social Security Act of 1935, her contribution to the mission, values, and ethics of social work may be relatively unknown by modern practitioners, scholars, and students, however Perkins reminds all in the field what social work, social reform and social justice really mean. It is important to remember Francis Perkins and her contribution to social work practice, policy, education, and community work.

Frances Perkins: Her Life, Work, and Message to Social Work

> "Historical perspective is necessary if one is to comprehend and evaluate the ideas, the actions, and the direction of individuals who become leaders in society and affect the structure and behavior of society, who bring about or modify patterns in the economic, social, political, or religious life of their times" (Perkins, 1954, p. 12).

1933 was a year of many profound historical events in the world (Harvey, 1999). The Reichstag parliament building in Berlin was set on fire (Tobias, 1964); Joseph Stalin made sweeping statements that the Soviet Union was far superior to the United States, and Adolf Hitler was appointed Chancellor of Germany by the president at the time, Paul Von Hindenburg (University of Virginia, n.d.). Locally, construction on the Golden Gate Bridge (Starr, 2010), one of modern constructions greatest feats and a WPA project (Works Progress Administration) began (Axinn & Levin, 1992), Newsweek was published for the first time (U.S. News, 2007), the 20th Amendment to the U.S. Constitution was passed and the 32nd president of the United States, Franklin Delano Roosevelt was inaugurated (University of Virginia, n.d.). Roosevelt's inauguration followed the 1929 Stock Market Crash and the new president entered office in the throes of the Great Depression (Martin, 1976). Needless to say, both the world and the country were in a time of rapid change politically, socially, culturally, and economically (Cohen, 2007; Harvey, 1999; Kilty & Segal, 2006). It was during this time of human evolution, the early 1900s that a brand new field began to develop: Social Work. Undoubtedly, one of the most influential people in the mission, goals, and values of the profession was none other than Francis Coralie Perkins.

Francis “Franny” Perkins: A Beginning

The first female cabinet member, Francis “Franny” Perkins, was born on April 10th, 1880 in Boston and spent her childhood living a comfortable life in Massachusetts (Martin, 1976; Mohr, 1979). Perkins’ parents made education a family priority and thought that the appropriate role for a woman was to become a community school teacher: “Her parents hoped Franny on graduation would return to Worcester and after a round of visiting friends in the summer, either teach school or work for the church and, soon or later, marry” (Martin, 1976, p52). This was the traditional expectation for young women at that time and most of Perkins’ female classmates did exactly what they were told to do (Downer, 2009). However, Perkins had an unquenchable thirst for knowledge and an equally passionate spirit; throughout college she was exposed to ideas about society, economics, and most importantly social reform (Martin, 1976). Perkins studied a variety of topics, obtained a bachelor’s in chemistry and physics in 1902, and then a master’s in political science in 1910 (Martin, 1976, Mohr, 1979). Despite her scientific education, she continually sought out the company of a variety of individuals as she had a true passion for people and social justice issues (Martin, 1976). College was a deeply profound time for her as she was able to integrate what she was learning in her classes with those who were experienced in working on actual social problems (Martin, 1976).

Florence Kelly, a mentor whom Perkins met during her undergraduate degree time, worked as a Chief Inspector of Factories while advocating on behalf of the labor unions and simultaneously raising a family as a single mother. Described as a “raging furnace” and “impatient crusader” when it came to social justice issues, Kelly was close with Jane Addams and Mary Richmond; together the three social workers further influenced Perkins to take the path less traveled and encouraged her to enter the newly burgeoning field of social work (Martin, 1976; Perkins, 1954). In later correspondence with a close friend, Perkins wrote that it was Kelly who “first opened my mind to the necessity for and the possibility of the work [social work] which became my vocation” (Martin, 1976, p. 52). Undoubtedly, this exposure to new ideas and active critical thinkers, like Kelley, led to the non-traditional life path that Perkins chose.

New York City, Charity Houses and Settlement Work

Upon graduation in 1902, Perkins’ father told her that she needed to come home but despite his protestations, she had other plans (Downey, 2009). Perkins left for New York City and immediately applied for a job with the Charity Organization Society (COS) (Kilty & Segal, 2006; Martin, 2009). The mission behind the COS intrigued Perkins, yet due to her youth and inexperience, she was unable to obtain a job there (Martin, 1976; Mohr, 1979). She stayed in New York substitute teaching for a few months and eventually, after making no solid earnings, left to return home to Massachusetts (Martin, 1976). Even though she was home, Perkins was not content to sit and wait for marriage; she began teaching sewing classes at a local settlement house and soon she organized a social-educational group of 25 young girls who were employed in a candy factory (Martin, 1976). One of these young girls, Mary Hogan, deeply affected Perkins as her hand was severed in a candy dipper during an 18 hour work day (Martin, 1976). The factory sent Mary home with no medical care and no pay; Perkins was outraged and arranged for her to obtain emergency medical care that likely saved her life (Martin, 1976). With the church supporting her she obtained $100 for the girl in medical pay (Martin, 1976). Despite her youth, Perkins was already creating a reputation of activism and impatience for social injustice.

A short time later, Perkins accepted a teaching job at Ferry Hall in Chicago where she taught for three years (Martin, 1976). While there she interacted with several Episcopalian nuns who were active members in the community; she found their humble service to people quite inspiring and as a result Perkins began to question the hierarchical and patriarchal structure of the Christian religion that she was raised with (Martin, 1976). As a result, Perkins converted to the Episcopal faith and she felt it was closely aligned with the social work values of charity, community, and just governance (Martin, 1976; Mohr, 1979). Perkins, a disciplined and hard worker, also found a sense of careful earnestness in the Episcopal community that, she felt, if replicated in politics, would strengthen the overall purpose and quality of the U.S. governmental system (Martin, 1976; Mohr, 1979).

This new found faith was looked down upon by some of her long standing friends yet Perkins was not dissuaded; she began to feel that her purpose as a teacher was coming to an end and left to work in the settlement houses nearby (Downey, 2009; Martin, 1976). It was here that Perkins again met Jane Addams, and together the two fought for the underrepresented and abused child factory workers who made less than one-third of the living wage despite working 80 hours a week (Martin, 1976, Seeber, 1990).

Working in New York: Social Action and Grassroots Service

Perkins began working for the New York City Consumers League on sanity standards, safety regulations, and fire prevention strategies for bakeries and factories after finishing her master's degree in 1908 (Downey, 2009; Martin, 1976). During her time with the League Perkins worked on a "54-hour bill to prohibit women of any age and boys under eighteen from working in factories more than fifty-four hours a week" (Martin, 1976, p.77). Perkins was routinely associated with representing the people's interests as she began to work with the women's suffrage movement (Berg, 1989; Downey, 2009; Pirro, 1998). Needless to say, Perkins' efforts preceded her as she was known not just for her social and oration skills but also her commitment to social justice through hard work and community integration (Martin, 1976; Pirro, 1998).

With the support of Perkins, factory workers began to realize further the need to unionize and in 1912 she was assigned to resurrect the dead and forgotten Factory Investigating Committee (Martin, 1976). Serving as a community organizer and government leader was not all Perkins was doing as she decided to start her family as well. In 1913 Perkins married Paul C. Wilson, an economist also working in New York City and three years later she gave birth to their only daughter, Susanna (Frances Perkins Center, 2011; Downey, 2009; Martin, 1976). Shortly thereafter Wilson began to show symptoms of bipolar disorder and for the majority of his adult life he was placed in an institution unable to provide for his young family (Downey, 2009; Martin, 1976; Mohr, 1979).

Embodying an ethic of self-care and work-life balance that is pivotal to modern social work, Perkins served as a wife, mother, and caretaker, while continuing to work for the New York State government. Her reputation grew and in 1929 she was appointed as the State Industrial Commissioner (Perkins, 1934a/b; Martin, 1976; Wandersee, 1993). Under Governor Franklin Delano Roosevelt, Perkins expanded her progressive, pro-worker reforms with increased and regular factory investigations and a 48 hour work week for women (Martin, 1976;

Wandersee, 1993). Simultaneously, Perkins continued to labor for minimum wage laws and unemployment insurance but was left without little public support for such expensive programming (Downey, 2009; Martin, 1976; Perkins, 1962).

Perkins Goes to Washington

Governor Roosevelt ran for president and in 1933 succeeded Herbert Hoover to win the election (Goldberg & Collins, 2001). The only president to serve more than two terms, Roosevelt came into office with a clear plan to revitalize the nation stating in his inauguration acceptance speech: “I pledge you, I pledge myself to a new deal for the American people... This is more than a political campaign. It is a call to arms” (Burns, 1956, pg. 93). President Roosevelt already having worked with Perkins for several years in New York City, expressed deep desire to have her as a part of his cabinet as the Secretary of Labor (Burns, 1956; Downey, 2009; Martin 1976).

Initially, Perkins refused the position feeling inept and undereducated for the position, and instead, suggested several other notable female union organizers (Downey, 2009; Seeber, 1990). Perkins, supported and encouraged by Jane Addams and Eleanor Roosevelt, finally accepted the position with two mandatory preconditions (Downey, 2009; Seeber, 1990). A strong believer in family, Perkins first precondition of appointment was that she be allowed to visit her husband every weekend in upstate New York where he resided in a mental illness facility (Martin, 1976). The second precondition was that she expected Roosevelt and his administration to support her liberal social policies namely: the abolition of child labor, standards for working conditions including a regular work week, regular safety inspections for factories, minimum wage laws, universal health care as well as allowing and encouraging the participations of unions in the formation of labor laws (Martin, 1976; Perkins, 1934a, 1943, 1962). Roosevelt agreed to both of her demands and for the duration of her career in the White House, Perkins proceeded to telecommute between Washington, DC and the countryside of New York (Downey, 2009; Martin, 1976). Perkins also made sure that Roosevelt followed through on his promise to implement her social aid policies and during his time as president, Roosevelt created many of the social welfare programs that are still in existence today.

Perkins and Roosevelt Together: A Unified Front

Upon taking office on March 4th, Roosevelt immediately called Congress to a special session and proceeded to keep them there for the next three months (Burns, 1956). Roosevelt’s conception of the ‘first hundred days’ in office has remained a way by which a presidential campaign is still judged (Walsh, 2009). Roosevelt’s passion and direction combined with the dire state of the country at this time led much of Congress to drop their concern for partisanship and many of the Congressmen “had forgotten to be Republicans or Democrats” (Walsh, 2009, para. 7). During these first few months in office, sweeping forms to the banking industry, and the Works Profess Administration (WPA) occurred while the Federal Emergency Relief Administration (FEMA) and the Civil Works Administration were created (Fisher, 1980; Goldberg & Collins, 2001, Gregory, 1961; Kilty & Segal 2006). It was Perkins and Roosevelt working together that enabled these radical and systemic changes to occur. A portion of their programming included the creation of new jobs and the protection of banks that allowed both people to obtain work, while also placing money back into the economy at the same time (Fisher, 1980; Goldberg & Collins, 2001). Farms received subsidies as well, and as such, the entire nation was afforded aid (Burns, 1956; Fisher, 1980; Goldberg & Collins, 2001). When Congress adjourned on June 16th 1933, fifteen of Roosevelt and Perkins’ major bills had passed and the country, while not out of the water, was much more stable than before (Goldberg & Collins, 2001). It was her courage, ethics, and social work training that helped Perkins enact these massive changes in a very short time.

Francis Perkins: The Secretary of Labor

Through Roosevelt's tenure as president, Perkins became a close advisor and confidant to him and it was through their collaboration that Perkins was able to form the Civilian Conservation Corps (CCC) while instituting both the National Labor Relations Act and the Fair Labor Standard Act (Barber, 1989, Burns, 1956, Fisher, 1980, Martin, 1976; Perkins, 1934a, 1962; Social Security Administration, 2010, 2011; United States Department of Labor, 2010/b). The CCC, a specific work program, was intended for unemployed and unmarried young men between 18 and 25 who with undefined skill sets had very limited employment opportunities (Barber, 1989; Deming, 1923). The workers were assigned to construction or conservation projects and over nine years the CCC provided work for over 2.5 million young men (Barber, 1989; Deming, 1923; Perkins, 1962). The National Labor Relations Act of 1935 supported unions to engage in collective bargaining and promoted the ability for workers to strike by limiting the reactionary measures that employers could take against such workers (Barber, 1989; Burns, 1956). The Fair Labor Standard Act of 1938, one of Perkins most ardent causes, created a minimum wage with extra pay for overtime at a rate of 150% that of the regular rate (Gregory, 1961; Martin, 1976). This law also prevented children in city settings who were under the age of 16 (and 18 for extremely dangerous work) from employment; for children under the age of 16, working on farms, were now for the first time, not allowed to work during school hours (Downey, 2009; Gregory, 1961; Martin, 1976). Throughout the passage of these acts, Perkins continued to develop long-term sustainable macro-level projects to encourage local economic growth (Downey, 2009). Indeed these acts were very impressive, yet it was the Social Security Act that Perkins is most known for.

Francis Perkins and Social Security

Enacted in August of 1935, the Social Security Act (SSA) was the shining star of Roosevelt's New Deal. The intent of the SSA, to limit the risks and dangers that workers would face as a result of life events such as old age, unemployment and poverty, also protected the most vulnerable populations such as children and widows (Social Security Administration, 2011). Perkins here was inspired again by Florence Kelley's mentorship, her work in the settlement houses, and her time as a union organizer, as she continued to promote the primary responsibility of government to its people. In order to pass the SSA, Perkins also befriended and worked with Harry Hopkins, another founder of social work. The two had the same views on government and shared a passion for social justice issues; it is thought that their ability to work together helped further support the passage of the New Deal Policies (Martin, 1976; Seeber, 1990).

Under the provisions of the SSA, assistance was provided for those who were retired and unemployed as well as for those who were blind (Social Security Administration, 2011). Additionally, large reaching public health services were outlined, although Perkin's desire for Universal Healthcare was never realized (Downey, 2009, Martin, 1976). Finally, the SSA outlined the Aid to Families with Dependent Child or AFDC (Downey, 2009). This law stood relatively untouched for over 60 years, until 1996, as a way to provide financial assistance to children with single parents as well as those families with very low or no palpable income

(United States Health and Human Services, 2009). Undoubtedly, these acts, while supported by Roosevelt, were truly the doing of Perkins and they have stood the test of time (Burns, 1956; Martin, 1976; Seeber, 1990).

Conclusion

Despite the accomplishments of Roosevelt and his cabinet, Perkins detailed how at times the President lost confidence as he felt his policies were too grandiose and that they would never pass Congress (Perkins, 1934b). During these times of doubt, it was Perkins who stayed true to her social work calling and in essence coached President Roosevelt to continue to push his legislative agenda (Downey, 2009; Martin, 1976, Perkins, 1934b). Scholars have since doubted if the bills would have passed without Perkins' unending energy and passion (Downey, 2009; Martin, 1976). Perkins is often known as the 'woman behind the New Deal' and while she does not always get the credit she may deserve, she was more than pleased that in such a short time, large and impactful changes were made to the ultimate benefit many people in need (Downey, 2009; Martin, 1976).

Until her death on May 14, 1965, Perkins continued to work for community organizations and guest lectured at colleges all over the nation; even today she is regarded as a founder of social work, emblazoned community organizer, and advocate of the people (Downey, 2009; Pirro, 1998). Francis Perkins shaped the profession of social work while traversing gender roles, and cultural norms that was unheard of during that time. "The heedless optimism of the boom years is past. We now stand ready to build the future..." (Downey, 2009, p. 38). Perkins words could not be more appropriate during this economic, social and political time; her work, life and legacy will continue to infuse the future of social policy as well as the minds, hearts, and souls of many social workers every day.

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Elisa Kawam is a PhD student in the School of Social Work at Arizona State. She obtained her Bachelors of Social Work in 2007 and her Masters of Social Work in 2008. During her Masters, she specialized in Policy, Advocacy, and Community aspects of Social Work as well as obtaining a graduate specialization in Child Welfare. Previously she has worked as an investigator for Child Protective Services in South Phoenix as well as supervising a transitional housing facility for pregnant and parenting teenage mothers. Her research interests include trauma symptomology, transmission, treatment and prevention. She also researches the overlap between the child welfare system and intergenerational patterns of trauma and violence. She presently works for the Center for Applied Behavioral Health Policy (CABHP) at ASU and is involved in multiple projects surrounding child welfare service engagement, assessment, community involvement, and evaluation. Further she is passionate about teaching and continues to pursue her pedagogical interests. She plans on graduating in Spring 2015 after which she will continue to pursue high level teaching and research opportunities. She can be reached at ekawam@gmail.com

Bookworm's Corner

Book Review

Cozolino, L. (2010). *The neuroscience of psychotherapy: Healing the social brain.* New York: Norton.

Reviewed by David Axlyn McLeod
Virginia Commonwealth University

Content and Style

The Neuroscience of Psychotherapy: Healing the Social Brain is a useful addition to the literature base and could be used as a tool to both inform the future of clinical social work and to further legitimize many of the profession's long-held standards of practice. In his book Cozolino, a clinical psychologist and professor of psychology at Pepperdine University, has written extensively about the social aspects of the human brain, neurological development, attachment, consciousness construction, and the conflict between needs people face in modern society and the evolutionary developments their brains continue to carry.

The author organizes the book into 6 sections with a total of 18 chapters, and his writing style appears to be both accessible to the practicing clinician and useful to the research-intensive academic. It appears Cozolino's intention is to give the reader a solid foundation of understanding in reference to the history of neuroscience and its application to mental health. He works to advance the idea that the human brain is an evolutionarily developed and socially integrated organ distinctly tethered to relationships and individual perception of personal history.

Cozolino works to communicate the relationship between neuroscience and psychotherapy and writes, "Psychotherapists are applied neuroscientists who create individually tailored learning environments designed to enhance brain functioning and mental health" and this concept is evident throughout the book (p. 341). The author assembles clinical examples using popular culture and historical references to convey his understanding of the manner by which human neurodevelopment is impacted by personal experiences, yet remains open to positive growth. The book appears to be targeted at improving clinical practice by enhancing clinician skills and generating new perspectives that could be incorporated into research.

Strengths and Weaknesses

The possibility for practical application is one of the primary strengths of this text. Cozolino makes a strong argument for the importance of attachment theory and its integration into clinical practice. He ties this position to descriptive research associating the complexity of human thought and consciousness development to the manner by which the brain is structured to rapidly assess observations and attempt to relate them to previous life experiences. He details that this is done in a manner explicitly and evolutionarily tied to human survival and the ability to gauge levels of safety in every-day situations. He speaks directly to the need for the human brain to be involved in a narrative process, and describes this in the context of the manner by which the left-brain imports and exports linguistic data, while the right brain interprets that experience.

Cozolino pays particular attention to explain the manner by which the human brain processes what is perceived as reality and how these perceptions are developed. He consistently finds ways to relate these concepts back to clinical practice, through case studies and explicit details about psychotherapeutic techniques like cognitive behavioral therapy, psychodynamic approaches, and narrative therapies.

Perhaps the only weakness to his book could be Cozolino's use of scientific terminology and abbreviations from the field of neuroscience. The scientific nature of some language could find a reader new to the field exploring this book within constant arm's reach of Google for clarification of unfamiliar terms. All in all, this could be a good problem to have for a reader who wants the most technical and up to date communication of the topic.

Contribution to Social Work Practice

Cozolino's text could add to the profession of social work in several different ways. First his depiction of the manner by which psychotherapy and the clinical relationship is helpful to the positive development and healing of the human brain serves as a validation of the style of clinical practice for which the profession of social work has often come to be known. Cozolino details, using the latest scientific research methods, how psychotherapy can have positive impacts on people at all stages of life, and how new advances in the understanding of brain plasticity and the effectiveness of the psychotherapeutic setting empirically validate practices social workers have been using for the past century.

Secondly, Cozolino speaks to an understood foundational tenet of social work practice. Social workers have historically approached individual well-being in the physical and psychological senses with a presupposed assumption that the individual is intrinsically linked to his or her environment. Social workers attempt to work from "where the client is." Cozolino speaks to the social nature of the brain and its development, particularly the method by which the developing brain bases a person's observations on predetermined understandings and perceptions of the world. He posits the mere existence of human beings at this point in time, and our survival on this planet, is directly related to our evolutionary drives to remain together as a social unit. He explains throughout the book how our brains are hardwired to be socially connected to, and dependent on, each other as interactive units in partnerships, groups, families, and societies. One implication for his position in reference to the importance of relationships on neurodevelopment is that clinical practitioners should not only retain the value of the person's story in the context of the systems in which they are involved, but also work to professionally expand acceptance and understanding of neurological complexity in clinical practice.

A third implication of Cozolino's work for social work practice is in its applicability for practice theory. In this book the principles of modern neuroscience are applied to clinical situations where diagnoses like PTSD, borderline personality disorder, depression, anxiety, among others, are explored. He addresses the implications of exploring these issues from a neuroscientifically informed perspective and with the most modern research in mind. These perspectives could give clinical social workers a new tool set to access in order to improve the delivery of multiple methods of intervention in the clinical setting.

Conclusion

In short, Cozolino's work is an excellent addition to the library of any social work student or practitioner, especially those with a clinical focus. He puts forth examples of some of the most progressive research available today in reference to neurological development and the psychological, behavioral, and social implications associated with it. In doing so Cozolino not only validates many practice approaches historically held by social workers, but pushes forward a model of neurologically-informed practice which could be remarkably helpful as the profession moves forward well into its next century.

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David Axlyn McLeod, PhD, MSW, defended his dissertation at Virginia Commonwealth University on February 26th, 2013, and will be moving on in his journey as an Assistant Professor with the Anne and Henry Zarrow School of Social Work at the University of Oklahoma in the Fall of 2013. David has accumulated over 15 years of clinical and professional experience with, among other things, time served as a special victims police detective, CPS investigator, sex-offender treatment provider, and psychosexual risk evaluator for the court systems. David's research is affiliated neuroscientifically informed approaches in the areas of *forensic trauma* and the development of *criminal psychopathology*. For more information, and a curation of his professional activities, please visit www.damcv.com.

The CV Builder

University of Houston, Graduate College of Social Work
Perspectives on Social Work congratulates the following doctoral students on their accomplishments during Fall 2012 through spring/summer 2012.

Christine Bakos-Block

Publications

McIngvale, E., **Bakos-Block, C**., Hart, J., Bordnick, P. (2012). Technology and obsessive compulsive disorder: An interactive self-help website for OCD. *Journal of Technology in Human Services*, *30*(2), 128-136.

McIngvale, E., **Bakos-Block, C.**, Hart, J., Bordnick, P. (2012). The OCD Challenge: An online self-help program for obsessive compulsive disorder. (B. Barcaccia, D. Dettore, & F. Mancini, Eds.). *Psicoterapia Cognitiva e Comportamentale, 18*(3), 83-97.

Presentations

Bakos-Block, C. (2012). Virtual reality, cravings, and clinical implications for treatment. The Houston Licensed Professional Counselors Association. Houston, TX (August 3).

Bakos-Block, C., & Hart, J. (2012). The OCD Challenge: Preliminary findings for the use of a web-based intervention for OCD. International Obsessive Compulsive Foundation Conference, Chicago, IL (July 29).

McIngvale, E., & **Bakos-Block, C**. (2012). The OCD challenge: Implications and possibilities of a web-based intervention with preliminary findings of the pilot study. Second Meeting of the EABCT S.I.G. on OCD, Assisi, Italy (May 12).

Traber Davis Giardina

Publications

Singh, H., **Davis Giardina, T.**, Meyer, A.N.D., Forjuoh, S.N., Reis, M.D., Thomas, E.J. (2013) Types and Origins of Diagnostic Errors in Primary Care Settings. *JAMA Internal Medicine*. 2012. Accepted.

Singh, H., Khan, R., **Davis Giardina, T.**, Wilson, L., Daci, K., Gould, M., & El-Serag, H. (2012) Post-Referral Colonoscopy Delays in Diagnosis of Colorectal Cancer: A Mixed-Methods Analysis. *Qual Manag Health Care.* 21(4):252-261.

Sarkar, U., Gonacum, D., Strull, W., Spitzmueller, C., Jin, N., Lopez, A., **Giardina, T.D.**, Meyer, A., & Singh, H. (2012) Challenges of making a diagnosis in the outpatient setting: a multi-site survey of primary care physicians. *BMJ Qual Saf.* May 23. [Epub ahead of print].

Presentations

Davis Giardina, T., King, B., Ignaczak, A., Paull, D. Hoeksema, L., Mills, P., Neily, J., Singh, H. Understanding Diagnostic and Treatment Delays in Ambulatory Care: A Review of Root Cause Analyses Reports**.** VA HSR&D National Meeting, Washington, DC, July 16-19, 2012.

Singh, H., **Davis Giardina, T.**, Forjuoh, S.N., Reis, M.D., Khan, M.K., Thomas, E.J. Characteristics of Primary Care Visits Associated with Diagnostic Errors. VA HSR&D National Meeting, Washington, DC, July 16-19, 2012.

Smith, M.W., **Giardina, T.**, Singh, H. Overcoming barriers in healthcare: Strategies for resilience in coordination of follow-up for cancer diagnosis. In: Proceedings of the 2012 Symposium on Human Factors and Ergonomics in Health Care: Bridging the Gap; 2012 March 12-14, Baltimore, MD.

Elizabeth McIngvale

Publications

McIngvale, E., Bakos-Block, C., Hart, J., Bordnick, P. (2012). Technology and obsessive compulsive disorder: An interactive self-help website for OCD. *Journal of Technology in Human Services, 30*(2), 128-136.

McIngvale, E., Bakos-Block, C., Hart, J., Bordnick, P. (2012). The OCD Challenge: An online self-help program for obsessive compulsive disorder. (B. Barcaccia, D. Dettore, & F. Mancini, Eds.). *Psicoterapia Cognitiva e Comportamentale, 18*(3), 83-97.

Presentations

McIngvale, E., & Bakos-Block, C. (2012). The OCD challenge: Implications and possibilities of a web-based intervention with preliminary findings of the pilot study. Second Meeting of the EABCT S.I.G. on OCD, Assisi, Italy (May 12).

Holly K. Oxhandler

Presentations

Oxhandler, H.K. (December 2012). *Measuring the Integration of Clients' Religion/Spirituality In Clinical Practice: Introducing the Religious/Spiritually Integrated Practice Assessment Scale.* Presented at the University of Houston Social Work and Research Conference, Houston, TX.

Oxhandler, H.K., Alquicira, L.M., & Parrish, D.E. (November 2012). *Pay it forward: Implementation and evaluation of a MSW peer mentoring program.* Paper to be presented at the annual program meeting of the Council on Social Work Education, Washington, DC.

Oxhandler, H.K. (2012, May 15). *Faith and Social Work Practice: A dual relationship. (*Invited) [Web blog posting]. Retrieved from http://nacsw.org/blog/2012/faith-and-social-work-practice-a-dual-relationship/

Oxhandler, H.K. (May 2012). *Religion/Spirituality Integrated Practice Assessment Scale*. Invited presentation at the Institute for Spirituality and Health in the Texas Medical Center, Houston, TX.

Micki Washburn

Fellowships/Awards

2012	University of Houston Teaching Excellence Award for Outstanding Faculty, Teaching Assistants/Fellows (Nominated – selection complete in Spring 2013).
2012	Texas Counseling Association Educational Endowment Fund Award.
2011	Mark Phillip Magaziner Fellowship Endowment Award.

Publications

Washburn, M. (In press). Five things social workers should know about DSM-V. *Social Work.*

Washburn, M. & Parrish, D. (in review). Licensed Professional Counselors Use of the Evidence Based Practice Process: The Evidence for Change is Promising.

Ren, Y., **Washburn, M**. & Kao, D. (in review). The role of health insurance on health outcomes and out-of-pocket expenditures of Chinese rural and urban children.

Other Publications and Media

Singer, J.B. (Host) (2012, November 10). *Proposed Changes in DSM-V: Interview with Micki Washburn, MA, LPC-S and Danielle E. Parrish, Ph.D.* Podcast can be retrieved from: http://socialworkpodcast.blogspot.com/2012/11/proposed-changes-in-dsm-5-interview.html

Presentations

Washburn, M. *DSM-V: Changes and Challenges for Social Work Education*. Skills Training Workshop. Council on Social Work Education 58th Annual Program Meeting. Social Work: A Capital Venture. Washington, DC. November 9-12, 2012. (Refereed)

Washburn, M. *I've Never Done This Work Before – Culturally Competent Practice with Gender Variant Clients.* 56th Annual Professional Growth Conference of the Texas Counseling Association. Galveston, TX. November 17, 2012. (Refereed)

Washburn, M. *DSM-V: Implications for Social Work Practice, Research and Policy*. To be presented at the 36th Annual National Association of Social Workers – Texas State Conference. Houston, TX. September 9-12, 2012. (Refereed)

Washburn, M. & Meier, S. C. *Culturally Competent Practices With Gender Variant Clients*. Presented at Texas Counseling Association annual TAGLBTIC training seminar. St. Mary's University, San Antonio, Texas. June8th, 2012. (Invited)

Guidelines for Submission

In order to be considered for publication in *Perspectives on Social Work,* all submissions must meet the following criteria:

- The first author must be a currently enrolled doctoral student.
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- Only electronic submissions are accepted. Submissions should be e-mailed as a Microsoft Word attachment to the following e-mail address: swjourna@Central.UH.EDU
- Submissions for the featured articles should be 6 – 10 pages in length with not less than one-inch margins and 12-point font. Submissions for book reviews may be 3-5 pages. Submissions must be double-spaced. The recommended page limits exclude references and tables.
- If you plan to submit an empirical study with human subjects ensure there has been an IRB review and notate the approval in your paper.
- Submissions must meet APA guidelines (6th Edition) for text, tables, and references.

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