

A publication by students of the School of Social Service Administration at The University of Chicago

Advocates' FORUM



2003

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2003

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Advocates' Forum is an academic journal that explores clinical implications, social issues, and public policies linked to the social work profession. The journal is written, edited, and created by students of the School of Social Service Administration, and its readership includes current students, alumni, faculty, and fieldwork supervisors. The editors of *Advocates' Forum* seek to provide a medium through which SSA students can contribute to the continuing discourse of social welfare and policy.

EDITORIAL POLICY

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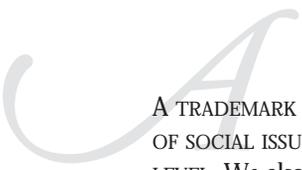
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GROWTH by C. Marks
School of Social Service Administration, The University of Chicago
Photographer: Patricia Evans



A TRADEMARK OF THE SOCIAL WORK PROFESSION IS ITS APPRECIATION OF SOCIAL ISSUES AT THE INDIVIDUAL, COMMUNITY AND SYSTEMIC LEVEL. We also make it our obligation as social workers to be aware of local, national and international issues related to human rights and social welfare. As we come to the end of another school year during a time of intense focus on international affairs, the need to be attentive to domestic concerns seems greater than ever.

The articles in this issue convey the diversity of interests of graduate students committed to the field of social work. From evaluations of systems to recommended treatment models, the article selection this year remains as diverse as the student body constituting the School of Social Service Administration. As students we have an invaluable opportunity to ask the questions that bridge a connection between policy and implementation.

Putting together the 2003 issue has been exciting and challenging for us and we hope you will experience as much in reading it. We have continued in last year's attempts to present a premier student produced academic social work publication. We revised our mission statement in an effort to better convey the intent of the journal. We hope it achieves our goal of providing a forum for informed discussion, challenging perspectives and motivating us to action.

“Live your questions now, and perhaps even without knowing it, you will live along some distant day into the answer.”

RAINER MARIA RILKE

Melissa Lang
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TRENDS IN CARE FOR THE DEVELOPMENTALLY DISABLED

by James Legner

During the past 30 years, significant changes have occurred in how health-care providers serve the developmentally disabled population. Non-state agencies are more involved in care provision, replacing the state-run institutional model that prevailed for many decades. Increases in the quality and effectiveness of health care for the developmentally disabled has accompanied this shift in provision of care. As a result, a population with chronically low life expectancies is now producing its first comprehensive population of elderly persons. They present unique challenges to health-care providers, as they couple the needs of the elderly with the specialized care required by the developmentally disabled. Care providers are faced with daunting challenges, especially in today's fiscal environment, as they strive to meet the needs of this emerging population.

I. INTRODUCTION

During the past 30 years significant changes have occurred in how health-care providers serve people with developmental disabilities. For years, institutionalization was the dominant service model, reflecting society's "out of sight, out of mind" mentality. Government-run facilities were the mainstays of the care system. However, the current emphasis on community integration and residential treatment has reduced the prevalence of government institutions and private organizations are now the dominant care providers. Increases in the quality and effectiveness of health care for persons with developmental disabilities have accompanied this shift in provision of care. As a result, a population with chronically low life expectancies is now producing its first comprehensive population of elderly persons.

Elderly persons with developmental disabilities are an emerging group, unprecedented in the American health-care system. They present unique challenges to care providers, as they couple the needs of the elderly with the specialized care required by people with developmental disabilities. This paper

focuses on the provision of care to persons with developmental disabilities in four areas: (1) organization of care providers, (2) financing provision of care, (3) cost containment and (4) quality assurance. Each of these issues presents continuing challenges to care providers.

II. KEY INFORMANT BACKGROUNDS

I interviewed two key informants for this paper. The first is the president and CEO of a private, non-profit agency serving the developmental, residential and vocational needs of people with developmental disabilities. The agency, called Rainbow for purposes of this paper, located in the western suburbs of Chicago, is a large organization with a budget exceeding \$15 million. The organization operates residential centers, therapy centers, vocation-training facilities, an intermediate care facility (ICF) and a dementia unit. The ICF is an 82-bed facility providing 24-hour nursing care, occupational therapy and physical therapy for adults with multiple developmental disabilities. The dementia unit provides 24-hour health care to developmentally disabled adults suffering from Alzheimer's disease and other dementias. The therapy centers provide specialized therapy and nursing care to persons of all ages with severe developmental disabilities. Another part of the agency serves children from birth to age 3 who have disabilities, developmental delays and at-risk conditions. That part provides developmental, physical, speech and occupational therapies, nursing care, vision and hearing clinics, and parental support services.

The other person is a close relative of mine (Phyllis for this paper) and the mother of an adult daughter (Elizabeth for this paper) who has moderate developmental disabilities. Although Phyllis is not a health-care provider in the technical sense, her experiences in obtaining care for her daughter provide insight into the state of health care for the developmentally disabled population.

Elizabeth is 27 years old and resides at home with Phyllis and her husband. Elizabeth also has one younger and one older sister. She does not have a specific diagnosis such as Down's syndrome or cerebral palsy, but due to complications during gestation and birth suffered brain damage, resulting in moderate cognitive disabilities. For instance, she can perform some basic life skills like brushing her teeth and using the bathroom, but she is completely unable to live on her own. Elizabeth does not have significant physical limitations, although some of her physical traits, like her gait and speech, are affected by her disabilities. She completed public schooling at the age of 21 and has worked several jobs since graduating from high school. She currently works at a local restaurant several days a week with the assistance of a job coach.

III. CARE PROVIDERS SERVING PERSONS WITH DEVELOPMENTAL DISABILITIES

Change in the types of organizations providing care to persons with developmental disabilities is an ongoing issue in this sector. Traditionally, state government dominated care provision, using large institutions that essentially warehoused the developmentally disabled (American Health Care Association, 1996). However, during the past 20 years, the population of large, state-run facilities has drastically decreased. Between 1980 and 2001, the average daily population of large state-run institutions decreased 65 percent, with three-quarters of the states experiencing decreases of 50 percent or more and 17 states seeing decreases in excess of 80 percent (Bruininks et al., 2002).

Private agencies like Rainbow have filled the gap and are now the primary care providers. These organizations moved away from the institutional model, instead emphasizing smaller-sized residential services, with rehabilitation and integration into the community as the primary treatment goals (Dougherty and Eggers, 1996; AHCA, 1996). According to research at the University of Minnesota's Institute of Community Integration, more than 80 percent of the total residential settings in the United States had 15 or fewer residents and 66 percent of those had six or fewer residents (Bruininks et al., 2002). Illinois (5 persons) was one of 18 states that exceeded the national average (3 persons) of persons per residential setting (Bruininks et al., 2002). The shift to private care providers in both smaller and larger residential settings has been equally dramatic. For example, as of June 2001, non-state agencies operated nearly all (98 percent) of residential care facilities with 15 or fewer residents and 83 percent of residential care facilities with 16 or more residents (Bruininks et al., 2002).

Within the network of care providers, a new niche is emerging. As the elderly developmentally disabled population continues to grow, more providers are desperately needed to serve this group. For example, Rainbow is the only private agency in Illinois with a facility specifically designed, equipped and staffed to provide care to developmentally disabled persons with Alzheimer's disease or other dementias. However, the agency's facility has a limited number of beds, not nearly enough to serve this expanding population. As a result, clients are forced to seek care at state institutions.

That option presents significant challenges in Illinois, as the state is currently downsizing and consolidating its institutions for persons with developmental disabilities. For instance, the state is currently closing parts of the Lincoln Developmental Center, a large state-funded center for developmentally disabled persons located in Lincoln, Illinois. Especially affected by the

closing were 28 residents who required intensive medical care (*Chicago Tribune*, 2002).

Another need is traditional health-care providers trained to work with and willing to provide care to patients with developmental disabilities. For example, when Elizabeth needed orthodontics, Phyllis was fortunate to have a care provider who adapted to Elizabeth's special needs as a patient. Although it took much searching, Phyllis has also established a network of other care providers who are comfortable working with Elizabeth. As policy-makers stress community integration, persons with developmental disabilities are increasing their demand for health care from private providers as opposed to institutions. In addition, persons with developmental disabilities expect providers to offer them a wider array of health care services than was provided in the past. Care providers need to satisfy these demands.

IV. CARE PROVIDERS' FINANCIAL CHALLENGES

Care providers face myriad challenges in receiving compensation for their services. Medicaid is a significant financial entity in this sector, funding intermediate care facilities and home- and community-based services, although levels of financing vary, with each state administering its Medicaid programs differently (Bruininks et al., 2002; Iglehart, 1999). Medicaid funding priorities have shifted in line with the new emphasis on community and residential care for persons with developmental disabilities.

Expenditures for home- and community-based services are growing significantly, with increases of more than 50 percent between 1990 and 2001 (Bruininks et al., 2002). This does not mean there was an increase in Medicaid funding, rather a redistribution of how that funding is spent. Medicaid is also shifting financing to residential services provided in the community, funding substantially more home- and community-based clients than institutional residents (Bruininks et al., 2002).

As a result, non-state care providers are receiving larger percentages of their revenues from Medicaid. Medicaid's complex reimbursement procedures create uncertainty among agencies about how to bill for services. For example, the 2002 Illinois regulations governing payment to providers of community living arrangements for persons with developmental disabilities (like Rainbow) are more than 400 pages long and contain numerous forms and payment worksheets. As a result, Rainbow employs staff with specific responsibility for Medicaid billing and reimbursement.

Heavy dependence on government funding puts private agencies in precarious financial positions. Illinois' current budget deficit is putting enormous

pressure on Rainbow and other care providers. Rainbow currently faces a significant gap per client between what Illinois pays and what costs Rainbow incurs in providing care. Illinois also changed its reimbursement schedule for day programs and intermediate care facilities, to where it now pays care providers at the end of each month with longer delays in receipt of payment. Illinois is considering a similar payment system for community programs, and that would complicate cash flow operations for Rainbow, which operates several community programs. The budgetary environment for care providers is not likely to improve (and probably will worsen) in the near future as Illinois legislators work to reduce the state's significant budget deficit.

There is also a trend toward "unbundling" services, meaning that the services provided within a community program such as day programs and individual therapy are no longer compensated in a single payment (Illinois Department of Human Services, 2002). Although unbundling was aimed to increase client choice in providers and type of services received, it has created funding problems for the service providers, as they now must navigate multiple payment processes.

Private-sector care providers also are subject to continual fiscal cutbacks and insufficient budget increases. For example, Illinois' funding for private community programs has run significantly under the cost of living index since 1992, and the gap is projected to widen again in 2003 (Arc of Illinois, 2002). However, despite the national trend toward privatization of care in smaller facilities, Illinois' funding of large state-run institutions has exceeded cost of living over that same time period (Arc of Illinois, 2002). Thus, in Illinois, there is a mismatch between funding priorities and the trends in care provision.

Because of the uncertainty and complexity associated with government funding, private agencies must diversify their funding base to survive. For example, the majority of Rainbow's funding comes from state government, with the remainder coming from the United Way, private foundations, local and county government grants and individual donations. However, these funding streams are also subject to cyclical volatility, especially in the uncertain economic climate the nation is currently experiencing.

With the increasing number of persons with developmental disabilities integrated into local communities and in the workplace, other forms of payment to care providers are becoming more prevalent. For instance, private medical insurance has increased its role in reimbursement, but still primarily covers more medically focused care for infants and children. Moreover, private insurance coverage is almost exclusively limited to families who have working members who, in turn, have insurance coverage.

In addition, with the advancements in care, persons with developmental disabilities are more routinely outliving their parents and inheriting assets such as trust funds that are then used to finance their health-care needs. This is an interesting development, but it also raises questions about how the funds are managed and who is responsible for management of the funds once the person's parents are deceased. Another dilemma raised by trust funds or inheritances is whether they are sufficient enough to cover care for the person's remaining life. This is particularly tricky if the amount of the funds moves the person above the maximum asset threshold for qualifying for government funding. In that case, the person might lose government funding and have to completely rely on the alternative funds. Then, someone must ensure that an application for renewal of government funding is completed, but that still leaves the potential for a significant gap in coverage once the private funds are expended.

V. COST CONTAINMENT STRUGGLES

As with other health-care sectors, providers of services to persons with developmental disabilities also face constant cost pressures. This concern is intensified when an agency, like Rainbow, relies primarily upon government funding and the funding provided leaves a deficit between revenues and expenses. However, the cost control battle is not unique to private-care providers. Large, government-run facilities face increasing costs, especially regarding personnel (e.g., salaries and benefits). In 2000, for example, those costs comprised 81 percent of large state-run facilities' total costs, increasing to 86 percent for Illinois facilities (Bruininks et al., 2001). High turnover rates at large state-run facilities contribute to increasing personnel expenses, as institutions are continually seeking new workers and incurring the startup costs associated with training new employees. In 2000, almost one-third of a large state-run facility's staff turned over annually (Bruininks et al., 2001). Illinois had a lower rate, but facilities still experienced an 18 percent turnover rate (Bruininks et al., 2001). More troubling is that Illinois' turnover rate increased 59 percent and the national rate 33 percent between 1998 and 2000 (Bruininks et al., 2001). In the current fiscal environment, that rate will likely continue to increase.

Although care has shifted from large institutions to smaller settings, costs have continued to rise for the care of persons remaining in the institutional setting (Bruininks et al., 2001). In 2000, the average expenditure for care in a large state-run facility was \$113,864 per individual, a 6 percent increase from 1999 (Bruininks et al., 2001). A primary reason for this trend is that the large institutions generally serve those persons with the most severe developmental

disabilities (Bruininks et al., 2001). For example, in 1977, 46 percent of residents in large state facilities had severe disabilities; by 2000 the number was 62 percent (Bruininks et al., 2001). Consistent with this concentration, Medicaid per-resident expenditures for large institutions continue to rise, even though the number of residents and facilities steadily decreases (Bruininks, 2001).

Despite overall rising costs, there is evidence that the cost-control philosophy so prevalent in the health-care field also has influenced care providers to persons with developmental disabilities. For example, the average annual per-person Medicaid expenditure for care in large state facilities increased 5 percent during the 1990s, whereas the same expenditures increased 15 percent from 1970 to 1989 (Bruininks et al., 2001). One reason for the cost controls is the growth of managed care for persons with developmental disabilities. This change especially affects the private agencies, which are subject to managed care in private insurance relationships as well as the cost controls imposed by state agencies responsible for Medicaid administration. Illinois' payment guidelines are extremely detailed, specifying reimbursement amounts for items such as telephone usage by clients and the different rates of pay for workers who are working during prime time, non-prime time, at night and during the day (Illinois Department of Human Services, 2002). This attention to cost control is likely to continue and even intensify, especially with the emergence of the elderly developmentally disabled population, a group that is likely to need increasing amounts of health care services.

VI. PROMOTING, ASSESSING AND MEASURING QUALITY CARE

Despite the financial challenges providers continually face, overall quality of care for persons with developmental disabilities has significantly improved over the past 30 years. This increase in quality is a major reason why the developmentally disabled population is producing its first comprehensive generation of elderly clients. However, promoting, assessing and measuring quality of care in the developmental disabilities sector presents similar challenges to quality evaluation in other health-care sectors.

As with physicians and hospitals, care providers for persons with developmental disabilities face layers of regulation from federal and state authorities. State government is the dominant regulatory force, although federal agencies also have authority. The Illinois Department of Public Health and the Illinois Department of Human Services' Office of Developmental Disabilities have licensing and sanctioning authority over providers, with extensive regulations that govern all aspects of care. For example, the portion of the Illinois

Administrative Code governing providers of community living arrangements for persons with developmental disabilities requires that providers have written quality assurance plans and a mechanism for conducting quality review (Ill. Adm. Code, 2002). Failure to meet state quality standards can result in withdrawal of state certification (Ill. Adm. Code, 2002).

Quality assurance is an emerging national trend in this sector. States are implementing review programs rooted in business concepts like Total Quality Management and Continuous Quality Improvement (Polister et al., 1998). Other programs are specifically designed for care providers to persons with developmental disabilities. For instance, Oklahoma is conducting an ambitious longitudinal study of service quality involving approximately 3,700 persons with developmental disabilities in a variety of care settings (Polister et al., 1998). That program focuses on outcomes in levels of independent living, community integration and patient satisfaction (Polister et al., 1998). Likewise, Illinois recently began a comprehensive quality evaluation project to assess care for its developmentally disabled population, and the Illinois Council on Developmental Disabilities has a five-year goal of improving the quality of care provided to residents with developmental disabilities (Illinois Department of Human Services, 2002).

An interesting development in this sector is the power vested in independent accrediting organizations. The Rehabilitation Accreditation Commission (CARF) is the primary accrediting organization. Although private agencies pay for CARF audits, Illinois requires certification by an accrediting agency like CARF before a care provider receives government funding. This is a promising development, as CARF certification is extensive, and with the state power behind it, it can serve as a powerful tool for quality assurance and improvement. For example, Rainbow uses its CARF accreditation review and CARF's quality guidelines as integral parts of the organization's quality assurance program.

Unfortunately, governmental budget cuts, particularly in Illinois, could have a powerful negative effect on quality care. The scarce funding means that public and private agencies generally offer low wages in proportion to the demands of the jobs, often resulting in a substandard employment pool and the high turnover documented earlier. The national average starting wage for large, state-run facilities in 2000 was \$9.19 per hour, with an average wage of \$11.57 per hour (Bruininks et al., 2001). For similar facilities in Illinois in 2000, starting wages were \$8.87 per hour and average wages were \$12.43 per hour (Bruininks et al., 2001). However, between 1998 and 2000, Illinois average wages increased less than 1 percent (Bruininks et al., 2001).

Moreover, those wages are for workers at Illinois state-run facilities, which consistently receive more total dollars in funding than private community programs. The ever-present budget crises in this sector pose a serious threat not only to care providers' financial status but ultimately to the quality of care they provide to their clients.

VII. CONCLUSION

With the extensive involvement of government in both funding and regulation, providers face an environment where they are continually asked to do more with less. As the developmentally disabled population continues to live longer, issues will arise that providers never considered before, such as caring for persons with developmental disabilities who also have Alzheimer's disease. Unfortunately, the complex environment in which care providers exist is slow to adapt to changes, a trait that ensures continual challenges. ■

RESOURCES

- American Health Care Association (1996). "Intermediate Care Facilities for the Mentally Retarded: Meeting the Long-Term Care Needs and Maximizing the Potential of Individuals with Mental Retardation and/or Developmental Disabilities."
- The Arc of Illinois (2002). "The Negative Impact of State Funding Decisions on Community Programs Versus State Operated Institutions."
- Bruininks, R., Kwak, N., Lakin, C., Larson, S., Polister, B., Prouty, R. & Smith, J. (2002). "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2001." Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota.
- Bruininks, R., Kwak, N., Lakin, C., Larson, S., Polister, B., Prouty, R. & Smith, J. (2001). "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2000." Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota.
- Dougherty, R. & Eggers, W. (1996). "Delivering Services for the Mentally Ill and Developmentally Disabled: A Consumer Choice Model." RPPI
- "Four deaths at state center call cuts into question." *Chicago Tribune*, Metro Section, April 28, 2002.
- Iglehart, J. (1999). "The American Health Care System: Medicaid." *New England Journal of Medicine*, 340:5, pp. 403-408.
- Illinois Administrative Code, Title 59, § 115.320 (2002).

Illinois Department of Human Services, Office of Developmental Disabilities (2002).
“Community-Integrated Living Arrangement (CILA) Individual Rate Determination Model.”

Illinois Department of Human Services, Office of Developmental Disabilities (2002).
“Core Indicators Project.”

Polister, B., Blake, E., Prouty, R. & Lakin, K.C. (1998). “Reinventing Quality: Sourcebook of Innovative Programs for the Quality Assurance and Quality Improvement of Community Services.” Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota.

The Rehabilitation Accreditation Commission (CARF) (2002). Quality standards.

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FAMILY ADJUSTMENT TO LIVING WITH CYSTIC FIBROSIS

by Gretchen Lanka Allen

Cystic Fibrosis (CF) is an intriguing disease that raises myriad issues relating to health, wellness, treatment and adjustment for families living with the disease, as well as for healthcare and human-services professionals working with these families. To begin to understand this complex illness, we must explore the biological, physical and psychosocial needs and strengths of families living with cystic fibrosis. In addition, we need to look at how living with CF can affect child and family development and the adjustment into adolescence and beyond. This paper begins with an introduction to the Family-Systems-Illness Model, an adjustment model that provides a clear framework for social workers and other health care professionals working with clients with CF. The paper then looks at cystic fibrosis, its etiology, symptoms, course and prognosis. It then discusses how the particular features of CF can affect family and child/adolescent development. The paper continues with a discussion of the Family-Systems-Illness Model, and it ends with some questions that are important for a social worker to include when assessing a family caring for a child with cystic fibrosis.

INTRODUCTION

Cystic fibrosis (CF) is a complex and intriguing disease that raises myriad issues relating to health, wellness, treatment, and adjustment for families living with CF. While health care professionals and researchers continue to make significant steps to improve and extend the lives of patients with CF through experimental gene therapy, new medication treatments and improvement in physical therapy, there is still no cure (Cystic Fibrosis Foundation (CFF), 2002). Children, adolescents, and young adults with CF can live healthy, active and productive lives. However, without a cure, those living with CF always will have it and most will have a shortened life span. Until a cure is found, the best that doctors can do is to relieve the symptoms of CF so that individuals can live with an improved quality of life (National Heart, Lung &

Blood Institute (NHLBI), 2002).

To begin to understand this complex disease, we should have a framework or model through which we can assess and understand this disease and those affected by it in a holistic sense. We must explore the biological, physical and psychosocial needs and strengths of those living with cystic fibrosis and their families. In addition, we need to look at the ways in which living with CF can affect child and family development and the adjustment into adolescence and beyond. I begin this paper by introducing the Family-Systems-Illness Model, a normative model that provides a clear framework for social workers and other health care professionals working with clients with CF. Next, I describe cystic fibrosis, its etiology, symptoms, course and prognosis. I then discuss the particular features of how CF affects family and child adjustment through child and adolescent development. I end the paper with a discussion of the adjustment model that provides a clear framework for health care professionals working with patients with CF, along with some questions important to include when assessing a family caring for such a child.

INTRODUCTION TO THE FAMILY-SYSTEMS-ILLNESS MODEL

The Family-Systems-Illness Model was developed by Dr. John Rolland through his work at family health centers in New Haven, Conn., and Chicago. It is a normative model that describes the complex interactions between a particular physical illness or disorder, the patient or client and the family as a whole (Rolland, 1994). Often families referred for psychological or psychosocial help during an acute physical illness have never seen a mental-health professional. Some sources cite that up to two-thirds of families facing serious illness fit into that category, underscoring the importance of having a comprehensive model we can use to assist the average family coping with some common and expected stressors of illness (Rolland, 1994). The Family-Systems-Illness Model provides just that: a multi-systemic view of the many interactions and interactive processes between the demands of different illnesses over time and key parts of family functioning.

The model looks at family style, cohesion and adaptability through a “strengths” perspective, examining both a family’s strengths and its vulnerabilities. It offers a useful, systemic view of family adaptation to serious illness in a child as a normal and expected developmental process over time (Rolland, 1994). The model also provides social workers and health professionals with a conceptual base for approaching practice from a family systems perspective,

emphasizing the initial consultation and family assessment as well as the common issues and challenges that families face as they experience a condition over time (Rolland, 1994, 12). The model is useful when trying to understand and treat patients with severe illness and disability because it is interdisciplinary, and it can be used and applied by both health and mental-health workers, from physicians to social workers. The model is particularly well-suited to social workers within the health and mental-health environments because it takes into account various spheres of influence that affect family adjustment and development. The model moves within the broader sphere of belief systems, culture and ethnicity, to individual, family and illness life-cycles, and into the specific and precise type of illness, adversity, or loss (Rolland, 1994, 14). With this multi-systemic framework in mind, we can begin to look at the complexities of cystic fibrosis and begin to understand why the Family-Systems-Illness Model can help us understand families coping with this disease.

DESCRIPTION OF CYSTIC FIBROSIS

Cystic fibrosis is a chronic, progressive and frequently fatal genetic disease affecting some 30,000 Americans and their families (CFF, 2002; Rolland, 1994). Each year, around 2,500 babies are born with CF in the United States. Most babies with cystic fibrosis are born to families of Caucasian, northern European heritage, although CF affects all races and ethnic groups. In addition, around one in every 31 Americans (one in 28 Caucasians) is a healthy, unaffected carrier of an abnormal "CF gene." In other words, some 12 million Americans unknowingly carry the gene that causes cystic fibrosis. This prevalence makes CF the most common hereditary disorder in America (CFF, 2002; Hollander, 1997; NHLBI, 2002). The average person with cystic fibrosis lives into early adulthood. According to recent data, the current median life span for people with CF is 33 years (Desrosiers et al., 1996).

Cystic fibrosis mainly affects the respiratory and digestive systems in children and young adults. A child who inherits two CF genes from his or her parents has a defect in a protein that regulates the levels of sodium and chloride (salt) within cells lining organs such as the lungs and pancreas. A defect in this protein causes a person with CF's exocrine glands to absorb too much water and to produce abnormally thick and sticky mucus that can clog the lungs, pancreas, and other organs. This thick mucus can cause frequent lung infections and often prevents pancreatic enzymes from reaching the intestines to help break down and digest food (CFF, 2002; Silverstein et al, 1994).

CF can lead to various other medical problems, as well. The most common medical problems for people with cystic fibrosis include: sinusitis; nasal polyps (growths inside the nose); “clubbing” or rounding of the fingers and toes; pneumothorax (a tear in the lung tissue causing trapped air in the chest wall); coughing of blood; *cor pulmonale* (enlargement of the right side of the heart); abdominal pain or discomfort; rectal prolapse; and sterility in 98 percent of men. Some people with cystic fibrosis may also develop liver disease, diabetes, pancreatic inflammation or gallstones (NHLBI, 2002).

Cystic fibrosis has a variety of symptoms and does not follow the same pattern in all patients. While the majority of children with CF are diagnosed before the age of 2, some patients reach adolescence or early adulthood before receiving a correct diagnosis (Hollander, 1997). CF symptoms can seem similar to those of asthma, chronic bronchitis, or gastrointestinal disorders like celiac disease. The symptoms of CF affect different people to varying degrees in different ways (NHLBI, 2002). The most common symptoms of CF are salty-tasting skin, a persistent coughing or wheezing, excessive appetite with poor weight gain, or a “failure to thrive,” and bulky, foul-smelling stools (CFF, 2002). Occasionally, babies with CF are born with an intestinal blockage called meconium ileus. In those cases, the infant can be diagnosed at birth.

The test most often used to diagnose cystic fibrosis is the sweat test, a simple and painless test measuring the amount of salt in the sweat. The sweat test may not work well with newborns who do not produce enough sweat, and a small percentage of children with CF have normal amounts of salt in their sweat (CFF, 2002). Patients also can be diagnosed using chemical tests for the presence of the mutated CF gene, or through chest X rays, phlegm cultures, stool examination and lung function tests (NHLBI, 2002). After a positive diagnosis, the treatment for CF depends on the stage of the disease and which organs are affected. Cystic fibrosis is most often treated with antibiotics, to cure lung infections, and a combination of physical therapy, exercise and medications to treat and clear the accumulated mucus that coats and blocks the airways (Pulmonology Channel, 2002). The most commonly used treatments are airway clearance techniques (ACT) such as chest physical therapy (CPT), in which a caregiver or therapist uses vigorous percussion with cupped hands on the back, sides and chest to dislodge mucus from the lungs (CFF, 2002). This treatment is also known as chest percussion, thumping, clapping, bronchial or postdural drainage or chest physiotherapy.

Patients with CF also can use various breathing techniques, a hand-held flutter device that causes vibration to remove mucus, or an inflatable therapy vest, also known as high frequency chest compression (Pulmonology Channel,

2002). The breathing techniques, flutter machine and inflatable therapy vest all allow those living with CF to have greater autonomy and self-reliance. Adolescents away at school, or young adults in college or living on their own, often will use these techniques and devices for self-care (Desrosiers et al, 1996; Hollander, 1997; Lubich, 2002). In addition to chest physical therapy, it is important for children and adolescents with CF to exercise regularly to increase and maintain lung functioning. They also need dietary and vitamin supplements and often have to take pancreatic enzyme tablets before eating to aid digestion.

The course of cystic fibrosis is unpredictable. Most children with CF will need to have medical checkups every three months to ensure continued lung function and general health. Some children remain relatively symptom-free while others need frequent medical care and “tune up” visits to the hospital to stay alive (Harris & Super, 1995; Shapiro & Heussner, 1991). During the life course of a child or adolescent with cystic fibrosis, she will have frequent lung infections, changes in lung function and problems with digestion. At times her daily treatments are sufficient to maintain her health; at other times she will need adjunctive therapy. A child with cystic fibrosis may need extended hospital visits or may get by on occasional checkups. In addition, some children and adolescents with CF take up to 20 medications a day, while others rely mostly on physical therapy and exercise (Hollander, 1997; Lubich, 2002). The variability and unpredictability of the course of cystic fibrosis can mean different things for each individual patient’s prognosis.

Technological advances over the past 50 years have raised the median life span for a person with CF from less than eight months in the 1940s, to 11 years in the 1960s, to the current average life span of 33 years (Desrosiers et al., 1996). This means, however, that some people with CF die in childhood while others may live into their 50s or 60s. Some patients who receive successful lung, pancreas, heart and liver transplants are enjoying health they never knew. While the course and prognosis for people with CF can be varied, cystic fibrosis is nonetheless a fatal disease. According to current literature, CF is described as a disease that leads to a “shortened life span” (Rolland, 1994). Most patients with cystic fibrosis eventually die from respiratory failure or *cor pulmonale*, an enlargement of the right side of the heart. About 95 percent of people with CF die from lung infections (Pulmonology Channel, 2002). That sense of inevitability, anticipation of grief and the highly unpredictable nature of the disease can lead to countless difficulties for children and families who have to continually adjust and readjust to living with cystic fibrosis.

FAMILY/CHILD ADJUSTMENT AND DEVELOPMENT

Although individuals and families living with cystic fibrosis can have active and healthy lives, there is no denying the amount of time and energy those affected have to spend on daily treatment, physical therapy and the many psychosocial issues associated with CF. Children and families living with cystic fibrosis face numerous additional daily stressors. Many features of living with cystic fibrosis can have a deep impact on the psychological functioning and adjustment of the child with CF, other family members and the family as a whole. In particular, CF's chronic nature, uncertainty about long-term prognosis, the genetic link and the great impact on daily family life all affect functioning and adjustment (Harris & Super, 1995; Rolland, 1994). Like other chronic diseases in children, cystic fibrosis can cause a host of problems for the family and individual living with this disease. The additional burden on the family posed by dealing with cystic fibrosis may lead to marital conflicts, limit social life, siphon attention away from healthy siblings and drain financial resources (Shapiro & Heussner, 1991).

Since most CF diagnoses are made in early infancy or childhood, the parents, caregivers, and siblings are usually the first to experience psychological distress (Harris & Super, 1995). After the initial shock and grief, the most marked change for a family with a new diagnosis of cystic fibrosis is the amount of time and energy necessary for "home care." Families caring for a child who has a new CF diagnosis will not have any preparatory time to adjust before they must begin the child's complex daily care routine. People with cystic fibrosis usually need three to five hours of daily medication and physical therapy to maintain health (Hollander, 1997; Desrosiers et al, 1996; Pulmonology Channel, 2002; Shapiro & Heussner, 1991). These particularly rigorous treatment demands can be exhausting, and the various treatments and medical devices necessary to maintain health and improve quality of life can be prohibitively expensive.

Most children diagnosed with cystic fibrosis adapt well to the diagnosis and need to spend little time in the hospital (CFF, 2002; Harris & Super, 1995). When they learn the home-care routines necessary each day, they are generally flexible and able to incorporate treatment as "just part of the day" (Hollander, 1997). However, certain developmental issues and difficulties often arise for those with cystic fibrosis and their parents or caregivers. The rigorous treatment demands and amount of time and energy most people with CF have to spend on maintaining health can be exhausting and overwhelming.

In addition, some aspects of the disease may be embarrassing for children

and adolescents. For parents of very young children with CF, issues like toilet training and “appropriate touching” can be problematic. Because children with CF often have large, bulky, and foul-smelling stools, toilet training can be awkward. As the young child with CF begins school and has to use public restrooms, the “stinky poop” that permeates the bathroom or hallway might embarrass him and subject him to ridicule (Shapiro & Heussner, 1991). Older siblings also may be embarrassed by the foul smell and may feel uncomfortable inviting friends over.

As communities become more open and aware about child abuse, it can seem horrible for parents to perform chest physical therapy on a small child. While the child learns in school that she shouldn’t ever be hit and about “appropriate” and “inappropriate touching,” she has to go through daily sessions of being hit on the back, chest and sides by adults. As a child becomes more aware and sensitive about his body, he can be uncomfortable with all of the doctors, nurses and physical therapists that examine, poke and prod him. In addition, a school-aged child with CF may be embarrassed about the number of pancreatic enzyme pills she has to take before eating a school lunch. Some children have been known to conceal or discard their capsules (Harris & Super, 1995). A child may also be resistant to having CPT sessions interfere with school or play time. Furthermore, a child who is sick and requires frequent hospitalization can fall far behind her classmates in school.

Because a child with cystic fibrosis can be particularly vulnerable to respiratory infections, parents may want to overprotect that child from being exposed to germs. This could mean keeping a child with CF away from other kids or keeping her inside so that she won’t catch anything. Health providers must remind parents of children with CF that it is impossible to protect any child from all germs, and that a child’s emotional and mental health and growth/maturity depend upon living “as normal a life as possible” (Silverstein et al., 1993).

As children progress toward adolescence, independence, physical appearance and behavior become paramount. Adolescents can become obsessed with their appearance, relationships with friends, and blossoming sexuality. This is a time of emerging independence, when peer groups and others’ opinions become paramount, and parents become terribly “un-cool.” These developmental issues can be particularly charged for adolescents living with CF.

In terms of behavior, while smoking or taking drugs can be devastating for anyone, they could seriously hurt or shorten the life of an adolescent with CF. While other teens experiment with smoking, a teen or child with CF cannot experiment in the same ways. This can lead to feelings of extreme isola-

tion and resentment of the disease, doctors, parents and others. In addition, a teen with CF may not be able to tolerate being around others who smoke, as the smoke could cause severe reactions such as coughing fits. Even if a teen with CF wants to fit in by “hanging out” with friends who experiment with cigarettes and drugs, he might not be able to. A teen with CF also may seek independence and autonomy with their treatment, and parents need to work with health care professionals to allow for some flexibility, if needed.

The most devastating “side effect” of adolescence on cystic fibrosis can be rebelliousness or resistance to treatment. Most teens with CF at some point try stopping their medications and daily therapy, but that rebelliousness can lead to disastrous and long-term effects (Lubich, 2002). While healthy teens may feel invincible and unstoppable, adolescents with CF have to face mortality at a young age. Having to be “old before your time” can take its toll on an adolescent’s development (Hollander, 1997). At such times, teens with cystic fibrosis can benefit greatly from support from other teens with chronic illnesses. Most cystic fibrosis care centers will have some type of supplemental support system for teens in crisis.

While children and adolescents with cystic fibrosis may appear just like any other child, there are certain physical traits associated with CF (Hollander, 1997; Lubich, 2002; NHLBI, 2002). Many children with CF have trouble gaining weight and may be short and skinny. The “failure to thrive” they experienced around the time of diagnosis may continue and cause them to look smaller than their peers. In addition, a number of people with cystic fibrosis develop a barrel-shaped chest because air gets trapped in their lungs, causing the rib cage to expand. Some children with CF have puffy, “chipmunk” cheeks because of medication (Lubich, 2002). Additionally children and adolescents with CF may try not to cough because they are embarrassed about coughing all of the time, but coughing is necessary to loosen and bring up mucus to maintain healthy airways (Lubich, 2002; Silverstein et al., 1993, 41).

Dieting and food can be another developmental issue for adolescents with CF. Many people with CF need to eat a great deal of food to maintain their weight, sometimes ingesting upwards of 3,000 to 5,000 calories a day. While other adolescent girls may obsess about dieting and fat intake, a young teen with cystic fibrosis might eat a pint of ice cream and a 1-pound steak in one sitting. That discrepancy in dietary habits may cause girls with CF, in particular, to feel awkward or left out. One 14-year-old girl with CF commented that while she loves “getting to eat whatever I want, whenever I want,” she sometimes gets embarrassed by the amount she has to eat in front of her friends (Hollander, 1997).

To help children, adolescents and families cope with these difficult aspects of adjustment and development, it is important for health care providers to have an understanding of the complexities of each family's adjustment. As each of the some 30,000 Americans with cystic fibrosis and their families may react, cope, develop, and adjust differently, it is crucial for social workers, psychologists, and nurses to have some theoretical basis from which to address their needs. Dr. John Rolland Family-Systems-Illness Model offers a theoretical framework particular to the varying needs of different families coping with illness (Rolland, 1994).

ASSESSING FAMILY ADJUSTMENT

The Family-Systems-Illness Model provides a useful, systemic view of family adaptation to serious illness in a child as a developmental process over time (Rolland, 1994, 12). The complexity of this model is particularly well suited to understanding the varying needs of individuals and families with cystic fibrosis. Beginning with a psychosocial typology of illness, the Family-Systems-Illness Model describes the intricacies of psychological and familial issues that interplay with a particular disorder's characteristics.

The typology conceptualizes patterns of onset, course, outcome, type and degree of incapacitation, and degree of uncertainty (Rolland, 1994, 23). It lays out a psychosocial understanding of illness in systems terms, including the expected pattern of practical and emotional demands of disorders over time, and looks at the timeline of a disease in its relevance to the related developmental tasks associated with different levels of the disease as it unfolds. In addition, the Family-Systems-Illness Model seeks to understand the values, beliefs, and multigenerational legacies that underlie health problems and care giving systems. Lastly, the model is sensitive to the undercurrent of anticipatory grief and separation that permeates all phases of individual and familial adaptation (Rolland, 1994, 29).

The model fits particularly well with assessing adjustment in a family with cystic fibrosis because it allows for variety in development and needs. Rolland addresses issues relating to CF as a slowly progressing, gradual, and unpredictable illness. The Family-Systems-Illness Model helps account for the particular psychosocial demands for individuals and families facing the effects of a perpetually symptomatic family member whose disability increases in a step-wise and progressive fashion. The model acknowledges the difficulty of continual and perpetual adjustment for children and families with CF, that family

members can never settle into any one phase because uncertain disease progression looms (Rolland, 1994, 24). But, this model also touches on the strengths and “goodness of fit” for particular families and particular illnesses. A family with stamina and flexibility can have great success in coping with the changing needs of a child with CF. Most importantly, the Family-Systems-Illness Model normalizes the complex, mutual interactions between the disorder, the patient, and the family (Rolland, 1994, 9).

Within a medical or hospital mental health setting, the social worker would have an important role to play in both assessment and supportive aid to the family caregiving system. Because social workers are trained to interpret, understand, and help families and individual clients understand the many interacting systems that can affect family adjustment, the social worker can be a lifeline to families attempting to navigate the many different levels of need and adjustment necessary to coping with and living with cystic fibrosis. Throughout the initial assessment and long-term treatment process, the social worker can help and advocate for families and their various needs.

When assessing a family caring for a child or adolescent with cystic fibrosis, a social worker needs to look at issues important for any family of a child with a chronic or terminal illness. For cystic fibrosis, it is important to ask about the meaning of the illness to that family: What are their individual expectations about health, daily living and life span? A social worker would need to explore the family’s past strengths and deficits in dealing with losses and grief. It would be important to explore the flexibility or elasticity of familial roles, and family members’ willingness to use outside resources when necessary. In addition, the health care professional would need to carefully assess a family’s financial situation, with particular attention to health insurance coverage. Lastly, and perhaps most importantly, the social worker should make sure that a family and child with cystic fibrosis know about the positive outlook for treatment and life span while maintaining open communication about health and prognosis. One of the most valuable and life-saving things a family can do is find the strengths and abilities each member brings to coping with CF. Children, adolescents and young adults with cystic fibrosis are often described by others as having infectious laughs, a positive attitude, adaptability and great faith (CFF, 2002; Hollander, 1997; Lubich, 2002). By working to support those individual strengths, and by building and maintaining medical and social support networks, families and individuals with cystic fibrosis can begin to face the changeable course of this disease and can hopefully live full and meaningful lives. ■

REFERENCES

- Cystic Fibrosis Foundation. (2002, April). *Facts about Cystic Fibrosis* Retrieved April 20, 2002, from <http://www.cff.org/facts.htm>
- CYSTIC-L. (2002, April). *CYSTIC-L: An email support group and newsletter for people with Cystic Fibrosis and their friends, families, and health-care providers*. Retrieved April 20, 2002, from <http://www.cystic-l.com/handbook/>
- Desrosiers, C. (Director), Dufour, C., & Verville, L. (Producers). (1996). *Cystic fibrosis in adults* [Videotape]. Canada: Multimedia Group of Canada
- Harris, A., & Super, M. (1995). Chapter 6: Psychology of cystic fibrosis. *Cystic fibrosis: The facts*. New York, N.Y.: Oxford University Press Inc.
- Hollander, F. (Producer/Director). (1997). *Living with cystic fibrosis* [Videotape]. Sherborn, Mass.: Aquarius Healthcare Videos.
- Lubich, L. (2002, April). *How to handle living with Cystic Fibrosis* Retrieved April 20, 2002, from <http://www.geocities.com/HotSprings/Villa/4210/>
- National Heart, Lung, & Blood Institute (NHLBI). (2002, April). *Facts about Cystic Fibrosis*. Retrieved April 20, 2002, from http://www.nhlbi.nih.gov/health/public/lung/other/cys_fib.pdf
- Pulmonology Channel. (2002, April). Cystic Fibrosis lung treatment. Retrieved April 20, 2002, from http://www.pulmonarychannel.com/cf/treatment_lung.shtml
- Rolland, J.S. (1994). *Families, illness, & disability: An integrative treatment model*. US: Basic Books.
- Shapiro, B.L., & Heussner, R.C. (1991). *A parent's guide to cystic fibrosis*. Minneapolis, Minn.: University of Minnesota Press.
- Silverstein, A., Silverstein, V., & Silverstein, R. (1994). *Cystic fibrosis*. New York, N.Y.: Franklin Watts.

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THE COGNITIVE-INTEGRATIVE FRAMEWORK AND THE CASE OF NICOLE: USING TOOLS OF NARRATIVE THERAPY AND PASTORAL COUNSELING TOWARD EFFECTIVE CLINICAL PRACTICE

by Shaun Douglas Marshall

Quite often in clinical social work, it can be difficult to find just the right theoretical framework for understanding and helping our clients. Most theoretical perspectives focus solely on the psychological processes of the individual, offering little foundation for addressing the person's environment or accessing the client's local knowledge. At these times, an integrated approach, respectful of the core values of social work, may be most useful. This paper provides a specific case-analysis from the Cognitive-Integrative (C-I) perspective. The treatment involved the integration of theories from Task-Centered Social Work Practice, Narrative Therapy and Spiritual Counseling with the goal of demonstrating how the incorporation of these theories, as guided by the C-I framework, can inform effective clinical social work practice.

COGNITIVE THERAPY, CLINICAL SOCIAL WORK AND THE C-I PERSPECTIVE: THE CASE FOR INTEGRATION

Over the years, social workers have become more involved in doing work that not only addresses the social conditions of an individual but also enhances their psychological and emotional well-being. As *clinical social workers* have expanded their knowledge base in various theoretical frameworks, they have begun to debate whether traditional psychotherapy is consistent with the core values of social work practice.

One theoretical orientation in which clinical social workers are often trained is cognitive therapy. Cognitive therapists, who have their foundations in the theories of psychiatrists such as Alfred Adler, Albert Ellis and Aaron T.

Beck, believe that irrational beliefs or distorted thinking patterns can cause a variety of serious problems, including depression and chronic anxiety. Therapists operating from this framework try to teach people to think in more rational, constructive ways (Berlin, 2002).

The underlying idea of traditional cognitive therapy is that over the course of repeated experiences, we store memories about who we are, what life is like, and how well our relationships with others tend to work. To the extent that ongoing events fit with our memories of previous experience, we continue to add to what we already know and, in the process, build up elaborate and easily activated memory networks (or schemas). These memory patterns give us a readily available framework for understanding and responding to new events that seem similar in some way.... “No I’m not surprised... I knew things wouldn’t work out...they never work out for me...” (Berlin, 2002). [Appendix A illustrates how people process information according to cognitive theory, and how memory impacts the processing of new information.]

While most traditional psychotherapies focus almost exclusively on the *psychological functioning of the individual*, social work focuses on the person-in-environment (Berlin, 2002). Thus, a clinical social worker moves beyond how the person is processing information to address the systems that provide that information.

“Having built my career around these ideas, I am not about to just toss them out, but I find them troublesome ... because they make it very easy to ignore the environment as an independent force. Is this a negative event? A stressful event? A situation of injustice, oppression, or deprivation? ...While I don’t doubt for a moment that we read and respond to and select situations according to memories of past experiences, it is also the case that we are handed situations that we did not make and over which we have precious little control. ... In these cases, we will need to work both to generate new streams of information and to help the client create enough mental space to notice these differences and use them.”

(Berlin, 2002)

The Cognitive-Integrative (C-I) perspective, developed by Dr. Sharon Berlin, asserts that clinicians should help clients not only deal with how their processing of information impacts their lives, but they also should work to address the sources and systems that provide the information. The theory suggests the integration of practice methods from other psychotherapies, guided by the C-I framework, to help the client and to inform the therapeutic process.

[See Appendix]

To proceed with the case analysis, and throughout the course of therapy, principles from the following theoretical orientations were used.

Narrative Therapy

Narrative therapy is a postmodern approach that centers the client as the expert in his or her own life, and it views problems as separate from people. Narrative therapy assumes that people have many skills, competencies, beliefs, values, commitments and abilities that will assist them in reducing the influence of problems in their lives (Morgan, 2000).

The word “narrative” refers to the emphasis on telling and retelling the stories of people’s lives and the differences that can be made by doing so. Narrative therapy works to understand these stories and explores ways to “re-author” these stories, in collaboration with the therapist, to produce a more preferable life story. It is a way of working with a client who is interested in history, the larger social context that affects the lives of clients, and the ethics or politics of therapy, as it is known to the client. The idea is that people develop a set of beliefs about themselves and the world [called “ways of knowing”], which are informed by external “forces” that gain power in the authoring of our life stories. For example, themes of incompetence may give the “force” of rejection more power and cause a client to tell stories about himself that show him as an isolate who doesn’t seem to fit in anywhere. Themes of injustice may give the “force” of racism more power and cause a client to tell stories about her life in which she is the constant victim of racial injustice (Friedman & Combs, 1996).

A narrative therapist seeks to have conversations that allow clients to tell stories about their lives. These conversations help both the client and therapist to understand how the client has come to know the negative forces and how such forces have influenced their lives, and also to listen for “exceptions” to dominant stories to assist the client in reducing the influence of the problems and rewrite their stories. Change occurs when the client can recognize the role that her own gifts, abilities and resiliencies play in these exceptions and can build upon them to defeat the influences of negative forces in her life. Narrative therapy also provides some unique practice methods, including ways of interviewing that help the client to externalize the problem and that also help the client to define goals for work. For example, a narrative therapist may ask, “If I were to take a picture of your life at the end of our work together, what would it look like?” Such questions allow the client room to reflect on the process in a respectful and more meaningful way (Morgan, 2000).

Pastoral Counseling

“To God belongs wisdom and power; **counsel** and understanding are his.”

JOB 12:13, KING JAMES VERSION OF THE BIBLE

Pastoral counseling is a form of psychotherapy that uses spiritual resources as well as psychological understanding for healing and growth. Individuals struggling with depression, grief, substance abuse and family violence, among other personal issues and societal problems, often seek help from religious organizations. Many people who are in need and possess a strong faith commitment believe that their help will be found in the religious community, and thus they seek their spiritual leader for help as a way of seeking God. Most religious leaders, however well intentioned and committed to their faith, lack the training to do effective psychotherapy. Over time, clergy have come to see the need for integration of professional training with their faith in order to offer clients the help that they truly need.

The link between spiritual and emotional well-being began to receive serious attention more than a half-century ago when the Reverend Anton Boisen, considered the father of the Clinical Pastoral Education movement, placed theological students in supervised contact with patients in mental hospitals. The specific integration of religion and psychotherapy began in the 1930s when Norman Vincent Peale, a renowned minister, and Dr. Smiley Blanton, a psychiatrist, formed the American Foundation of Religion and Psychiatry, now the Blanton-Peale Institute. Since then, pastoral counseling has evolved from religious or spiritual counseling to pastoral psychotherapy, which integrates theology and the behavioral sciences. This transformation has been influenced by such figures as Carl Jung, Abraham Maslow and M. Scott Peck, all of whom have written extensively on the need for integration of spirituality and clinical practice. The result is a form of psychotherapy that honors and operates within the framework of the client’s understanding of God and faith, using professional skills to help the client seek solutions. Today, pastoral counseling accounts for 3 million hours of treatment annually in institutional and private settings (AAPC, 2003)

CLIENT AND CLIENT SYSTEM, PROBLEMS AND CONTEXT

“Nicole” (whose name and information have been changed to protect confidentiality) is a 22-year-old African-American female who resides in South Holland, Illinois. She is the older of two daughters and lives with her father,

an artist, and her stepmother, an employee of Northern Illinois University. Nicole has a younger sister, Lauren, 21, who is away at college. Nicole graduated from Northern in 2001 with a B.A. in marketing. While she lives in the south suburbs, she works and spends most of her free time in Chicago with friends from high school and college.

I began my work with Nicole through the ministry of the Salem Baptist Church of Chicago. The church, located on Chicago's far South Side, has what is called "professional ministries," in which members of the church who are professionals from selected fields draw on their expertise to provide free services, under the guidance of trained church staff, to other members and persons in need. The ministry allows persons who are informed by a faith tradition to provide services or "ministry" that is not only faith-driven but enhanced by specialized skills, training and knowledge.

Nicole, a devout evangelical Christian, first became familiar with the church through its external ministries in high-school bible clubs, and she has visited the church off and on for several years. Nicole is not a member of Salem Baptist Church, however, her faith is very important to her and to her family. We began our conversations because she felt stressed and unsatisfied with her current job at an advertising firm, and because she was worried about graduate school. The fact that my work with Nicole was not through an agency but within a church introduced a perspective of spirituality that is not present or is often limited in other settings of my professional work, such as field placement.

In our first meeting, Nicole and I discussed details about the clinical process, such as confidentiality and expectations of her role and mine, and I asked Nicole to tell me a bit about herself. I quickly surmised that Nicole was an extremely insightful individual with a vivid imagination, and that a narrative approach might be highly effective in working with her. My goal was to be respectful of Nicole's experiences as I allowed her to share her story. This beginning process of narrative therapy values the client's story and their understanding and interpretations of their lived experience. Respect for the client's story establishes mutual respect and trust, and it provides us with the opportunity to begin to map out areas of exploration.

CLIENT'S PERSPECTIVE ABOUT HER PROBLEMS

In the beginning phases of our conversations, Nicole was most concerned about the direction her life and career was headed. In her last year of college, Nicole had the opportunity to study abroad in Paris. Her father objected very much to the idea of her going to France, she said, but she went anyway. She

regards the year she spent in Paris as “the best time of my life.” When she returned home, she took a job with an advertising firm in downtown Chicago. She stayed with this firm for eight months before she was fired because she refused to forge a colleague’s signature on a set of contracts as instructed by her boss. “I wasn’t going to do that; that goes against my integrity,” she said. At first, she seemed rather glad that she was fired because the job and her negative interactions with her boss, who consistently berated her, made her feel “incompetent” and were a constant source of stress and anxiety. After awhile, however, she could no longer afford her lifestyle with part-time work and unemployment and she thus sought another full-time job, where she felt her ideas were not appreciated and she wasn’t respected. Within two months, she was asked to leave.

Nicole’s career is not the only source of concern for her future. Shortly after Nicole was fired from her first job, she became engaged to a young man named Martin, a naval officer. Her parents did not approve of the relationship because they doubted his religious commitment. According to Nicole, she initially felt good about the relationship; however, about a month into the engagement, Nicole began to pay attention to messages she was receiving from her friends and family, and she started to worry if she was moving too quickly. She began to wonder, “Is this the man that God intends for me to marry? Is this really the will of God?” She consequently broke off the engagement after less than three months.

Nicole is currently dating a young man named Brent, however, it is a long-distance relationship as he lives and works in Trinidad. During both of her recent relationships, she has had a strong attraction to another man named Ronald, whom she has known since high school and with whom she has secretly aspired to be involved romantically. She expressed her feelings for him twice, but, unfortunately he did not reciprocate. The second time she attempted to explore a relationship with him, not long after she was fired from her second job, he said to her, “Didn’t we talk about this?” Nicole wept bitterly and said, “I feel like such a fool.” She said she frequently finds herself in situations where she is attracted to someone but she feels like they don’t think she’s good enough, and she becomes the best friend rather than the love interest. “I’m always second place,” she said. Nicole said she felt “like a failure” and wondered, “Can I do anything right? I mean, it looks like I can’t do anything.” While she has experienced these thoughts and has felt very deeply about them, Nicole maintains hope and she says that her faith in God and her belief that “He will work it out” helps her to be hopeful about her future.

Another problem, Nicole said, was her relationship with her father and stepmother. Nicole shared that she and her sister, Lauren, lived with her birth

mother, who divorced from their father, until she was 12. During that time, the two girls were involved in various extracurricular activities, including dance, skating and tennis. Their mother, who was also a dancer, kept them active and regarded them as “queens.” When Nicole was 12, her mother died from a serious illness, and she and her sister went to live with their father and his wife, whom after a short time they began to refer to as “Mom.” Nicole described her father affectionately, but she said she often felt that he was over-protective. He removed them from many of the extracurricular activities they were in, she said and she told them they needed to focus on more “practical” things. On the day her mother died, Nicole said, her father told the two girls, “All you’ve got now is each other.” He also told them, “While I am your father, and I love you, your mother [his second wife and their stepmother] will always have first place in my life.” As a result, Lauren became very distant toward their stepmother, while Nicole’s response was that she “became like Mom. Lauren would come to me to talk about boys, feminine things and when she was sad. I had to put my feelings aside and take care of her.” Nicole said her relationship with her stepmother is strained, and that her stepmother will complain to her father about Nicole’s lack of contribution to household finances, her indecisiveness in relationships and incomplete household chores. When Nicole’s stepmother complains, Nicole’s father almost immediately reprimands her.

Nicole finds it difficult to share anything with them and would like to communicate more openly and honestly with them. She said she couldn’t share her decisions with them because they make her feel as though she always makes wrong choices. “They make me feel like I can’t make decisions for myself. I can’t do anything right, according to them.” While their relationships are strained, she said the family still attempts to attend church together, and she is able to communicate with them on “some levels.” She sees her father as a loving person whom she can relate to sometimes and on whom she relies for spiritual guidance, and she often talks with her stepmother about potential romantic relationships.

PROBLEMS WE AGREED TO WORK ON

Nicole and I agreed that her major concern was about her future and the direction her career was taking. Therefore, many of our conversations were centered on where she wanted her life to go. Using narrative interviewing, we decided we would review her life goals. I asked questions such as, “If I were to take a picture of your life in five years, what would it look like?” From those kinds of conversations, Nicole outlined her goals for the next few years that

she would like to have a master's degree in business, work at an advertising firm and live on her own. She said she also would like to work on her relationship with her parents, so she can feel more comfortable discussing the details of her life with them, and we agreed that we would talk about ways to improve communication. She also said she'd like to explore the history of her reputation as "the little sister" with the men in her life, and as "second place" in her romantic endeavors.

INFORMATIONAL CUES AND PATTERNS OF UNDERSTANDING: SOCIAL ENVIRONMENT

In understanding Nicole's condition using the CI perspective, her ideas of being a "failure" and "not being able to do anything right" are a function of the kinds of information she has received and are themselves a source of anxiety. These overall feelings are maintained by several sources of information in her social environment. First, most of Nicole's friends are working successfully in full-time jobs, and they are living on their own in apartments or town homes. Ronald, her would-be love interest, has been very successful financially and owns his home at the age of 23. Therefore, she has socially located herself at a lower position than the majority of her peers, and she factors this into her assessment of her financial condition. Moreover, the fact that Nicole has been fired from two stable, full-time positions within the past year provide two very poignant memories which have caused her to even question whether advertising is the right field for her.

Her romantic relationships have fed into her self-perception of being a failure. She reflects often on at least three individuals, each of whom she was very attracted to and felt she could have married. But when she introduced this idea and tried to explore deepening the friendship, each of them "let me down easy" and said she was more like a "sister" than someone they could be involved with romantically. Nicole believes that in each of these experiences, the "real" reason why they did not want to become romantically involved was that Nicole did not fit their idea of "the ideal woman." Thus, her inability to be with men whom she feels sincerely attracted to feeds into her idea of failure.

Next is her relationship with her parents. Nicole receives information from them frequently that suggests that she is not doing "as well as she could be." The messages she gets from them are, "Well, why did you do that?" or, "Why did you decide that, instead of this?" She further said they will use scripture to justify their comments, saying, "We just don't want you to be out of the will of God."

BODY STATE

Nicole has battled depression-like symptoms, such as oversleeping and drastic changes in appetite, such as extreme hunger to no hunger, which have contributed further to the meaning that she draws from her current condition. She believes these and the other negative circumstances of her life are “attacks of the enemy [the devil],” yet at the same time she complains sometimes of abdominal pain and headaches and she wonders if these are somehow “punishments” for being “out of the will of God”. Because Nicole decided to spend less time at home and more time seeking employment, her eating patterns had changed and she was eating far less nutritionally, but she was not directly factoring this reality into her specific assessment of the situation.

CLIENT'S UNDERSTANDING OF THE PROBLEM

The meaning that Nicole gathers from the elements of her story are that she is “failing” and that she doesn’t know if she’s “in the will of God and being attacked by the devil” or “out of the will of God” and somehow out of God’s protection. While she is insightful, and she enjoys the narrative approach that I incorporate in practice, she has difficulty with the alternate stories. For example, despite having been fired from two jobs, Nicole has successfully maintained three part-time positions in three completely different fields. Rather than attributing those facts to her strength as a communicator and to her abilities, she said, “Well, they needed to hire somebody, and I guess I was just in the right place at the right time.” Interestingly, while Nicole struggles with the negative information that feeds her ideas of being a failure, she maintains confidence in several areas including her creativity. She says, “I have great gifts and a good imagination,” and she will alternately explain her situation as indicating that “maybe I need to be in a place where I can use my gifts more.” She also believes overall that despite her frustration with present conditions, God is using these circumstances to “teach me how to trust Him more” and to develop her character.

The factors listed above all represent pieces of Nicole’s memory patterns that are activated whenever she experiences an event or experience in which she “fails” or “falls to second place.” She encounters the external cues whenever she has another experience with Ronald or another male to whom she is deeply attracted in which she is rejected. This makes her feel like she’s never important or “special enough” to these men, and these experiences resurrect the memory of the last such experience, which causes her to feel generally less competent in her life. Because she is consumed with this idea of being second

place, she may make sudden decisions to commit quickly in new relationships and come home to messages that reinforce the idea that she makes poor decisions—not just in relationships, but also in her career. Her responses to the messages she receives from her parents can be self-destructive, in that she avoids their physical presence, which means she avoids coming home, which compromises her sleep and eating habits, which changes her body state and increases the frequency of her headaches and abdominal pains. When this pattern is activated she feels depressed and frustrated, which all reinforces the idea that she is failure. When activated, these patterns serve as themes that further consume her as a victim in this narrative account of her life.

CLIENT'S RESPONSE TO HER UNDERSTANDING OF THE PROBLEM

As stated, Nicole's output patterns can serve to be self-defeating, in that her behaviors and responses usually precipitate exactly the patterns that she aims to avoid. Her need to feel as though she can “keep step” with her friends socially adds to the stress she feels about her financial condition. This puts her in a position where she cannot contribute as expected toward household expenses, which opens the door for more criticism from her parents. Nicole understands that on several levels, her responses can bring more confusion and feed into ideas that she would like to jettison. For example, Nicole realizes that she will get into relationships to compensate for failed opportunities in other relationships, as she did when she became engaged to Martin to compensate for not being with Ronald. When she acknowledges that the relationship is not something that she truly wants and decides to end it, this feeds into her image as a poor decision-maker, and that puts her more at odds with her parents. She also has brief moments when we can highlight ways that she has managed to survive and do well despite her setbacks—for instance, she has managed to focus more on artwork and drawing, which she loves. As Nicole's therapist, I believe that if she can find an audience for the alternate story and become more comfortable living in it, then she can begin to overcome these negative schemas and themes that have hindered her experience of life at this stage in her development.

CLIENT'S PERSONAL STRENGTHS AND SOCIAL RESOURCES

In our meetings together, Nicole has been very willing and prepared to explore the conditions of her life and how she has gathered meaning from them. She is able to engage in insightful conversation; she is exceptionally reflective and

values introspection. She is also very creative and brings her creativity and imagination to the sessions with her, and thus the narrative approach has worked well. Her creativity has enabled us to explore themes in her life in some rather abstract conversations, from which we can deconstruct meaning in ways that may not be possible or as effective with a more concrete thinker. Nicole is also very talented, and she recently has become involved in a dance troupe in Chicago, which helps her to vent negative energy and to be more physically fit. This activity also has helped to build up her sense of pride in her talents. She also has winning interpersonal skills and is a great communicator. Despite her specific assessments of her current financial and social condition, she seems to be well respected by her friends and peers and by her sister, Lauren, who is her closest confidant. Because of Nicole's strong faith in God, she has been able to retrospectively view her past troubles with varying degrees of optimism, which fuels some hope for the future.

TARGETS AND GOALS FOR CHANGE

My assessment of Nicole's situation is that she is an extraordinarily gifted and talented individual who has experienced some extreme early professional hardships, largely because she has not found the most nurturing professional environment. In addition, she is experiencing pressure from her social environment and her belief system to be at a certain level of independence, which, because of the aforementioned hardships, she has yet to attain. I believe this is further complicated by some negative self-schemas that have hindered Nicole's abilities to be resilient and make progress in her professional and social life. In seeking support for her condition, she has encountered relational conflicts that have a thick history (as we will discuss later) and are associated with other negative memory patterns.

Considering these factors, and based upon our goals, the targets for change are to help Nicole find new sources of information that contribute to the alternate story of success at overcoming difficulties using cognitive and narrative tools. Another target of change was to draw on narrative and relational tools to help Nicole explore how her relational history may have impacted her current relational functioning and to brainstorm ways to avoid further conflicts.

GENERAL INTERVENTION PLAN AND CLIENT INVOLVEMENT

Because of my training in narrative therapy, I wanted to gather a thick

description of Nicole's story, listen for strong themes and identify the major characters in the story. With this done, we could then move on to areas of Nicole's story for deconstruction.

On level one of the intervention plan, one of Nicole's greatest concerns was her finances, especially when she lost her first job. Using a task-centered approach, I informed her that she may be able to apply for unemployment compensation to help offset some immediate financial difficulties, and referred her to the appropriate agency. She did apply and received financial assistance, which helped to ease some of her immediate concerns as it related to her expenses. At that point, Nicole decided to volunteer at Northern Illinois with her mentor to stay busy and to use the time spent in Chicago to look for alternate work.

Nicole struggled very early with feelings that God was somehow punishing her and had abandoned her because she was out of the will of God. Integrating tools from pastoral counseling in a way that was respectful and didn't make her feel somehow immoral for questioning God¹, we reviewed Nicole's God concept; I asked if she believed that God would "punish her" if she was out of the will of God, or if He would correct her in a different and less vindictive way. She said she believed that He would rather not intentionally make her suffer, and we reviewed some biblical scriptures related to the subject, which helped Nicole to understand that perhaps these feelings were not punishment. We then discussed how she knew whether she was in the will of God. Again, she referred to scriptures that led her to the assessment that God's will for her was that she would be happy and prosperous and that God didn't want her to be second best. Nicole decided that God wanted her to move on despite her troubles, and that she was "still destined for greatness." I then provided encouragement in the spiritual model, based upon her stated desires and upon what she felt that the will of God was for her life.

To make sure that she was aware of her role in the process, and to decentralize the power in the working relationship, I felt it was best at this point to clarify Nicole's own will and intentions. We mapped what's called a statement of position, which clarified what Nicole wanted in her life. This 'contract' states what a client wants for herself, and throughout the therapeutic process it can help measure whether the client is really doing what *she* wants to do, or if she's becoming subject to some force or new negative theme. She said she did not want to live subject to the themes of the old story, which included failure and the idea of being "second best." While we were doing this, Nicole and I brainstormed some ways that we could develop the new story and help to move out from her new position. She said she wasn't ready for a full-time job

right away, only because she felt that she couldn't handle another major failure such as being fired from the previous two.

This opened conversation about how she was doing in her volunteer position at Northern. She said she was received very positively there, and that they wanted to pay her to teach high school students over the summer but she didn't know if she could do it. We reviewed the best and the worst things that could happen if she took the opportunity, while referring back to her statement of position. She said she very much wanted to teach full time one day, and that this would be a great experience. We assessed the risk, and we concluded that it fit with her new statement of position and she said that she would like to try the job.

She did and, although she had some trouble early with the behavior of the students, by the end of the summer the students had received her very well and she got very high marks. She enjoyed the experience thoroughly, and we took advantage of opportunities for her to share those experiences. The new endeavor increased her confidence and helped her to reach a place where she could explore more ways to incorporate her natural gifts and talents in her professional endeavors. To help her become more aware of her successes, I asked Nicole to keep a journal about her strengths and gave her an assignment to write at length about all of her talents and gifts. We are using what she has written in this journal to help her explore more of what she can offer to a job or career or position, which makes her feel more empowered and hopeful about her professional future.

Nicole also wanted to connect to other extracurricular activities, which focused more on her artistic talents. I agreed, as I felt that would help build her confidence and self-esteem. This is when she auditioned and was accepted to a dance troupe in Chicago. She also decided to branch out and find part-time employment at Marshall Field department store and at a museum in the south suburbs. She said she enjoys working these jobs part-time because she can manage and balance her schedule and still do the things she'd like to do. Her ability to better manage her professional endeavors with the freedom to use her gifts and her positive relationships with her new co-workers provide her with more positive information that's helping her become more comfortable with the alternate story.

Noticing that a shift in the informational cues had taken place², I felt it might be time to devote more attention to analyzing the history of Nicole's schemas. Nicole and I began to talk more about her relationships, particularly with her parents, which were a concern to her. As she told stories about her interactions with her parents, I reflected back to her the themes that came up

in those stories. One major theme was that she felt her father had regarded her stepmother as more important than her, and that her stepmother was “spoiled” and always got her way. I reflected to Nicole that this was a theme also present in her descriptions of her romantic relationships, in that she often concluded that she “was never as important as another woman.”

I allowed Nicole time to process these themes and make her own assessments about them. She concluded, based upon these externalizing conversations, that the statement made to her by her father when her birth mother died (“my wife will always be first”) had impacted her in several ways. This message, given to her at a critical point in her life, had established a schema from which she had been operating in her relationships, that she could never have “first place” or be regarded as important enough based upon her self-worth, rather than by comparison.

My concern about this new understanding, which Nicole regarded as a “revelation” was that it could have put more strain on her relationship with her parents, which we did not want. Using concepts from spiritual counseling, we talked about why it might be important for Nicole to think about initiating a healing process with her father (Davis, 2003). We brainstormed ways and role-played how she could discuss more of her feelings with her parents. Since that time, Nicole has been able to see that her father was grieving in his own way when her mother died, and she has managed to talk with him more about her concerns in her relationship with her stepmother, discovering in the process several things that have made her somewhat surprised and even more understanding of her father’s position. For example, she was able to point out that her father must have been in a difficult position to feel as though he had to make a choice between his new wife and his daughters. Wondering how she might respond to being in the same position, Nicole developed empathy for her father that has helped her become motivated to continue the healing process with him. She is also hopeful about her peer relationships, and she is currently working on ways to become more aware of the schema’s operation in her romantic endeavors.

Her relationship continues very positively with Brent. She said, “I don’t feel rushed by him, so we can take it slow, and that’s nice.” Nicole’s sister, who has been a constant source of support, is a part of Nicole’s audience for the new story, and she has been encouraging to her in the process as Nicole continues to make progress and gain victory over the schemas that have dominated her life. She believes her experience has given her a testimony that she can use to “minister” to others about their self-confidence, and she aspires to minister to people in the same areas of hurt that she has experienced.

FINAL THOUGHTS

The integration of the various frameworks for understanding and tools for practice provided Nicole and me with opportunities to deconstruct her memory patterns and brainstorm real solutions for her troubles, as well as identify other themes that Nicole may want to explore in the future. This case illustrates dramatically how one's belief system can impact the course of one's life, but it also demonstrates how life circumstances can impact an individual's psychological processes. As clinical social workers, we must work within a theoretical framework that gives us the tools necessary to provide best clinical practice, but we also must have a commitment to our core values and provide clients with a holistic process of change. ■

REFERENCES

- Ahlskog, G. (2001). Three puzzles surrounding the persistent non-integration between psychology and pastoral counseling. *Journal of Pastoral Care*, 55(1), 3-5.
- Bandura, A. (1986). *Social foundations of thought and action: A social cognitive theory*. Englewood Cliffs, N.J.: Prentice-Hall.
- Beck, A.T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.
- Berlin, S.B. (2002) *Schemas about schemas: How cognitive theories help us think about change*. [Web Site] http://www.ssa.uchicago.edu/news/lodge_prize.shtml
- Berlin, S.B. (2001). *Social work clinical practice: A cognitive-integrative perspective*. New York: Oxford University.
- Caspi, A. (1993). Why maladaptive behaviors persist: Sources of continuity and change across the life course. In Funder, D.C., Parke, R.D. Tomlinson-Keasey, C., & Widaman, K. (1993) *Studying lives through time: Personality and development* (pp. 343-376). Washington, D.C.: American Psychological Association.
- Davis, A. (2003). *Christ-centered inner healing: An integration model*. (Web Site). <http://www.hisresources.com/davis/>
- Epston, D. & White, M. (1990). *Narrative means to therapeutic ends*. New York: Norton.
- Freedman, J. & Combs, G. (1996). *The social construction of preferred realities*. New York: Norton.
- Hill, E.W. (2001). A collaborative pastoral care and counseling supervisory model. *Journal of Pastoral Care*, 55(1), 69-81.
- Morgan, A. (2000). *What is narrative therapy? An introduction*. Australia: Dulwich Centre Publications.
- What is pastoral counseling? (2003). American Association of Pastoral Counselors (AAPC). [Web site]. <http://www.aapc.org/practice.htm>

White, M. (1988) *The process of questioning: A therapy of literary method*. Dulwich Centre Newsletter, Winter, 8-14.

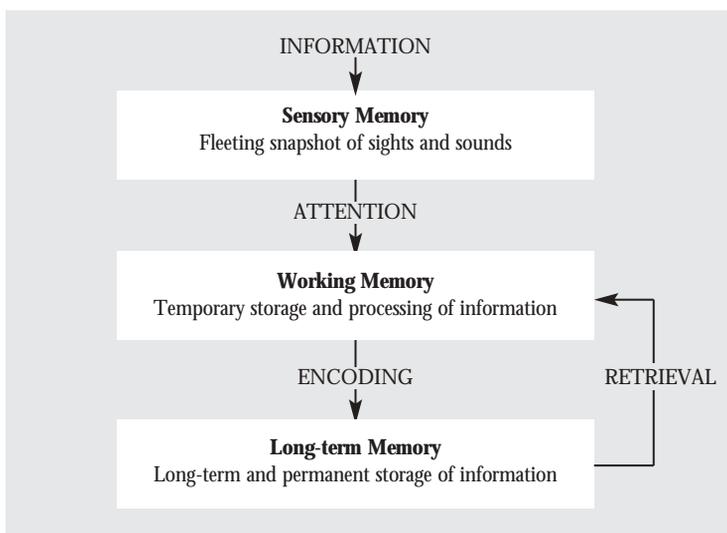
FOOTNOTES

¹In the type of spiritual counseling that I provide, I allow people to challenge traditional views about what can and cannot be said about God, with the conviction that it is helpful and liberating for a client to acknowledge certain feelings about or toward God that may be unpopular or seen as heretic, such as anger, resentment, or feelings of victimization by God, and to be one with those feelings. I felt here, however, that it was critical for Nicole to clarify her beliefs about whether God was punishing her because it would indicate her motivation level for the rest of the process. If she felt “out of the will of God” and that God was “punishing her,” then she may not have been willing to continue because her situation, according to her, would have become hopeless. However, had she held that as a stronger conviction, we would have proceeded with the clinical interventions and I would have referred Nicole to a full-time clergy worker for more spiritual counseling concerning her God concept, in that one goal was to empower her to better social functioning.

²According to the C-I perspective, the therapist should work with the client to address systemic issues that are providing information that feeds the negative schemas. Having addressed some of the sources of negative information that Nicole had to deal with in the present, she and I could now devote more time to analyzing the history and origination of those schemas.

APPENDICES

Appendix A: Processing of information according to traditional cognitive theory



Appendix B: Suggested outline for case analysis using the C-I framework:

- I Identify the problems and set the context (briefly describe the client, her social environment, and presenting concerns)
- II Describe the client's perspective about her problems, goals and resources for change (include specific client statements about the problem(s) and coping skills)
- III List the problem or problems that you and the client have agreed to work on
- IV How do you understand the problem? Consider how the social environment (cultural meanings, connections and disconnections, socioeconomic conditions, past and current interpersonal relationships, circumstances, or events) influence the client's sense of problematic meanings. Also consider body state (considerations of general health, chronic tension or fatigue). Then consider how the client symbolizes, phrases, or puts words on her experience of herself in relation to her problematic circumstances. Do these propositional meanings—situation-specific appraisals in the client's own words—help her in coping with the problem and her problematic meanings or somehow make them worse?
 - According to theory, these various sources of input will be rapidly synthesized into a pattern of implicit meaning to give the client an overall felt sense of herself in relation to a set of circumstances ("I'm incompetent"). How would you, the clinician, describe these overall themes and feelings?
 - How do the client's emotional, behavioral, and interpersonal responses to her implicational understanding serve to maintain, improve or exacerbate the pattern of negative meaning?
- V How do you understand your client's personal strengths and social resources that might be drawn upon, elaborated and/or extended in forging solutions? For example, what are her sources of social, emotional and material support? What are her goals, hopes for the future, visions of possible selves?
- VI Given your analysis of the problem, what are the targets and goals for change?
- VII Given all of this and the client's strengths and resources, what is your general intervention plan?
- VIII Discuss the client's role in developing this plan. To what extent does it incorporate her perspective or belief system?
- IX Final thoughts and reflections

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CHALLENGES IN ASSESSMENT AND IDENTIFICATION OF DEPRESSION AMONG OLDER ADULTS: IMPLICATIONS FOR THE NATIVE AMERICAN COMMUNITY

by Rebecca Donaldson

In our society, changes in older adulthood are consistently framed in terms of loss and deficiencies. This paper examines the prevalence and nature of depression among the elderly, and how depression relates to the developmental stage of older adulthood. Mental health concerns, particularly depression, are widespread among older adults. Focusing on the Native American elderly, a disproportionately impoverished minority population with a disproportionately high rate of older adult depression, this paper uses a multicultural lens to examine the different experiences of depression among older adults, and the resulting implications for service delivery. Increasing knowledge in the professional community has important implications for increased coordination and improved services for older adults suffering from depression.

Older adulthood is a life stage filled with many physical, cognitive, emotional and psychological changes. In present-day American society, such changes in older adulthood are consistently framed as leading to losses of roles and abilities. Our society's emphasis on youth and devaluing of age and experience is reflected in our attitude towards older adults. Fry (1986) conceptualizes our view of the aging process as "a gradual, downward trajectory with ever-increasing levels of inadequacy, impairment, and physical and psychological decline" (p. ix). Bearing this in mind, it is not surprising that our society sees high rates of mental health issues, particularly depression, among the elderly (Ruiz, 1995, p. 6). Research estimates that 15 percent of older adults demonstrate clinically significant symptoms of depression (Bower, 1991). Many studies demonstrate, however, that such decline is not inevitable. Research suggests that various environmental, biological and socio-cultural factors and experiences of stress can influence older adults' likelihood of experiencing depression (Chaisson-Stewart, 1985; Fry, 1986). The Bio-Psycho-Social-

Cultural model's focus on a person's subjective experience of events acknowledges the individualized experience of depression and the need for multifaceted solutions to this prevalent problem (Fry, 1986, p. 2). Understanding the factors and experiences contributing to high rates of depression among the elderly is critical if our society hopes to improve quality of life for older adults.

Despite the prevalence of depression among this population in our society, older adult depression is among the most vaguely defined mental health problems in regard to cause, origin and assessment (Fry, 1986, p. 114). Given the influence of environmental factors, it is important to examine the occurrence of older adult depression within a framework that acknowledges cultural influences in the subjective experience of aging. Ironically, current inadequacies in assessing older adult depression are particularly evident in our failure to consider or examine the complex influence of socio-cultural factors on depression. This discussion will examine these current challenges in understanding depression by focusing on the impact of depression among the Native American elderly, a disproportionately impoverished minority group.

THE NATURE AND EXTENT OF OLDER ADULT DEPRESSION

Characteristics and Prevalence:

Data suggests that depression is the most common mental illness among the 12.3 percent of people over age 65 experiencing mental health problems that require intervention (Ruiz, 1995, p. 6). The physical and mental health of the elderly must be examined in an environmental or ecological context. The effects of environmental and psychological factors on health seem particularly evident among the elderly because they have fewer material and emotional resources to assist them (Coe, 1983, cited in Fry, 1983, p. 1). There is little question that older adults may face challenging biological, cognitive, psychological and social changes. Normal biological changes, however, generally do not explain the onset of late-life depression (Blazer, 2002, p. 27). Similarly, normal changes associated with aging can result in psychological stress, through the loss of social support, for instance, which may in turn contribute to depression. Again, however, research generally suggests that normal psychological or emotional changes associated with aging do not cause depression.

Research has shown a number of factors to correlate with high rates of depression. These factors can be understood best through the Bio-Psychosocial-Cultural perspective, which suggests four categories that interact and thereby influence an individual's behavior and experiences. A discussion of the

various biological, psychological, social and cultural factors that may influence one's experience of mental health illuminates the degree to which depression is a multifaceted and multi-causal phenomenon (Chaisson-Stewart, 1985). Our framework for understanding depression must truly examine and integrate these various factors to provide a comprehensive understanding of this complex problem facing older adults.

In regard to biological factors, a strong correlation exists between physical illness and depression. Such findings are particularly relevant for the elderly because of the frequency, and chronic and debilitating nature, of illness experienced among this population (Manson & Brenneman, 1995, p. 284). Suffering from physical illness, particularly chronic or serious illnesses including arthritis, cancer, chronic lung disease or heart disease, is a characteristic shared by many older adults experiencing depression. It is also important to note that the subjective meaning of an illness, or losing certain abilities to failing health, is relevant to mental health. A disease or disability that destroys a person's self-image, making a person more prone to frustration or feelings of hopelessness, holds great meaning to that individual and may put him or her at risk for depression (Fry, 1986, p. 5).

Psychological factors influencing an older adult's risk for depression may include his or her mental health history. Some researchers have suggested that as many as 50 percent of elderly medical patients require psychological care as urgently as medical care (Fry, 1986, p.1). Both extensive anxiety and depression are associated with greater clinical severity, chronicity and poor recovery prognosis (Lynch et al., 2000, p. 268). Personality factors can serve as risk or protective factors as well. For instance, a strong sense of control over one's life and circumstances is negatively correlated with depression among older adults and thus perceiving control serves as a protective factor. Similarly, an individual's ability to reinforce oneself through the use of mood regulation skills, or the ability to control one's cognitive or emotional reactions to certain stimuli, negatively correlated with depression in a study of adults (Wong et al., 2000).

In regard to social factors, feelings of social isolation and lack of social support correlate high rates of depression (Blazer, 2002, p. 284). Alternatively, social support and feeling connected serves as a protective factor for individuals. Levin (1960) identified loss as the primary category of stressors for older adults, influencing self-esteem and mental health. Such findings are particularly relevant to the elderly population, as the loss of important relationships through the death of friends or a spouse is common and may lead to feelings of hopelessness (Fry, p. 5). One study suggested that 60 percent to 80 percent

of depression in the elderly is precipitated by a major event, almost always involving loss (Post, 1968, cited in Chaisson-Stewart, 1985). Similarly, feelings of social isolation and lack of support, often stemming from disconnection with family, may also have an important impact on mental health.

Sociocultural factors affecting depression among older adults include the attitude of the individual and their society or cultural group toward aging. For instance, members of lower socioeconomic status groups tend to express greater fear of poverty and abandonment than members of higher socioeconomic groups (Fry, 1986, p. 5). Sociocultural factors also can relate to social support, in that individuals' cultural norms may influence how much support they receive from their families. Sociocultural norms also might determine one's expectations of the support he or she should receive from family, which may impact positively or negatively that person's feelings of self-worth and value.

UNDERSTANDING ELDERLY VS. NON-ELDERLY DEPRESSION

Our understanding of depression among older adults is based on a framework designed for a non-elderly population (Bower, 1991, p. 310). Lewisohn, Biglan, and Zeiss (1976) suggested five classes of depression symptoms: 1) *dysphoria*, or feelings of sadness and apathy; 2) *behavioral deficits*, such as decreased verbal or physical activity; 3) *behavioral excesses*, such as intense feelings of guilt; 4) *somatic symptoms*, such as headaches; and 5) *cognitive expressions of extremely low self-esteem or negative expectancies* (cited in Fry, 1986, p. 80). Researchers and professionals typically understand depression among older adults by these standards. Though the elderly demonstrate hopelessness and loss of interest similar to younger depressed populations (Blazer, 2002, p. 39), numerous symptoms of older adult depression, which are not conceptualized in the model of major depression, are difficult to differentiate from normal aging symptoms. For instance, depressed older adults generally complain about discrete medical symptoms rather than classic symptoms of depression (Bower, 310, 1991). Findings have emphasized the importance of adjusting the younger client-based model of depression to understand older adult depression. Attempts to incorporate changes can be seen in the development of the Geriatric Depression Scale, which emphasizes psychological and cognitive symptoms, differing from the non-elderly-focused Beck's Depression Inventory by (Fry, 1986, p. 101). However, additional adjustments to such measurements of depression, to best reflect nuances in the experiences of elderly versus non-elderly depression, are needed.

DEPRESSION IN THE CONTEXT OF “NORMAL” OLDER ADULTHOOD

In examining depression among older adults, it is important to understand the context in which depression occurs. Keeping the challenges of older adulthood in mind, assessment tools must establish criteria for what level or range of functioning is considered normal. It is important to reiterate that close to 15 percent of older adults in the United States, who do not meet the criteria for major depression as based on the younger-client model of depression, demonstrate “clinically significant” symptoms of depression (Bower, 1991, p. 310). This is also true of 25 percent of older adults living in acute medical facilities (O’Riordan et al, 1988, cited in Blazer, 2002, p. 21). More research comparing the characteristics and prevalence of “clinically significant” depression symptomatology to major depression among the elderly is critical if professionals hope to fully understand the ways in which older adults experience depression. We also must acknowledge that our perceptions of aging directly affect our conceptualization of mental health in older adulthood. Specifically, our ideas about aging determine what level of negative effect or depression should be considered problematic. Some research demonstrates that depression is under-diagnosed (Bower, 1991), suggesting the normalization of older adult depression in our society, consistent with our idea of old age is a sad and “depressing” time.

Rutter (1993) proposes examining life transitions in terms of the new challenges faced and the ways in which occurrences and negotiations are influenced by strengths from the past. Such life-cycle models emphasize the role of environment throughout the life span, suggesting that historical events, environmental variables, societal expectations and value orientations influence an individual during the life course (Bigot & Munnichs, 1978, cited Fry, 1986, p. 6). Life cycle frameworks allow for an understanding of intra-generational similarities and intergenerational differences, as well as offering one’s past experiences as an explanation for why different individuals react differently to seemingly similar occurrences (Rutter, 1993). Most comprehensively, the Bio-Psycho-Social-Cultural model provides an important framework for understanding how specific and complex factors interact to influence an individual’s behavior and experience. Helping us understand complexities, this model also makes clear why single-entity problems among the elderly are rarely encountered, and that many interactions between behavioral, organic and cognitive process interactions exist in

the lives of older adults. The Bio-Psycho-Social-Cultural model's focus on a person's subjective experience of events acknowledges the individualized experience of depression. Additionally, this framework facilitates a multifaceted and strengths-based understanding of how older adults, as individuals, cope with depression.

THE ROLE OF CULTURE IN UNDERSTANDING OLDER ADULT DEPRESSION

Looking at differences across cultures is particularly important in our examination of the developmental context in which depression occurs. In examining American society from a multicultural perspective, there are a number of general cultural differences that should be acknowledged. First, some theorists suggest that general similarities of values exist within American minority cultures, which differ from mainstream societal values. These include the values of harmony with nature, reciprocity, traditional medicine, respect for elders and family commitment, among others (Padgett, 1995). Despite such similarities, much heterogeneity exists within the United States, including among minority groups, which results in different health and mental-health care experiences and outcomes for different populations. Specifically, variance exists in distribution of disease, the need for and seeking of health care, attitudes toward self-medication and the role of the health-care provider or healer, help-seeking and compliance, and response to health care professionals, among others (Padgett, 1995, p. 24). Secondly, one must consider how depression fits into the norms and values of a different culture. For instance, research has shown that minority elderly are much more likely to seek help for a physical problem and fail to mention relevant emotional or mental problems. This example not only emphasizes the importance of professionals understanding cultural differences to work effectively with different populations, but this has important implications for program planning and implementation.

More research is needed to examine the various socio-cultural influences on risk factors and experiences of depression among older adults. A great deal of past research has focused on homogenous populations and thus can only be cautiously generalized to ethnically or socioeconomically diverse populations. Few studies focus on differences between racial or ethnic groups in examining specific issues around depression, and those that do rarely examine the differences between elderly and non-elderly depressed populations. As a result, research that looks at mental health issues among the ethnically diverse elderly is not extensive. The quantity of research on socio-cultural factors in depres-

sion among the elderly must be expanded, and the scope of such research must be extended as well. In particular, more research must be done examining service use patterns among minorities, to plan future intervention and treatment programs that can be successful (Manson, 1995). Additionally, research must not only look at differences between minority and non-minority elders but also address the needs and characteristics of specific minority populations in America today. While some similarities of values may exist between American minority cultures (Padgett, 1995, p. 25), different minority cultures, whether defined by racial, ethnic, socio-economic, gender or sexual orientation status have different specific needs and strengths.

OLDER ADULT DEPRESSION WITHIN THE NATIVE AMERICAN COMMUNITY

Mental health research has failed to adequately examine the Native-American community, particularly older adults. Manson and Pambrum (1979) say regarding gerontological literature, "The elderly in question are usually white, seldom black, and never Indian" (cited in Thompson, 1994, p. 91). Thompson emphasizes that this tendency in literature has not changed a great deal in the past two decades. Though research on mental health among Native Americans is sparse, existing studies demonstrate that depression is the most commonly occurring mental-health problem among older Native Americans (Ruiz, 1995, p. 11). In fact, the Native-American elderly experience significantly higher rates of depression than non-Native-American elderly (National Indian Council on Aging, 1981; General Accounting Office, 1977, cited in Manson, 1995, p. 138). Considering how epidemically high depression rates are among older Americans, the surpassing rate of depression among Native Americans is particularly alarming. The Bio-Psycho-Social-Cultural model provides an essential framework for understanding the experience of depression among individuals in the Native American community.

Manson (1995) focuses on the ways in which extensive poverty, biological vulnerabilities to alcoholism and poor health interact to contribute to depression within the Native-American community. Though the mainstream American elderly population experiences extensive health problems, these statistics pale in comparison to the rate of health problems experienced by Native Americans. Pneumonia, diabetes, alcoholism and poor dental health are especially problematic in the Native American community. Particularly alarming, research estimates that 73 percent of the Native-American elderly are mildly to totally impaired in coping with the basics of daily living (National Indian Council on Aging, 1981, cited in Manson, 1995, p. 138).

Social isolation and poverty interact to result in the high rates of depression among the Native-American elderly. Barney (1995) emphasizes that, unlike urban dwellers, Native Americans living in rural reservation communities would not likely be reached through community mental-health center outreach programs, or other social and recreational services. The lack of access to public transportation further takes away from their ability to access services and information. Such effects of living in rural areas are seen among white populations as well. Similar to white populations, most Native Americans living in poverty are over age 75 and in rural areas. However, there is a much higher proportion of rural to urban Native Americans (1:1) than there are white Americans (1:3), thus making the problems of rural poverty more acute in the Native American community (Barney, 1995, p.136).

It is important to note that extensive diversity exists within Native-American communities. Socioeconomic and cultural differences often exist between those living in urban communities and on reservations, as well as among the several hundred Native-American tribal groups in North America today. Additionally, Thompson (1994) suggests that the influence of majority American culture has further diversified the Native-American community, as the impact made by majority culture has varied among tribal groups and among individuals within these groups (p. 93). Across the board, significant heterogeneity exists between American minority groups, and research design and conclusions must recognize this. Heterogeneity within different minority groups, whether among various tribes within the Native American community or different ethnicities within the Latino or Asian communities, also must be acknowledged.

Less is known about the impact of psychological factors on the experiences of older Native Americans. As one of the primary researchers in health-care issues among Native Americans, Manson expresses concern that despite much evidence of extensive need in recent years, little has been done to spur research and increase our understanding of mental-health issues in the Native-American community. Additional studies should focus on improving our understanding about service-use patterns, to provide a more rational base for planning of programs, treatments and interventions. Additional data on specific differences between Native Americans and the general population likely would suggest protective factors of Native Americans to be built upon, as well as risk factors of which to be aware. Additionally, studies are needed to address specific topics previously neglected in the literature on Native-American elderly, including research on the overall psychiatric status, differences in treatment or access to services within Native-American communities, or issues such as alcoholism that disproportionately affect Native Americans (Thompson,

1994, p. 92). Thompson (1994) also emphasizes the importance of examining mental-health implications for the Native-American elderly, as mainstream American culture and continuing poverty may result in some deterioration of the long history of respect for elders within Native-American communities (Thompson, 1994).

CONCLUSION

The concerns and goals for future research and planning regarding older Native Americans reflect to a large degree the across-the-board needs in relation to depression among older adults. Specifically, research in new arenas is needed as well as continuing research on the role of specific socio-cultural factors, as well as mental health issues. Criteria must continue to be established and refined in regard to “normal” versus depression-level functioning, taking into account the subjective and culturally influenced experience of depression among older adults. As discussed previously, this challenge exists in all areas of health and mental health in regard to the elderly, but is especially important with regard to depression, the most prevalent, but least understood, mental illness affecting older adults (Fry 1986, p. 114).

Though much progress in research has been made in recent years, increasing the knowledge of professionals working in geriatrics has important implications for the possibility of increased coordination and improved services for older adults suffering from depression. It is important to emphasize that *comprehensive* changes are needed in the way we plan and address the various needs of older adults. Older adults lack visibility in our society and thus their extensive physical, cognitive, social and mental-health needs are easily neglected. Finally, it is also important to elicit the thoughts, values and opinions of older adults in such service planning, as well. It must be kept in mind that older adults, like any group of individuals, likely will not benefit from a service unless it is tailored to fit the needs and desires of their community. The notion that services must fit the needs, characteristics and barriers to change of a particular community has significant implications given the diversity of race, culture, and socioeconomic status in our society. ■

REFERENCES

- Angel, R.J & Angel, J.L. (1995). *Mental and physical comorbidity among the elderly: The role of social class*. In D.K. Padgett (Ed.) *Handbook on Ethnicity, Aging, and Mental Health* (pp. 47-72). Westport, Conn.: Greenwood Press.

- Barney, D.D. (1995). *Use of mental health services by American Indian and Alaska Native elders*. In D.K. Padgett (Ed.) *Handbook on Ethnicity, Aging, and Mental Health* (pp. 203-216). Westport, Conn.: Greenwood Press.
- Blazer, D. (2002). *Depression in late life: third edition*. New York: Springer Publishing Co., Inc.
- Bower, B. (1991). Marked questions on elderly depression. *Science News*, 140, 20, 310.
Retrieved 10/23/02 from http://plinks.epnet.com/delivery.asp?tb=1&_ug=db5+5+In+en.
- Chaisson-Stewart, G.M. (1985). *An integrated theory of depression*. In G.M. Chaisson-Stewart (Ed.) *Depression in the Elderly: A Multi-Disciplinary Approach* (pp. 56-104). New York: John Wiley & Sons.
- Fry, P.S. (1986). *Depression, stress, and adaptations in the elderly: Psychological assessment and intervention*. Rockville, Md.: Aspen Publications, Inc.
- Jackson, J.S., Antonucci, T.C. & Gibson, R.C. (1995). *Ethnic and cultural factors in research on aging and mental health: A life-courses perspective*. In D.K. Padgett (Ed.) *Handbook on Ethnicity, Aging, and Mental Health* (pp 22-46). Westport, Conn.: Greenwood Press.
- Lynch, T.R., Compton, J.S., Mendelson, T., Robins, C.J., & Krishnan, K.R.R. (2000). Anxious depression among the elderly: clinical and phenomenological correlates. *Aging & Mental Health*, 2000, 4(3): pp. 268-274.
- Manson, S.M & Brenneman, D.L. (1995). *Chronic disease among older American Indians: Preventing depressive symptoms and related problems of coping*. In D.K. Padgett (Ed.) *Handbook on Ethnicity, Aging, and Mental Health* (pp 284-303). Westport, Conn.: Greenwood Press.
- Manson, S.M. (1995). In D.K. Padgett (Ed.) *Mental health status and needs of the American Indian and Alaska Native elderly*. *Handbook on Ethnicity, Aging, and Mental Health* (pp. 132-144). Westport, Conn.: Greenwood Press.
- Ruiz, D.S. (1995). *A demographic profile of the ethnic elderly*. In D.K. Padgett (Ed.) *Handbook on Ethnicity, Aging, and Mental Health* (pp. 3-21). Westport, Conn.: Greenwood Press.
- Rutter, M. & Rutter, M. (1993). *Developing minds*. London: Penguin Books Ltd.
- Thompson, J.W. (1994). Issues in the psychiatric care of American Indian and Alaskan Native elders. In K. Sakauye, (Ed), *Ethnic minority elderly: a task force report of the American Psychiatric Association* (pp. 91-114). Washington, D.C.: American Psychiatric Association.
- Wong, S.S., Heiby, E., Kameoka, M., Dubanoski, V. et al. (1999). Perceived control, self-reinforcement, and depression among Asian American and Caucasian American elders. *Journal of Applied Gerontology*, 18, 46-62. Retrieved 10/23/02 from <http://newfirstsearch.oclc.org/WebZ/FSPage?pagename==tempftascii>.

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GENTRIFICATION AND TAX INCREMENT FINANCING: THE ROAD TO MIXED-INCOME COMMUNITIES?

by Ilana Gotz

This paper examines gentrification, its causes and consequences, and illustrates how Tax Increment Financing (TIF) can be used to promote neighborhood change. This process will be analyzed using the Logon and Molotch (1996) theory of the city as a growth machine. The use of TIF has the potential to create successful mixed-income communities; however, it also can be used to displace current residents and create benefits not for the residents, but rather for local elites who stand to benefit from growth.

INTRODUCTION

Gentrification is an issue facing many communities across the United States. Many people now recognize the signs: perhaps a new condominium development, lofts, or even a Starbucks Coffee. Much of the grassroots organizing happening in neighborhoods surrounds this issue, and often neighborhood organizations find themselves fighting to minimize the possible negative outcomes of gentrification once it is occurring. But why is it that urban development may result in gentrification? This paper will examine gentrification as a process of urban development by using the theory of the city as a growth machine, as proposed by Logon and Molotch (1996). I will apply this theory to development and neighborhood change in Chicago, and to the city's frequent use of Tax Increment Financing as a method of achieving growth.

Logan and Molotch (1996) consider the city as a "growth machine." In their view, place-based elites have the power to affect patterns of land use within the city. These place-based elites, including actors such as property owners, real estate developers, the construction industry, banks and insurance companies, promote growth in order to enhance their wealth. According to

this theory, urban development is a process that is not controlled by the average people who live and work in communities, but rather by local elites who stand to benefit from neighborhood change through increased property values, rents or development contracts.

In Chicago, neighborhood gentrification has served to enhance the wealth, status and image of local elites. These elites benefit from gentrification and the increased growth and value it brings. This group of local elites, or the “growth coalition,” can actually induce gentrification, particularly through partnerships with elected officials. Presently, one of the main tools available for city officials to promote growth is Tax Increment Financing, known as TIF. Through the use of TIF, a municipality can designate an area for reinvestment and subsidize developers and businesses that want to invest in the area. Often, as can be seen in Chicago, once an area is designated as a TIF district, it is highly prone to gentrification and displacement of residents. First I will examine gentrification, its causes and consequences, and then I will illustrate how TIFs are used to promote neighborhood change.

GENTRIFICATION

There are many different definitions of gentrification. Merriam-Webster Dictionary defines it as “the process of renewal and rebuilding accompanying the influx of middle-class or affluent people into deteriorating areas that often displaces earlier, usually poorer residents.” Most definitions incorporate the issue of class, and some state that gentrification is a process of physical and social change in a neighborhood. Kennedy and Leonard (2001) define gentrification as “the process by which higher-income households displace lower-income residents of a neighborhood, changing the essential character and flavor of that neighborhood.” I believe a combination of these two definitions is appropriate: gentrification is the process of renewal and rebuilding in which higher-income households move into a neighborhood previously comprised of lower-income households. The process often, but not necessarily, displaces earlier lower-income residents and changes the character and flavor of that neighborhood.

Kennedy and Leonard (2001) outline the three stages of gentrification as defined by Berry (1985):

“In the first stage, newcomers buy and rehab vacant units, causing little displacement and resentment. In the second stage, knowledge of the neighborhood and the rent gap spreads, displacement begins to occur and conflict erupts. Finally, as the effects of rehabilitation are more apparent, prices escalate and

displacement occurs in force, new residents have lower tolerance for social services facilities and other amenities that they view as undesirable, and original residents are displaced at a larger scale, along with their institutions and traditions.”

This process can be seen in action in a number of Chicago community areas. For example in Uptown, as new condominiums are built and single-room occupancy and affordable housing is eliminated, the character of the neighborhood is changing. Many also fear that gentrification will occur in Pilsen, causing this primarily Mexican neighborhood to lose its ethnic character.

Some would say that gentrification is a natural process—neighborhoods go through cyclical change every two or three decades. Others would say that the process is not natural, but rather controlled by those who stand to benefit from growth in particular places, i.e. the local elites, such as those involved in real estate development, construction, and other industries tied to land use. Gentrification benefits these local elites, for it maximizes growth from the land. Logan and Molotch (1996), referring to these local elites, hold that “the activism of entrepreneurs is, and always has been, a critical force in shaping the urban system, including the rise and fall of given places.” Historically, we see how the elites who built American cities “strained to use all the resources at their disposal, including crude political clout, to make great fortunes out of place” (Logan and Molotch, 1996).

While growth inducement strategies that lead to gentrification are mainly in the hands of local governments, Logan and Molotch (1996) argue that the growth coalition has the means to apply pressure on local officials to mobilize growth to their benefit. They say these local elites play a large role in electing local politicians and this, in turn, gives them systemic power. Local elites support candidates with campaign contributions resulting in “candidates of both parties of whatever ideological stripe, hav[ing] to garner the favor of such persons, and this puts them squarely into the hands of growth machine coalitions” (Logan and Molotch, 1996). The growth coalition holds that growth benefits everyone, for it “strengthens the local tax base, creates jobs, provides resources to solve existing social problems, meets the housing needs caused by natural population growth, and allows the market to serve public tastes in housing, neighborhoods, and commercial development” (Logan and Molotch, 1996). But it is precisely this growth that leads to gentrification and the displacement of low-income residents in favor of the middle and upper class.

The extensive, targeted investment that leads to and intensifies gentrification can be detrimental to the previous residents of the neighborhood. As an area begins to gentrify and property values increase, property owners are faced

with increased property taxes. If a homeowner cannot afford to pay the increased property tax on his home, he is forced to sell and move to a less costly neighborhood. Or if a property owner with rental units finds that area rents have increased, she will renovate the units and begin to charge higher rents, forcing previous residents out if they cannot afford the new rents. Additionally, gentrification brings people who want to buy homes in the neighborhood, especially in the earlier stages of the process when prices are still low. This creates a large incentive for apartment owners to convert to condominiums and sell the units, thereby decreasing the availability of affordable rental units in the area.

Businesses that operate in a gentrifying area face similar challenges. Rental rates increase, often driving out small businesses that once characterized the neighborhood. New businesses that cater to the middle- and upper-class residents of the neighborhood enter the commercial district and compete with the existing businesses. As businesses that once characterized the area leave, so do the jobs they provided. The businesses that enter may not replace the lost jobs, or they may have jobs that require a different level of skills. Many times, as land becomes more and more valuable in the area, businesses supplying manufacturing and industrial jobs also will leave, taking away jobs from the low-income residents of the neighborhood.

Significant changes also may occur in the political landscape of the area. Kennedy and Leonard (2001) point to gentrification bringing change to a community's power structure and elected leadership as well as political, religious, and social-services institutions. New residents may bring contacts and political clout, leading to improved public services. To everyone's benefit, "newcomers advocate for improved schools, lower crime and improved public services" (Kennedy and Leonard, 2001), yet their interests may not always be in line with long-term residents, which can lead to conflicts over priorities and strategies.

As Kennedy and Leonard (2001) show, gentrification is intensified in cities with tight housing markets. As the demand for housing outpaces the supply, the cost increases and the low-income residents no longer can afford to pay the price to live in that neighborhood, and they are displaced. The same authors also point to rapid job growth in a particular area (i.e., jobs requiring a high skill set that attract middle- and upper-income employees), proximity to city amenities, frustration with increased traffic and long commutes, and targeted public sector policies as factors leading to gentrification of city neighborhoods. It is primarily such public-sector policies as tax incentives and subsidies through which gentrification directly benefits the growth coalition.

Gentrification clearly benefits those elites who make up the growth coalition and those who move into the neighborhood when the housing cost is still low. Yet, while it has the potential to create negative outcomes for residents who lived in the neighborhood prior to development, it also can benefit these long-term residents. New development can bring jobs to the community, particularly in housing construction and rehabilitation, and it also brings increased amenities and commercial developments. If businesses are able to stay in the neighborhood, they may benefit from increased consumers and spending. And as Kennedy and Leonard (2001) point out, some original homeowners “may welcome price appreciation and the increased financial equity it brings.”

If low-income residents are not displaced by gentrification, mixed-income communities that benefit everyone can be achieved. Concentrated poverty is expensive for cities and for social service provision. Deconcentrated poverty, on the other hand, has a number of benefits, including reduction in crime rates and enhancement of social capital. The city of Chicago is currently attempting to achieve mixed-income communities through the transformation of public housing and the construction of housing developments that contain market rate, affordable and public housing units.

The key to achieving successful mixed-income communities and minimizing the harmful effects of gentrification is ensuring that lower-income residents are not displaced by the influx of investment, capital and new residents. However, it is not in the growth coalition’s interest to do this, for it means fewer immediate profits. The elites instead push for increased gentrification and growth. One of the main tools the growth coalition can use to do this is Tax Increment Financing (TIF), an economic development tool that allows for targeted investment in a specific area. In Chicago, TIFs have been used in ways that spur gentrification, thereby benefiting the local growth coalition. However, this tool could instead be used in ways that minimize the costs of gentrification imposed on long-term neighborhood residents and promote the development of mixed-income communities.

TAX INCREMENT FINANCING

Tax Increment Financing (TIF) is a policy tool that can be used to stimulate gentrification and benefit the growth coalition. However, it does not have to be used solely to benefit the local elite and those who buy property in an area just beginning to gentrify. If community interests are integrated into the TIF plan, it can create long-term benefits for everyone. Unfortunately, in Chicago, TIFs have been used as means to gentrify neighborhoods and increase the

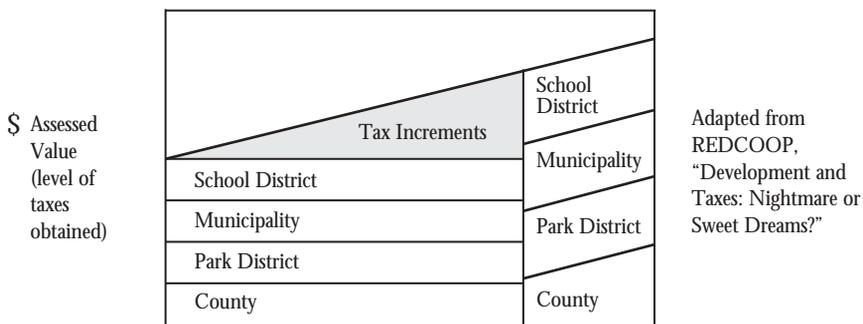
wealth of local elites. To see how this occurs, we must first examine what a TIF is and how it functions.

What is a TIF?

TIF is an economic development tool that is made available by state statute and is implemented by city government. The Chicago Department of Planning and Development listed 124 different TIF districts as of October 2002 (DPD Web site, 2002). The TIF statute has been on the books since 1977, though the number of TIFs being created has increased substantially in the past few years. Between 1998 and 2000 alone, the city designated 56 TIF districts (Neighborhood Capital Budget Group (NCBG), 2001).

A TIF is created for a specific geographic area. It allows the city to capture any new property tax from within the TIF district and reinvest it directly into that area for 23 years. When a TIF district is established, the level of taxes divided between all taxing districts in the area (e.g. school districts, park districts, the city, the county) is essentially capped at its current level. For 23 years, any additional tax, or increment, received above that amount goes into the TIF account and is to be used within the TIF district. After 23 years, property taxes are again divided between all the taxing districts. Graph 1 shows how the tax increment is captured. When the TIF district is created, in year one, the level of property taxes collected by the school district, municipality, park district and county are frozen at current levels. For 23 years, as property taxes increase, these taxing bodies continue to receive the same amount of money while additional tax revenue, or increment, is placed in the TIF account (the shaded portion of the graph) to be used for projects within the TIF district. After 23 years, the TIF account is no longer used and all property taxes, which have risen since year one, are again divided among all taxing districts.

GRAPH 1: HOW A TIF CAPTURES REVENUES



Illinois' TIF law "requires that municipalities only create TIF districts in areas that show significant signs of 'blight' and in which no significant private investment is occurring, or is likely to occur, without a TIF subsidy" (Statewide Housing Action Coalition (SHAC), 2002). To qualify as "blighted," an area must show signs of five out of 13 blight categories outlined in the TIF legislation. Some of these include: deterioration, inadequate utilities, building code violations, overcrowding structures, and vacant buildings (NCBG, 2001). Once this is established and the TIF is created, the idea is to spur investment to increase the value of the area, thereby increasing property taxes, and then to continue using the tax increment to sponsor development in the area. Therefore, a TIF is only successful if it is able to attract investment and raise property values in the area.

What can TIF funds be used for, and how is development created?

According to the Neighborhood Capital Budget Group (NCBG) (2001), TIF funds can be used for the following purposes: infrastructure and other public improvements (including schools, parks and other public buildings); planning expenses, such as studies and surveys, legal and consulting fees, accounting, and engineering; acquiring land and preparing it for redevelopment; job-training and day-care expenses for companies located within or planning to locate within the TIF district; renovation and rehabilitation of existing buildings; and financing and interest subsidies for the loans a developer takes out to pay for a project.

The municipality must create a redevelopment plan outlining the goals for redevelopment and the intended uses of the TIF funds in that district. As explained by the Statewide Housing Action Coalition (SHAC) (2002), "Once a TIF is established, the municipality will either borrow money through a bond issue or use general revenue funds to make initial improvements within the TIF area." These improvements should increase property values and generate an increment. This increment can then be used to pay off the initial development expenditures and to fund new projects in the district. NCBG (2002) outlines the three ways to increase property value: "(1) new buildings can be built on vacant land, (2) improvements can be made to existing buildings, or (3) existing buildings without improvements can be assessed at a higher level." The third way is possible when gentrification is occurring and the neighborhood has become more desirable. To allow municipalities to proceed with redevelopment plans, which sometimes require acquiring property in the area, the TIF statute allows the use of eminent domain.

TIF Districting Impact and Outcomes

TIF is an economic development tool that can be used to gentrify an area, thereby displacing low-income residents. Growth coalition members can initiate the consideration of an area as a TIF district to receive subsidies for development. SHAC (2002) explains that TIF districts can be as small as a couple of blocks or as large as an entire municipality, and that “smaller TIF districts are usually created at the initiative of a private developer, or a business that promises to locate in an area (or not to leave an area) if it receives a TIF subsidy.” Such TIFs greatly benefit the local elite and pose threats to low-income residents. But TIFs need not be used solely in this manner. With community participation, TIFs can be used to benefit the entire community. We will now consider some of the outcomes of TIF districting.

TIFs are only successful if property taxes increase, which can lead to displacement of low-income households. SHAC (2002) points out that rarely does low-income housing increase property values; therefore, “those concerned primarily about maximizing the tax revenues generated in a TIF are likely to oppose most low-income housing development.” TIFs have a tendency to promote gentrification by sponsoring development that is attractive to middle- and upper-income residents, resulting in property taxes and rents that force displacement of low-income residents. Further, the possibility of using eminent domain within the TIF district puts residents and businesses at risk of displacement.

However, TIFs are not entirely negative for long-term residents. The community can benefit greatly from TIF funds in a number of ways. First, property taxes generated from a specific community remain in that community and are used to improve that geographical area. If the TIF functions properly, it can increase the quality of life for residents and contribute to the creation of a mixed-income community. NCBG (1999) points to the use of TIF dollars for public works and basic infrastructure, job creation, employment training, career education and rehabilitation of existing homes and businesses as ways in which the community potentially can benefit. However, whether TIF funds are used for these purposes and whether local residents benefit from them depends on the types of projects ultimately supported.

The establishment of TIF districts impacts other taxing districts in the area, since the level of property taxes they receive is frozen for 23 years. In 1995, Chicago property tax dollars were divided in the following manner: 43 percent went to the schools, 21 percent to the city, 10 percent to Cook County, 7 percent to the park district, and the remainder to several other smaller taxing districts (SHAC, 2002). Advocates of TIF districts argue that

these districts would not be getting additional revenue had the TIF not been created, since development is only taking place in the area because of the TIF. However, this is only true if the TIF is created in an area that truly would not otherwise have received private investment. Unfortunately, as NCBG (2001) asserts, “the State law does not provide us with a good set of rules for determining whether or not development would take place without the TIF. This has opened the door to widespread abuse of TIFs in some areas.”

NCBG conducted a study of 36 TIF districts in Chicago to find out whether these TIFs were created in areas that would have achieved growth without the TIF, and whether the benefits of TIF justify the costs incurred. As the name of the study declares, NCBG (2002) set out to discover “Who Pays for the Only Game in Town?” What they found was that in the lifetime of these 36 TIFs, “The local taxing bodies that draw on Chicago’s property tax base will lose \$1.3 billion in tax revenues they would have probably collected if these areas had not been declared TIF districts.” The danger is that, as costs rise for other taxing bodies and the level at which they collect taxes is frozen, they will not collect enough revenue. Taxing bodies will be forced to increase their tax rates; in fact, “the Chicago Public Schools has raised its tax levy each year for the past five years” (NCBG, 2002). The TIF district itself creates part of the increased cost for Chicago Public Schools, for additional residential development in the area brings in additional demand for school services.

The fact that the Illinois TIF law does not specifically define how to determine whether development would take place in an area without the TIF is only one way in which the law is vague. Even the requirements for determining “blight” before the creation of a TIF district are not clearly defined and leave room for interpretation. One of Chicago’s most controversial TIF districts is the Central Loop TIF, encompassing much of the downtown Loop area, created in 1997 as an expansion of the 1984 North Loop TIF. As SHAC (2002) points out, at the time of its proposal, “many people questioned whether it was credible to claim that no private investment in the area could ‘reasonably be anticipated’ without the creation of the TIF district.” SHAC also notes that there had been recent investment in retail in the area (e.g. the State Street shopping district), a low office vacancy rate, and rehabilitation and conversion of older buildings. This is all hardly what one typically thinks of when hearing that an area is “blighted.” But since the TIF law allows for subjectivity in determining “blight” and whether investment is likely to occur, the city was able to TIF most of its downtown area. Additionally, the statute allows TIF funds to be transferred between bordering TIFs but does not specify for what purposes. This allows for money generated in one district to

be taken away from that community and given to another.

TIF legislation also leaves room for variation in the amount of community participation allowed throughout the TIF process. Prior to 1999, when SHAC successfully lobbied for changes to the TIF law in the area of community participation, municipalities were able to enact TIF districts without much attention. Now, particularly in districts that include 75 or more units of occupied housing, “The municipality must convene an early public meeting, mail notice of that meeting and main public hearing to every residential address in the district, and it must create an interested parties registry for all individuals and organizations in the municipality who want notice of activities in the TIF” (SHAC, 2002).

However, TIF legislation still does not stand strong on the issue of community participation. It allows for the creation of Community Advisory Panels to oversee the use of funds in a TIF district, but the law does not required such panels. Therefore, TIFs in Chicago are often implemented with no community input, other than the public notice and hearing. In fact, in all of the 124 TIF districts in Chicago, not one has an officially recognized community oversight or advisory committee.

In Chicago, there are communities seeking to have more input into TIF fund usage to ensure that the needs of existing residents are met. The residents impacted by the Wilson Yards TIF organized and even gained the support of their alderman. Although the Organization of the North East (ONE) has hailed the Wilson Yards redevelopment plan as “the most democratized TIF process yet in Chicago” with goals and objectives that are “really representative of how the community wants these dollars spent,” the city refuses to grant formal recognition to a community oversight panel (Community Media Workshop, 2001).

These residents and others in Chicago communities affected by TIF districting are coming together to try to ensure that TIFs are used in ways that lessen the displacement that TIF-induced gentrification can cause. Some uses that would reduce negative TIF impact include: using funds for affordable housing, ensuring that TIF funds go to diversified commercial projects, and only subsidizing businesses that will provide jobs for local residents at a living wage. NCBG (1999) emphasized the job component, saying, “New and better jobs are a key element in ensuring that TIFs do not displace existing residents.” If there is access to good jobs, then the increase in the cost of living caused by TIF may be more bearable.

TIFs can be a tool for the promotion of equitable development if the city also designs policies to lessen the impact of increased property values on resi-

dents at risk of displacement. Such policies could include tax breaks for long-term and low-income residents, incentives not to convert apartments into condominiums, and rent control. But this is difficult to achieve without consistent community participation, for these types of policies would be strongly opposed by the local elites who comprise the growth coalition.

CONCLUSION

In Chicago, TIFs are a tool implemented with little community input. Logon and Molotch's (1996) theory of the city as a growth machine helps us understand how urban development and growth is used to benefit local, place-based elites. In the case of gentrification and TIFs, this translates into not only benefit for the local elites, but potentially negative neighborhood changes for current residents. Though the use of TIFs and the inducement of gentrification can be detrimental to low-income communities by displacing residents and changing the character of neighborhoods, with safeguards in place and community participation, they actually can be beneficial. As noted, de-concentration of poverty, neighborhood improvements, decreased crime, increased social capital and job opportunities are all potential benefits of TIF districting and the creation of mixed-income communities. Displacement of low-income residents from one disinvested neighborhood into another perpetuates the concentration of poverty in cities and results in higher costs for municipalities and social-service agencies.

The key is to ensure that low-income residents are not displaced by the policies intended to improve their communities, for if they are, the communities are no longer theirs to enjoy. The only way to achieve successful mixed-income communities is to implement policies that take into account the interests of community residents and not just those of the local elites who control the growth coalition. This can be accomplished only through consistent community participation and input to challenge the domination of growth coalition interests.

Policies and strategies of urban development continuously must seek community input. This can be gathered through oversight committees, surveys or frequent town hall-style meetings with city officials and aldermen. Eliciting community participation potentially will lead to greater community support and, hence, more effective implementation of development initiatives. If cities pursued this kind of development, the immediate financial benefits of the local elites would not be as great, yet in the long-run they would create healthier and more sustainable communities. ■

REFERENCES

- City of Chicago, Department of Planning and Development, TIF Program Information.
Downloaded in October 2002 from <http://www.cityofchicago.org/PlanAndDevelop/Programs/TaxIncrementFinancing.html>
- Community Media Workshop. (2001). Community groups seek to shape TIFs. In *Newstips*, edited by Curtis Black. February 27, 2001. Downloaded from <http://www.newstips.org/2-27-01.htm>
- Kennedy, M. and Leonard, P. (2001). *Dealing with neighborhood change: A primer on gentrification and policy choices*. A discussion paper prepared for the Brookings Institution Center on Urban and Metropolitan Policy and PolicyLink.
- Logan, J.R. and Molotch, H.L. (1996). The city as a growth machine. In Fainstein, S. and Campbell, S. (eds.). *Readings in urban theory*. Oxford: Blackwell Publishers.
- Merriam-Webster Dictionary on-line: <http://www.m-w.com>
- Neighborhood Capital Budget Group. (2002). Nolan, P. lead author. *Who pays for the only game in town? A tax increment financing impact study*.
- Neighborhood Capital Budget Group. (2001). *NCBG's TIF handbook, second edition*.
- Neighborhood Capital Budget Group. (1999). Chris Schwartz, principal author. NCBG's TIF encyclopedia: The first comprehensive report on the state of tax increment financing in Chicago.
- Responsible Economic Development Citizens of Oak Park (REDCOOP). May 15, 2002 presentation. *Development and taxes: Nightmare or sweet dreams?*
- Statewide Housing Action Coalition. (2002). Jolin, M. and Meima, J. lead authors. *Tax increment financing: An organizer's guide*.
<http://www.cityofchicago.org/PlanAndDevelop/Programs/TIF/TIFMainMap.html>

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INCARCERATION AND COMMUNITIES: THE EFFECTS OF MASS INCARCERATION ON COMMUNITY DEVELOPMENT

by Melissa Lang

This paper attempts to describe the development of cities from the growth machine perspective. The paper explores the growth machine theory and how it offers an explanation for the involvement of mass incarceration within the urban growth machine as well as incarceration's inhibiting effect on specific community development, especially in cities such as Chicago. The paper recommends areas for future research and future policy planning to attempt to counter these effects.

Researchers such as Tonry and Petersilia have made compelling arguments that prisons are a microcosm of society: through studying them, we will learn about ourselves (Tonry and Petersilia: 1999). The impact of massive incarceration on communities historically has been overlooked in discussions of community development. It is important to consider the percentage of a given community involved with the criminal justice system when examining and understanding the political economy of the city and urban development. A number of different theories attempt to explain the economic and political development of cities; the growth machine theory is a particularly useful way to conceptualize urban change and community development. To view cities as growth machines and understand development from this perspective demonstrates how powerful stakeholders create and implement policies that benefit the elite at the cost of the lower class. Minorities are overrepresented in the criminal justice system and underrepresented as members of the growth machine. Powerful political stakeholders with little invested in these communities have endorsed policies that have had particularly tragic impacts upon the African-American population. The criminal justice system has become a manifestation of the growth machine in action, especially in the city of Chicago.

Logon and Molotch's portrayal of the growth machine theory starts with a question: who governs and for what? The theory asserts that powerful stakeholders develop and maintain policies that exclude a specific population. The result is the marginalization and oppression of these groups both economically and socially. These stakeholders seem to have little interest in seeing current policy change because they reap benefits from maintaining the status quo. The snowball effect of the criminal justice system has gone ignored because its negative impacts affect communities that are not considered a part of the growth machine. Members of these communities are not stakeholders in the growth machine; they are not economically powerful and are therefore politically weak.

Specific policies have influenced low-income and minority representation in the criminal justice system. Current drug control and crime policies unfairly target specific areas of major cities, perpetuating underdevelopment and inequality. These policies contribute to the marginalization of an already discriminated-against group. Particularly in Chicago, the overrepresentation of members of primarily black communities in the criminal justice system contributes to these communities' lack of power. Michael Tonry comments on the strong link between crime, race and economic status in the United States: "For as long as crime statistics have been compiled, crime and poverty have marched together" (Tonry: 128).

The nature of the criminal justice system is not preventative, which is evident in policy proposals targeting those individuals who are being released from the criminal justice system. The current policy around criminal justice places less attention on the antecedents to and prevention of crime. The majority of research in this area focuses on the effect of being involved in the system and issues of prisoner reentry into the community. The fracturing of communities as a result of mass incarceration inhibits community organization, ultimately impeding community development. Few prevention efforts are aimed at preempting criminal justice involvement.

Actual change and improvements in these communities requires that policy action be taken before individuals enter the criminal justice system. Laws that affect initial engagement in the system need to be evaluated instead of merely funneling money into increased policing and greater incarceration. Policymakers need to gain an appreciation of the socioeconomic factors associated with criminal behavior, and they must make efforts to change the power structure of the city to allow groups to reap the benefits of community development.

INCARCERATION AND COMMUNITIES

Since the 1980s, the United States has seen a significantly dramatic increase in its prison and jail populations. Beyond analyzing the rise in incarceration rates, much stands to be learned from looking at which individuals are represented in this growing population. Low-income minorities, in particular African-American males, are disproportionately represented at every level in the criminal justice system. The relationship to race, class and criminality is difficult to deny. In the United States, individuals of color are more likely to be in poverty and more likely to be incarcerated. Davis (2002) reports "53% of people warehoused in our nation's prisons earned less than \$10,000 a year prior to incarceration. Although the minority population is approximately 13%, 66% of the nation's prison population is people of color."

As of June 2002 in Illinois, 6 out of 10 of the adult Department of Corrections population was black, as well as approximately 6 out of 10 of the juvenile corrections population. In June 2001, approximately 7 out of 10 arrested males in Cook County were black (Bureau of Justice Statistics 2002). According to the Sentencing Project, recent figures show that an estimated 1 in 10 African-American males in the age group 25-29 is in state or federal prison, compared to just over 1 percent of white males. If black male inmates in local jails are added to this count, the proportion rises to nearly one in seven (Sentencing Project: 2001).

Not only are minorities overrepresented, but minorities from specific geographic communities. These trends are particularly obvious in cities like Chicago. There are six communities that the majority of offenders return to in the Chicagoland area: Humboldt Park, Englewood, Oakwood, North Lawndale, Austin and Auburn-Gresham. In the North Lawndale Community, 70 percent of males 18 to 45 years of age have a criminal record (Street et al., 2002). "Criminogenic forces are strongest in inner-city areas of concentrated poverty, where incomes are low and families unstable, and unemployment and welfare dependence are high. Blacks are far more likely than whites to live in such neighborhoods" (Tonry: 128). These same neighborhoods that have high numbers of their community members involved at some point with the criminal justice system are some of Chicago's most impoverished areas.

The ramifications of involvement with the criminal justice system are far-reaching, impacting the individual, family, and community. Following jail or prison experiences ex-offenders will struggle in obtaining employment, housing and education in addition to addressing psychosocial needs and family restructuring. Sizable economic and smaller ethnographic literatures convincingly

show that imprisonment reduces ex-offenders' subsequent incomes and employment (Fagan and Freeman: 1999, Tonry and Petersilia: 1999). Some literature suggests that the effect of involvement in the system is a portion of what contributes to recidivism rates. "According to findings of criminal careers research (Blumstein et al. 1986), the negative effects on ex-prisoners' incomes, employment prospects, and family involvement predict increased offending probabilities" (Tonry and Petersilia: 1999). It is hard to deny that being on probation or parole and having a criminal record has potentially severe consequences for an individual's quality of life. The goal of probation and parole is to limit recidivism¹ rates of offenders, but the success of these methods is threatened due to the circumstances prisoners encounter when reentering communities. The difficulties involved in reintegrating into society can be harsh when reintegration is happening in an underdeveloped and impoverished community with few to no resources.

THE GROWTH MACHINE

One way to conceptualize the structure of the criminal justice system is to view policy formation and implementation within the context of the city as a growth machine. Viewing the city as a growth machine involves understanding the role of different players and powerful stakeholders. According to Logon and Molotch (1996), "For those who count, the city is a growth machine, one that can increase aggregate rents and trap related wealth for those in the right position to benefit." The growth machine theory is based on the premise that cities have physical space or land value. The value of the city is placed on its capacity for the use and exchange value of this land or space.

The growth machine perspective assumes a city is made up of "elites" who work and live in the city and "others" who do not count because they do not contribute to the development process. According to Logon and Molotch (1996) these private and public actors, "the elites," are part of the growth machine. These actors have the strongest exchange value interest in the city because they have the most invested in the city. These actors include: property owners, real estate developers, construction, public sector actors-government at the local level and federal-media and universities. These groups act to control the political agenda. One argument is that cities are shaped by competition between cities. The growth machine theory, on the other hand, suggests development of the city is not shaped as much by competition between cities but by growth machine members' attempts to maximize the value of land and maximize benefits to growth machine members. Logon and Molotch (1996) stress

that “the activism of entrepreneurs is, and always has been, a critical force in shaping the urban system, including the rise and fall of given places.”

Another factor supporting the growth machine theory is the issue of prison privatization. The privatization of prisons has changed the face of incarceration. In 2002, the Illinois Department of Corrections had a budget of \$1,303,219,800. What was once considered a public need may now be considered a commodity. With a more than \$1 billion budget for one state’s department of corrections, it is clear that incarceration has value. It is valuable for a city to use its space for corrections purposes. In fact, it is possible to buy stock in prison companies in America. As Tonry and Petersilia (1999) report, “Prisons are now often managed by private corporations that operate hundreds of institutions and provide comprehensive services, such as medical-care systems ... communities now compete for new prison construction as a local economic development initiative.” The mental-health facility of the Cook County Jail, for example, is actually the largest mental health facility in the state. The services provided within the jails are becoming privatized at an increasing rate.

The powerful stakeholders in a city who influence and implement the policies that determine who is caught up in the criminal justice system have little concern for mass incarceration’s effect on specific communities. The people interested in these numbers are the people that are negatively impacted, the people that make up the communities that see a majority of their male members ensnared in a nebulous system. Elite stakeholders have no desire to see a change because they have nothing to gain from change and everything to gain from the system staying as it is. Logon and Molotch (1996) refer to the elites’ influence upon development, saying, “This competition, in addition to its critical influence on what goes on *within* cities, also influences the distribution of populations throughout cities and regions, determining which ones grow and which do not.”

Crime also has been used by elites as a political tool. Logon and Molotch explain this action as “symbolic” politics that depends upon media involvement. Misrepresentations of crime and the necessary modes of dealing with crime in the media sway public sentiment and lead to reactionary policies that can have long-lasting effects. Politicians often include “getting tough on crime” in their campaigns not because of a tangible need to do so but because it plays upon public fear and drums up support for candidates. Crime rates and incarceration rates rarely have been significantly correlated in the United States. This “symbiotic ‘dance,’” as Molotch calls it, allows politicians to avoid issues that may offend growth machine interests, and the result “often misleads public about the real stuff of community cleavage and political process. ... [T]o

the degree that rentier elites keep growth issues on a symbolic level, they prevail as the 'second face of power' the face that determines the public agenda" (L&M: 302). Crime in particular is an issue that has been sensationalized and manipulated through media.

Additionally, the power of elite stakeholders and the overlap of public and private interest are evidenced on a federal level. The two major private corrections companies are major contributors to the American Legislative Exchange Council (ALEC), a Washington-based public policy organization. "ALEC's members include over 40 percent of all state legislators. ... One of ALEC's primary functions is the development of model legislation such as privatization. Under their Criminal Justice Task Force, ALEC has developed and helped to successfully implement in many states 'tough-on-crime' initiatives including 'Truth in Sentencing' and 'Three Strikes' laws" (Sentencing Project: 2001). It appears these parties have a vested economic interest in seeing the population remain high in the criminal justice system. There is a direct connection between the legislation related to incarceration and private investment.

Criticism of the city as a growth machine has pointed to the ways in which this form of development benefits the elite group without having significant positive effects upon the "others." Logon and Molotch (1996) claim that "under current jurisdictional and ecological patterns, growth tends to intensify the separation and disparities among social groups and communities" (L&M: 325). This is evident in the situation of communities in the Chicagoland area. As the country experienced an economic boom in the 1990s, there was a simultaneous boom in the incarcerated population. Certain communities benefited tremendously from the successful economy while others experienced little if any development and fared worse. The effects of the criminal justice system compound the separation among social groups. A cycle is established whereby individuals involved in criminal activity are returned to their struggling communities with fewer resources than they had previously and yet face societal expectations to succeed.

ONGOING POLICY AND INITIATIVES

A number of policies laid the groundwork for the current state of the criminal justice system. In 1984 President Ronald Reagan signed the Comprehensive Crime Control Bill into law. Within this bill the Sentencing Reform Act of 1984 created the United States Sentencing Commission. The responsibility of this commission was to create sentencing guidelines to which every federal judge was held in order to ensure all defendants would be treated alike. In addition, mandatory sentencing statutes were included in the Omnibus Drug

Control Act of 1986. This mandated form of sentencing resulted in disproportionate incarceration of those committing crimes involving narcotics and immigration offenses (Kaufman: 1999). These legislative actions were major forces that led to the increase in rates of incarceration and criminal justice system involvement.

The result of these policies has been remarkable. The United States is now the operator of the largest prison system on the planet (Currie: 1998). The Federal Bureau of Prisons budget has increased by 1,400 percent between 1983 and 1997 (BJS: 1997). The impact upon low-income, minority communities must be noted; while African-Americans constitute 15 percent of the drug-using population, they represent nearly 40 percent of those arrested for drug violations and 55 percent of those convicted (Barry: 1997). The number of low-income minorities in the system grew exponentially while the amount of money spent in the system tremendously increased.

Once the groundwork was laid, the country experienced remarkable growth of the incarcerated population throughout the 1980s and '90s. Policymakers paid attention to crime control policies as additional proposals attempted to deal with a perceived increase in criminal behavior. Specific pockets or communities were associated with high levels of crime, gang and drug involvement. The approach for dealing with this issue was to target these areas with increased surveillance and community policing.

Community policing is considered the modern approach to reduce crime in neighborhoods and has become the prevailing force behind crime reduction efforts throughout the United States. Local and federal governments have been endorsing this approach, specifically through the passage of The Violent Crime Control and Law Enforcement Act in September 1994. This act approved \$8.8 billion for local law enforcement agencies "in the fight against crime through the enhancement of community policing capabilities" (COPS: 2002). At this time the Office of Community Oriented Policing Services (the COPS Office) was created. Over the past eight years, the COPS Office has contributed funding to law enforcement agencies allowing them to hire over 110,000 community police officers, purchase crime-fighting technology and support innovations in policing (COPS: 2002). While the prison population was on the rise and the rate of incarceration was multiplying, more funding was put toward increasing the amount of policing.

In 1998 Chicago was officially recognized as a Federal Weed and Seed site. According to its mission, "Operation Weed and Seed is foremost a

strategy—rather than a grant program—which aims to prevent, control, and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhoods across the country” (Executive Office Weed and Seed: 2001). Apparently the strategy involves a two-pronged approach: law enforcement agencies and prosecutors cooperate in “weeding out” criminals who participate in violent crime and drug abuse, attempting to prevent their return to the targeted area. It seems the weeding does not involve rehabilitation efforts; its purpose is to remove negative behavior from the areas. The “seeding” brings human services to the area, encompassing prevention, intervention, treatment and neighborhood revitalization. The weeding involves a community-oriented policing approach. When the contrast between weeding and seeding is broken down financially, the approaches seem less equally split. The “weeding” or law enforcement approach was appropriated \$162.7 million dollars for Illinois in 2001. The “seeding” approach, addressing community “revitalization,” was appropriated \$3.2 million dollars for Illinois in 2001 (COPS: 2001). While the program claims to have the interest of communities in mind, it ultimately fails its mission to revitalize neighborhoods. Obviously the revitalization programming is not a priority; the weeding approach, which contributes to the disempowerment and breakdown of communities, receives a tremendously larger amount of funds. This fiscal disparity between policing versus development programming is a terrific example of the lack of investment in these communities.

The remarkable rise in the prison population at the turn of the century is now producing a dramatic increase in the numbers of offenders returning to communities. According to the Bureau of Justice Statistics, 6.5 million Americans are now incarcerated or on probation or parole, an increase of more than 240 percent since 1980 (Bureau of Justice Statistics, 2001). Funding for rehabilitation programs is targeted to the behavior change of the individual and fails to address community needs. For example in October 2002, the Department of Health and Human Services Secretary Tommy Thompson awarded grants totaling \$33.9 million to provide substance-abuse treatment along with HIV/AIDS services in African American, Latino-Hispanic, and other racial or ethnic communities affected by both substance abuse and HIV/AIDS (SAMHSA: 2002). While these funds are useful, they are targeted toward individuals already involved in the system and demonstrate a lack of funding aimed toward prevention and community development.

Numerous studies have shown that in-prison programs help reduce recidivism among reentering prisoners, but there continues to be a shortage of vocational, educational, and substance-abuse programs in prisons (Bureau of

Justice Statistics 2001). In 1996, 6 percent of state prison spending was allocated to support rehabilitative prison programs—vocational, educational, treatment—and 94 percent was spent on staffing, building prisons, and maintaining and housing prisoners (BJS 2001). Of the reentering prisoners with substance abuse problems, only 18 percent received treatment while incarcerated (BJS 2001). While studies show that community supervision combined with some form of rehabilitative program following a prisoner’s release helps reduce recidivism, more than 100,000 prisoners are still released each year without any form of community correctional supervision (BJS 2001).

The greatest response to crime and poverty in Chicago’s communities has been an increase in funding toward policing. Hundreds of thousands of dollars have been put into the Office of Justice Programs & Office of Community Oriented Policing Services Grants for Chicago. More than \$11 million was given to the city of Chicago COPS-AHEAD program, with more than \$1 million put into the Local Law Enforcement Block Grants Program. It has been demonstrated that building more prisons does not reduce criminal activity, yet the majority of funding is directed toward programs that attempt to control criminal behavior without addressing the antecedents associated with it.

ANALYSIS OF POLICY

The legislative changes that came about to target crime included sentencing mandates, in an attempt to bring uniformity to the system and eliminate possible discrimination. At the same time crime and drug control policies introduced harsher sentencing and stricter sentencing guidelines, leaving less discretion for judges for individual cases. According to an analysis of federal sentencing guidelines, “Mandatory minimum sentencing has forced us to build many new prisons to house low-level and non-violent offenders for long periods of time” (Kaufman: 1999). Mandatory sentencing guidelines have failed in their initial claimed attempt to reduce discriminatory patterns. These sentencing mandates have been successful only in reducing discretion by judges, thereby incarcerating greater numbers of low-level offenders. This has led to the increased incarceration of minorities overrepresented in this population.

Sentencing guidelines and crime-control policies have been created, supported and enforced by elite members who rarely experience the consequences of their establishment. The elites are the interested parties in establishing severe crime laws and increasing spending on corrections, but they rarely are the individuals involved or impacted by these policies. Anti-drug laws clearly

have resulted in staggering increases in the imprisonment of members of inner-city communities. Yet policymakers and stakeholders seem to ignore the association between low-income underdeveloped areas and crime.

Law enforcement strategies contribute to the marginalization of already disadvantaged areas instead of focusing efforts on community development. The result is that impoverished areas continue to struggle, with dwindling resources. For the majority of individuals released from prison, the mandatory condition of probation or parole is that they return to the community from which they were arrested to be monitored for a specified length of time. Recidivism rates remain high and are correlated to rates of homelessness. According to the U.S. Department of Justice, 62 percent of those released from state prisons will be re-arrested within three years and 40 percent will be re-incarcerated, many for technical violations of parole (Davis: 2002). Once involved with the system, it is extremely difficult to reintegrate into the community.

Increased levels of law enforcement through community policing in neighborhoods experiencing high crime rates is the main response to communities struggling with a host of problems. Instead of putting funds toward community development, millions of dollars are put into increased security through policing. This may seem initially imperative, but fails to meet the intended goal of establishing safer communities and lowering crime rates. Unfortunately this approach seems narrow and shortsighted as it ignores the greater system in which these neighborhoods function. By increasing community-policing efforts, populations in jail and prison are increasing, the reintegrated population is increasing, and communities are left undeveloped. One researcher found that concentrated neighborhood-based law enforcement strategies (like New York's Tactical Narcotics Teams) have turned Rikers Island, a New York City jail, "into a neighborhood block party" (Moore: 1999). Increased police involvement has left communities like Woodlawn with 70 percent of their male population having been involved in the criminal justice system. Members of communities most in need of development continue to suffer at the hand of policies that focus on reactionary punishment instead of prevention.

Current initiatives perpetuate the stifling effects of an already flawed system, holding individuals and communities responsible without recognizing the greater contributing systemic factors. Policymakers must not just punish the crime but also understand why the crime is present. In areas with few resources, criminal involvement is often a form of economic as well as social survival. While minimal funding has been targeted toward improving community resources and increasing treatment, policy proposals have fallen short of

responding to the needs of communities with high rates of crime and substance abuse.

The loss of power of individuals involved in the criminal justice system is one of the most serious and least addressed impacts of incarceration. The involvement in the criminal justice system contributes to the lack of power of individuals as well as their communities. Power of the individual is inhibited both directly by the system and indirectly. Policy literature shows that various state and federal laws deny ex-offenders in some places the right to vote or hold office, the opportunity to engage in certain occupations, and the right to receive various public benefits and services (Fellner and Mauer 1998). Losing the right to vote is a direct consequence for some, while impaired ability to obtain employment, housing or supportive family services are effects for others.

Assuming the city is a growth machine, powerful stakeholders determine policies that enable them to experience the benefit of urban development. Communities with a significant amount of their members involved in some level with the criminal justice system are considered powerless. They will neither contribute to policies that will affect them nor will they benefit from the experience or influence of urban development. With a hindered ability to be politically involved it is nearly impossible for these communities to be politically powerful. "A steady flow of political demagoguery stigmatizes the poorest of African-Americans and Latinos, groups with little capacity for political influence" (Moore: 1999).

CONCLUSION AND FUTURE STRATEGIES

One way to attempt to explain urban development is to view the city as a growth machine. The growth machine paradigm suggests the value of the city lies in the ability to use land and its exchange potential. Urban development and consistent growth is obviously beneficial to interested stakeholders. These stakeholders encourage development in order to reap the benefits. An unfortunate dichotomy results separating those influential stakeholders from "others" who are merely impacted by and work within the growth machine. The growth machine theory articulates the power dynamic within a city between groups as it explains why development is pursued.

Historically in the United States there has been a connection between crime and poverty. This "other" group thus has been entrenched in the criminal justice system. Stakeholders have taken advantage of this connection for their benefit. Through the maintenance and development of an oppressive criminal justice system, elites have benefited financially. Additionally, the

system enables stakeholders to maintain power and secure their position as powerful elites in society. The lack of development of certain communities in the urban setting is intertwined with the members of these communities involvement with the criminal justice system. Stakeholders do not need to reap the benefits of the development of these areas because they reap the benefits of the developing criminal justice system.

Obviously, continued evaluation of the criminal justice system is essential, as individuals reentering the community are on the rise. "Tens of millions of people are directly affected by prisons. Any social institution affecting so many people should receive much more attention from scholars than prisons now do" (Tonry and Petersilia 1999). Many underdeveloped communities experience high rates of incarceration. These communities are often targets of community policing plans and reintegration strategies for offenders.

Current drug control and crime policies have helped to maintain the underdevelopment of certain areas of the city and perpetuate inequality. Minorities are overrepresented in the criminal justice system and underrepresented as members of the growth machine. Powerful political stakeholders have endorsed policies that have had tragic impacts upon the African-American population. These stakeholders have little invested in these communities and thus make no effort toward changing policies that have created the current system. Instead funds are put into increasing law enforcement because this seems like an immediate solution. Probation and parole programs attempt to deal with the number of individuals returning to communities. Reintegration programs are ineffective because they place all responsibility on the individual and the community to which the individual is returning. Change needs to focus on the communities as a whole by targeting schools, increasing job opportunities and providing housing.

It is difficult to separate sustainable community development from reducing criminal involvement. A more comprehensive analysis is needed to understand the interaction between crime and poverty. The criminal justice system can be considered a microcosm of the social ills and inequality within a nation, state or city. Emphasis also needs to be placed on understanding communities within the context of the city as a developing entity. Viewing cities as a growth machine means understanding the different parts necessary for functioning. Communities cannot develop independently. Reform of the criminal justice system can be realized from a growth perspective if change occurs on the systemic level as well as the community level. ■

FOOTNOTE

¹Recidivism refers to the tendency for ex-offenders to reoffend and reenter the criminal justice system. A large amount of research supports therapeutic programs and alternatives to incarceration that have lowered rates of recidivism, especially with drug-related crimes.

REFERENCES

- Bureau of Justice Statistics (1997). BJS Sourcebook, 20. Washington, D.C.: U.S. Government Printing Office.
- Cheung, Amy (2001). Sentencing Project Briefing and Fact Sheet: Prison Privatization and the Use of Incarceration. <http://www.sentencingproject.org>
- Congressman Danny K. Davis (2002). Executive Summary: Public Safety Ex-Offender Self-Sufficiency Act.
- COPS (2002) Office of Community Oriented Policing Services, U.S. Department of Justice. <http://www.cops.usdoj.gov/>
- Currie, E. (1998). Crime and Punishment in America. Holt Metropolitan Publishers.
- Executive Office for Weed and Seed, Illinois (2001) <http://www.weedandseeddatacenter.org/illinois.html>
- FY 2001 Awards to Illinois. <http://www.ojp.usdoj.gov/fy2001grants/map/ilstate.htm>
- Kaufman, Shari, L. (1999) The Federal Sentencing Guidelines: A formulaic and impersonal approach to dispensing justice. *The Nevada Lawyer*.
- Logan, John R.; Molotch, Harvey L. (1996) The city as a growth machine. Mass.: Blackwell Publishers Inc.
- McCaffrey, Barry (1997). Letter to Congressional Black Caucus, June 26. Sourcebook of Criminal Justice Statistics (1995).
- Moore, Joan. (1999). Bearing the Burden: How Incarceration Weakens Inner-city Communities. National Institute of Justice <http://www.ojp.usdoj.gov/nij>
- Sentencing Project Briefing and Fact Sheet: NEW PRISON POPULATION FIGURES: CRISIS AND OPPORTUNITY (2001). <http://www.sentencingproject.org/news/bjsreport-july2002.pdf>
- Street et al., (2002). The cost of mass incarceration and ex-offenders' struggle for employment in Chicago and Illinois: A fall conference.
- Tonry, Michael. (1995). *Malign Neglect: Race, crime and punishment in America*. New York: Oxford University Press.
- Tonry and Petersilia (1999). Prisons Research at the Beginning of the 21st Century. National Institute of Justice <http://www.ojp.usdoj.gov/nij/>

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BALANCING WORK AND FAMILY RESPONSIBILITIES: DESIGNING POLICY ALTERNATIVES

by *Sabrina Townsend*

Families of all shapes and sizes are struggling to meet work and caregiving responsibilities. While all parents have the option under law to take unpaid leave from work to meet caregiving demands, the lack of pay presents a significant barrier to most low- and middle-income families. This article begins by defining the problem faced by working families, particularly parents of newborn children, and then proposes three policy alternatives for the provision of financial assistance to help families balance their work and family responsibilities. The article concludes with an evaluation of the proposed policy alternatives and makes a final recommendation as to how the federal government could best meet the needs of working families.

DEFINITION OF THE PROBLEM

The current administration has placed considerable emphasis on the promotion of marriage and family within the United States, and yet families of all types and sizes continue to struggle with difficult day-to-day decisions. Those fortunate enough to be working during these tough economic times may be forced to choose between going to work and staying home to care for a newborn, sick child or dependent family member. This decision could result in substantial lost income, which is a path the majority of U.S. citizens opt not to take (Commission on Family and Medical Leave (CFML), 1996). In today's society, the demands and responsibilities of work are too often directly at odds with those of the family across all age groups.

Changes in gender roles, family structure and stagnant job design are all in part responsible for the current imbalance. Women began entering the workforce in droves during the World War II era, thus permanently altering their role within the world of work. The number of women in the workforce increased from 31.5 million in 1970 to 57 million in 1991. Today, half of the total labor force lives in dual-earner households (CFML, 1996). Throughout

the past 30 years, the United States has witnessed a dramatic increase in the number of single-parent, female-headed households. New pressures and responsibilities have been placed on the family as a direct result of these changes. Although the workforce has become somewhat “feminized” (Kelly & Dobbin, 1999), employers refuse to let go of the “male model” job structure, defined as a job formerly held exclusively by men designed with the assumption that workers can devote long hours to work without interference of personal responsibilities (Lambert, 1993). A disconnect has been created between employer expectations and the demands faced by the emerging female work force and families in general.

Both single parents and those living in dual-earner, dual-caregiver households face numerous challenges when it comes to meeting the competing demands of work and caregiving (Gornick & Meyers, 2001). Many single parents are in dire need of financial assistance and peer support, particularly following childbirth. In the '90s, more than 45 percent of single mothers were poor (measured as family income below 50 percent of U.S. median income) versus only 13 percent in France and 5 percent in Sweden, where more generous family supports are in place (Christopher, 2002). As maternal employment continues to increase, the need for paternal caregiving becomes more evident. In 1998, fathers spent 45 percent of the time their wives spent on caregiving (Gornick & Meyers, 2001). Perhaps more men would opt to take leave from work if the rates of pay across genders were more equitable. However, given that it is more profitable for men to remain attached to the workforce, women are the predominant leave takers and the predominant caregivers (CFML, 1996). Thus, the cycle of lost human capital and career advancement for women is perpetuated (Gornick & Meyers, 2001).

Although it would be ideal to take a comprehensive lifespan approach in addressing this social condition, the focus of this paper will be on achieving balance between work and caregiving responsibilities for a newborn child. By supporting mothers and fathers in balancing these dual demands, policymakers would have an opportunity to yield positive developmental outcomes for young children and economic benefits for all of society. “One of the greatest risks to the healthy development of young children may be the risk of the loss or disruption of important caregiving relationships” (Fenichel, 2002, p. 49). This relationship is key to the healthy development of children and begins the moment a child is born. Research shows that while child care in general does not have adverse effects on child development, the lack of quality infant care is more likely to have a negative impact on developmental outcomes (Children’s Defense Fund, 2001; National Child Care Information Center, 2002). Urie

Bronfenbrenner argues that in order to promote a child's intellectual, emotional and social development, child-caregiver interactions must continue long enough to become increasingly complex (Fenichel, 2002). Therefore, it is in the best developmental interest of the child that parents should be able to spend extended periods of time providing care, particularly in the first few months of life, to ensure positive attachment, or the development of trust between an infant and caregivers.

The potential economic benefits to society are another powerful argument for why this social condition should be addressed. In his 2001 paper, *Fostering Human Capital*, James J. Heckman, winner of the Nobel Prize in economics in 2000, provides evidence of the rate-of-return on investments made in the earliest years of a child's life. Heckman stresses that it makes economic sense to invest in the very young when trying to prevent the long-term consequences of poverty and costs to society. By investing in the caregiving relationship crucial to infant development, policymakers would, in effect, be investing in the long-term life success of all children.

All types of families are facing work-caregiving conflicts, including men and women; young, middle-aged, and older caregivers; whites, African Americans, Latinos and Asians; and married and single caregivers (Heymann, 2000). This social problem is practically universal in scope, except for the disproportionate amount of financial and social resources available to higher-income families that buffers them from potential negatives effects. Middle-income and, especially, lower-income families have a much smaller chance of successfully meeting dual work and caregiving responsibilities (Heymann, 2000). To mediate this social condition, policymakers should aim to achieve the following goals:

- Provide financial assistance to biological and adoptive parents of newborn children that enables them to take leave from work.
- Provide equal incentives and opportunities to mothers and fathers to care for newborn children.

POLICY ALTERNATIVES

Several policy alternatives may be utilized in an effort to resolve this social condition. The three policy tools described in this paper include the expansion of the Family and Medical Leave Act, Parental Leave Assistance (cash grants), and Temporary Caregiver Insurance. The proposed policy alternatives are to be enacted at the federal level to create a national minimum standard rather than a patchwork of uneven, local responses to the needs of families.

Expansion of the Family and Medical Leave Act

One way to address this glaring social problem would be to expand current legislation so that employers are required to provide 12 weeks of paid parental leave to parents of newborns. This approach provides additional legal protections to working parents of newborn children by imposing further rules upon businesses. It is a highly centralized approach that relies on indirect means for the delivery of intended benefits.

Erin Kelly and Frank Dobbin (1999) provide a concise summary of the ways in which the federal government has responded to the changing needs of society and the family over the past 40 years. In 1964 Congress passed the Civil Rights Act, which outlawed discrimination in many areas, including gender. Then, in 1972, the definition of discrimination was expanded to include pregnancy. This expanded definition was quickly and successfully challenged by General Electric, which yielded two important results. First, it generated so much publicity surrounding maternity leave that many employers across the nation took it upon themselves to institute maternity benefits out of fear of impending legislation. Second, Congress passed the Pregnancy Discrimination Act in 1978, since pregnancy could not be incorporated into existing legislation. This legislation required equal treatment of pregnancy and other disabling medical conditions, but it did not mandate that employers adopt maternity or family leave benefits as anticipated by much of the private business community. Finally, Congress passed the Family and Medical Leave Act (FMLA) in 1993 to assist all working families balance their varying responsibilities.

The FMLA has been successful thus far in allowing approximately 4 million men and women take time off from work each year to care for their loved ones (National Partnership for Women and Families (NPWF), 2002), but the law is incomplete. Under FMLA, workers are guaranteed 12 weeks of unpaid leave to care for a newborn, a newly adopted child or a seriously ill family member. To be eligible, one must work for a company with at least 50 employees within a 75-mile radius and have worked for a minimum of 1,250 hours in one year. This response to balancing work and family responsibilities has serious flaws. First, workers are guaranteed leave, but it is unpaid. "In 2000, 78% of people who needed but did not take family or medical leave said that they could not afford to take the leave" (NPWF, 2002). Twenty-one percent of workers who did take some leave had to turn to welfare for support (Institute for Women's Policy Research, 2000). Second, roughly 41 million people are not covered by the law (NPWF, 2002). Nearly half of the private

workforce in the United States does not meet basic eligibility criteria because they have either not worked for an employer long enough or their employer is too small (Heymann et al, 2002).

In August 2000, the Clinton Administration passed an administrative rule permitting states to compensate families with childbirths and new adoptions through State Unemployment Insurance (UI). States were given the option of enacting birth and adoption unemployment compensation to provide UI payments to parents for 12 weeks or more in the year following a birth or adoption. Additional details were to be developed by the states. During 2000, 15 states proposed to expand UI benefits, but no new policies or changes were enacted (Vroman, 2001). States' failure to provide compensation to parents for the birth or adoption of a child under this rule suggests that voluntary measures are ineffective and will not motivate nationwide change.

Expansion of FMLA, a law passed a decade ago, is one way in which to address the imbalance between work and caregiving responsibilities. This expanded FMLA would mandate employers to provide *paid* parental leave for up to 12 weeks so that mothers and fathers are able to take leave from work. Leave could be taken simultaneously or parents could take turns to provide a total of 24 weeks of paid leave. Employers smaller than 50 employees within a 75-mile radius would remain exempt from this rule; however, it would be left up to individual states to provide some minimum level of benefit to these eligible employees, most likely from general revenues.

Addressing the current limitations of FMLA will undoubtedly receive tremendous public support. Roughly 83 percent of working women say that providing paid leave through FMLA is important to them, and 80 percent of adults support paid parental leave that allows working parents to stay home to care for newborn children (AFL-CIO, 2001). Studies have shown that women who receive paid leave return to work in less time and have stronger attachment to the labor force (Ruhm, 1997), which will benefit employers and all of society across time.

According to businesses, the adoption of previous legislation had no noticeable negative effect on performance or growth (Ruhm, 1997); however, the financial impact of this mandate may be overwhelming for many companies, particularly those just over the 50-employee cutoff. Companies that do not have existing programs for the provision of paid parental leave, such as Temporary Disability Insurance, will be forced to come up with some sort of financing mechanism. The new mandate will allow one year for implementation with the option of receiving technical assistance from the federal government. Some companies are already providing benefits comparable to what this

policy aims to achieve. J. P. Morgan Chase & Co. in Florida sets a wonderful example and appears to be having little trouble supporting parents in their dual roles. This company provides employees with 12 weeks of employer-paid leave and eight weeks of free child care on site (Ackerman, 2002).

Parental Leave Assistance

Another way in which the federal government could address this social problem is by establishing a Parental Leave Assistance (PLA) grant to states, to provide outright cash payments to parents of newborn children who meet specified eligibility criteria. The target of PLA is low- to middle-income parents of newborn children. Cash payments are to be provided monthly for up to 12 weeks based on individual total household income. Households with dual caregivers (married or cohabitating) would be eligible for 24 weeks of cash transfers on the condition that both parents provide at home care either simultaneously or one after the other. Neither caregiver may exceed the 12 week limit. PLA would be administered through each state's Department of Health and Human Services Childcare Assistance program. This office is currently responsible for administering the Federal Child Care Development block grant, so it is expected to have many of the necessary administrative structures in place, and it is also most likely to come into contact with many low-income parents needing childcare assistance as they return to work. The PLA grant to states would be a categorical formula grant based on the total number of births and total income in that state in a given year. A 40 percent match would be required by all states that choose to participate. Additional rules and regulations associated with PLA would be left to states' discretion.

Currently, there is no explicit grant to states that provides funding for parental leave assistance. The Child Care Development block grant, in addition to providing child care subsidies to eligible parents, is being used by Minnesota, Montana and Missouri to fund the At-Home Infant Care (AHIC) program (Goodman, 2002; NPWF, 2001). AHIC provides parental-leave benefits directly to one parent to stay home to care for their infant rather than paying someone else to care for the child. In Minnesota, eligible families receive 90 percent of the child-care payment rate minus a co-payment based on the family's income for up to one year (NPWF, 2001). Montana followed in Minnesota's footsteps and implemented an AHIC pilot program that pays low-income mothers caring for children under age 2 the same child care worker's wage, \$17 a day (Goodman, 2002). This approach to supporting families may work well for single, low-income parents, but it does not provide

benefits to partners or the slightly poor to middle-class populations who are targeted by the PLA grant.

Temporary Caregiver Insurance

The third policy approach that may be taken is to provide insurance against the risk of lost income due to leave from work to care for a newborn child. Participation would be mandatory, related to earnings and universally applied. All who pay into the system would, at some point, be eligible to receive benefits should the need arise. The locus of control would be at the state level, in the same administrative body that now operates Unemployment Insurance (UI). The proposed policy alternative is to redesign UI to provide unemployment compensation to those temporarily not working due to caregiving responsibilities for a newborn child, or Temporary Caregiver Insurance (TCI).

Several examples exist of ways in which states are insuring against the risk of lost income due to caregiving needs. Five states and Puerto Rico provide compensation for medical disability related to pregnancy and childbirth through state Temporary Disability Insurance (TDI) programs, all of which were created more than 40 years ago and represent the nation's biggest paid medical leave program (NPWF, 2001). Payments typically begin four weeks prior to birth and end four weeks after birth (Vroman, 2001).

Recent legislation passed in California (SB 1661) allows employees to take six weeks of paid family leave to care for a newborn or newly adopted child at a 50 percent to 60 percent wage replacement rate (Dube & Kaplan, 2002). This is in addition to the 16 weeks of job-protected leave covered by the Pregnancy Disability Leave law and the 12 weeks of job-protected leave covered by both the FMLA and the California Family Rights Act (NPWF, 2002). Employees who voluntarily pay into the State Disability Insurance fund are eligible for paid family leave to care for a newborn or newly adopted child during the first year if they have earned sufficient wages during the disability base period, served a seven-day waiting period for eligibility determination, and do not have a family member available to provide care (NPWF, 2002). Employees living in other states lack the paid family-leave protection provided in California unless their employer voluntarily provides TDI. However, the California law is limited in that it does not allow both parents to take paid leave simultaneously to care for a newborn child.

Several European countries serve as excellent examples for how government is able to address the tension between meeting work and family responsibilities. Through a combination of national sickness, maternity and social

insurance funds, parents in Norway are entitled to 42 weeks of leave with full wage replacement or 52 weeks of leave with 80 percent wage replacement, while Swedish parents can share 52 weeks of full wage replacement plus an additional three months at a lower rate (Gornick & Meyers, 2001). Other affluent, industrialized nations provide a minimum of 12 weeks of paid leave to parents, with the majority granting closer to 20 weeks (Christopher, 2002). The third proposed policy alternative is to redesign State Unemployment Insurance so that it provides unemployment compensation to parents of newborn children called Temporary Caregiver Insurance (TCI). "Paying compensation would expand the scope of UI to situations where persons are not physically job ready and, perhaps more important, not psychologically ready" (Vroman, 2001, p. 10). Given that every state currently operates an UI program, it is a more viable option than TDI. All employees who are eligible for UI would also be eligible for TCI. The minimum length of leave for which benefits may be paid is 12 weeks. Parents may choose to take leave at the same time or alternate so that they can provide at-home care with wage replacement for a total of 24 weeks. States would determine benefit levels, lengths of leave for which benefits are paid and eligibility requirements.

In sum, the three policy tools that may be used to rectify the imbalance between work and caregiving responsibilities are rules and regulations, cushions and insurance. The first approach would amend the Family and Medical Leave Act so that employers are mandated to provide paid leave to employees. For employers that are too small, the state would fill in so that the playing field is somewhat leveled and that the odds of attracting workers are not unfairly tipped into the larger employers favor. The second approach would provide states with a categorical matching grant to distribute Parental Leave Assistance cash payments to mothers and fathers of newborn children. The third and final approach, Temporary Caregiver Insurance, would redesign existing State Unemployment Insurance system by making care for a newborn child an eligible category for coverage.

EVALUATION OF POLICY ALTERNATIVES

To evaluate the policy alternatives outlined above, one must first examine what is to be equitably distributed and what the ideal distribution should look like. Here, equity is defined as equal opportunity for all parents to exercise a choice to stay home to provide care for a newborn child during the first 12 weeks of a child's life. What needs to be equitably distributed to make this a reality is financial assistance through some policy tool. An equitable distribution process

will provide unequal levels of financial assistance so that in the end, all parents of newborn children have equal amounts of wage replacement. The level of financial assistance will vary from person to person given the drastic differences in total household income. The following evaluation measures each of the policy alternatives against seven benchmarks and rates them on a scale from one to five, with five being the highest. The ratings represent the author's best estimate and are therefore subjective in nature.

Benchmark 1: The financial assistance provided to parents of newborn children will vary, but in the end all parents will have equal levels of wage replacement.

The proposed expansion of FMLA requires companies to provide eligible employees in covered work sites with 12 weeks of paid leave at a minimum of 50 percent wage replacement. Currently, 11 percent of work sites are covered under FMLA, among which 52 percent of employees taking leave for one of the FMLA-covered reasons received full pay and 21.5 percent received partial wage replacement (CFML, 1996). No compensation was received by the remaining 26.6 percent of employees taking leave. The proposed policy change would have little to no effect on companies already providing the minimum amount of wage replacement set by the state; however, it may induce companies who are replacing wages at a higher rate to reduce coverage. Employees working in covered work sites that provide no compensation likely will benefit the most, but perhaps at the expense of those working in one of the previously described worksites.

While the expansion of FMLA is likely to affect a significant portion of the target population, it fails to provide needed financial assistance to those who are not attached to the workforce, have not worked a sufficient amount of time to be eligible under FMLA, or do not work for an FMLA-covered worksite. Therefore, this policy gets a 2 in relation to the first benchmark given that it provides unequal levels of financial assistance to create unequal total amounts of wage replacement for parents taking leave from work to care for a newborn.

The level of financial assistance provided under Parental Leave Assistance (PLA) varies depending on the total household income of the beneficiary. PLA is a means-tested cash assistance program targeted to low- and middle-income parents of newborn children. The exact level of financial assistance provided has been left up to states' discretion and is based on total household income and the number of caregivers (either one or two) present in the home. This

policy is designed so that parents with the least amount of income receive the greatest amount of financial assistance and as income level rises the amount of financial assistance decreases. Once a certain level of income is reached, parents are no longer eligible for PLA. Therefore, this policy gets a 5 in relation to the first benchmark.

The level of financial assistance provided to parents through Temporary Caregiver Insurance (TCI) depends on the amount paid into the system. TCI builds on the existing UI system to provide financial assistance to parents who take leave from work to care for a newborn. Participation is mandatory, which provides universal protection to all employees, although not all employees will need to access benefits, similar to Social Security. The level of financial assistance provided will vary depending on pre-leave wages and how much a particular employee has paid into the system, but it will result in equal wage replacement. This policy gets a 5 in relation to this benchmark.

Benchmark 2: Mothers and fathers have equal access to benefits.

Both mothers and fathers are guaranteed job protection and employer funded wage replacement under the recommended expansion of FMLA. The policy is highly flexible in that it permits both parents to take 12 weeks of paid leave at different times for a total of 24 weeks. Women bear the responsibility of child-birth and have traditionally been the predominant caregivers, suggesting they are more likely to take advantage of paid leave than men. However, due to glaring inequities in salary structures, this policy may make leave-taking more financially advantageous for men than women. In the end, more men may take advantage of the full 12 weeks of leave with wage replacement. This policy gets a 5 for providing equal access to benefits; however, until gender inequalities, such as unequal pay, are resolved, there will be unequal incentives for men and women to take advantage of such policies.

Both mothers and fathers are encouraged to stay at home to care for a newborn child under PLA. Dual-care giving households, either married or cohabitating, are eligible for a total of 24 weeks of cash transfers as long as neither caregiver exceeds the 12-week limit. Parents may stagger or overlap leave from work depending on their financial and parenting needs. Similar to the expansion of FMLA, this policy provides equal access to benefits and encourages dual caregiving responsibility. Therefore, the policy alternative gets a 5 in relation to the second benchmark.

TCI provides mothers and fathers equal access to financial assistance to stay home to care for a newborn child. Both parents are eligible for 12 weeks

of wage replacement through UI, which may be taken simultaneously following the birth of a child or in turn for a total of 24 weeks with wage replacement. Similar to the other two policies, one or both parents may find it more economically beneficial to work rather than take leave to care for a newborn child. However, the availability of wage replacement to both parents earns a 5 in relation to this benchmark.

Benchmark 3: The infringement upon the liberty of society at large is minimized.

By expanding FMLA to provide paid leave to workers to care for a newborn child, the liberty of society is infringed upon slightly, particularly in relation to non-parent employees. The majority of surveyed employees (71 percent) believe that every employee should be able to take 12 weeks of leave from work, however 54 percent feel that it is an unfair burden placed on co-workers (CFML, 1996). The overlap in employees' opinions suggest that some may feel torn between infringing upon the rights of individual employees who wish to take leave and the question of who bears the responsibility for covering for them at work. The intent of providing employees with financial assistance is to make taking 12 weeks of FMLA-covered leave a more feasible option, which will ultimately result in more parents taking leave. Given that using other employees is the most common method for covering work responsibilities (69 percent) (CFML, 1996), this policy may further infringe upon the liberty of non-parent co-workers, who will be required to provide coverage for those parents taking leave.

It is also important to consider the impact this policy may have on employers, children and society. A survey of employees found that 10 percent of those taking leave did not return to work, the most predominant of which were employees making less than \$20,000 annually and those who received no wage replacement (CFML, 1996). Low-income parents who take unpaid leave following childbirth are more likely to end up on welfare to make ends meet (CFML, 1996). By mandating employers to provide wage replacement, this policy will likely reduce turnover rates, which will benefit companies, families and children and prevent families from turning to alternative forms of public assistance. Overall, this policy gets a 3 in relation to the third benchmark.

PLA infringes somewhat on the liberty of society. The PLA grant provides states with the option to provide PLA cash transfers to low- to middle-income parents of newborn children. States have a financial incentive to do so in that they are able to draw down a higher federal match than what they are asked to

contribute to the program; however, they are not obligated to participate. States that choose to participate must commit a 40 percent match to satisfy grant conditions. The liberty of those living in a state that chooses to participate but may not directly benefit from PLA may be infringed upon. Therefore, this policy gets a 4 in relation to this benchmark.

TCI infringes upon the liberty of society by mandating participation. In doing so, it provides a universal benefit to all employees, who are then eligible to access benefits should the need arise. The liberty of non-parent employees may be particularly infringed upon given that all employees pay in equal amounts, but certain employees are able to access benefits for a greater number of categories. This policy gets a 2 in relation to this benchmark.

Benchmark 4: The number of families taking full leave to spend with newborn children is maximized.

The expansion of FMLA and PLA are likely to benefit a smaller number of families overall, bearing in mind that it is difficult to project with certainty the precise number of families who will take full advantage of available benefits. The FMLA mandate will disproportionately benefit middle- to higher-income employees, but these targeted families are likely to take full leave to spend with their children. Thus, this policy gets a 2. Likewise, PLA targets low- to middle-income families, not all families. There is a greater chance, however, that the number of families in this category taking full leave to care for a newborn will be maximized due to the provision of financial assistance. This policy gets a 3.

TCI is likely to result in the maximum number of families taking full parental leave, given that it is a universal system paid into by the majority of the income distribution, except for the very rich who are less likely to need financial assistance in the first place. Therefore, TCI gets a 4 in relation to this benchmark.

Benchmark 5: The level of administrative complexity is low.

The proposed expansion of FMLA is low in administrative complexity. For this policy to be implemented, additional rules and sanctions would need to be devised by the Wage and Hour Division of the U.S. Department of Labor, which is the agency responsible for the administration of FMLA (Ruhm, 1997). Processes would then need to be put into place for providing technical assistance to companies, monitoring the process and responding to complaints. The courts will be relied upon to remedy individual cases and many of these other systems are already in place. For example, between Aug. 5, 1993, and

Sept. 30, 1995, the Wage and Hour Division received 3,833 complaints against employers and has completed compliance actions on 3,650 of them (CMFL, 1996). In relation to this benchmark, this policy gets a 4.

The level of administrative complexity associated with PLA is extraordinarily high. First, there is the issue of administering the grants to states. This will require a formal application and approval process. Second, each state's Department of Health and Human Services Childcare Assistance program is expected to administer benefits to eligible parents. At present this program administers child-care subsidies made available through the Federal Child Care Development block grant to those who meet specific eligibility criteria. Some systems may be in place to take on additional means-testing; however, PLA is likely to be time-consuming and involve considerably more paperwork. Someone will need to process applications, verify income eligibility and birth certificates and verify the presence of more than one caregiver in the home. Due to administrative complexity on numerous levels, this policy gets a 1 in relation to this benchmark.

TCI is a redesigned form of the existing UI system. By adding an extra category of eligibility, the policy approach provides the intended benefits without creating a high amount of administrative complexity. TCI will use current UI systems to verify eligibility and administer benefits as needed and will simply require additional time and personnel. Therefore, this policy gets a 3 in terms of overall administrative complexity.

Benchmark 6: Political stability of the target population is maximized.

Two dimensions must be assessed when measuring the political stability of the target population, including how the target population is socially constructed or perceived (deserving versus undeserving) and how stigmatizing the policy may be toward the intended recipient. The broad target population of all three policy alternatives is parents of newborn children, which includes parents of all income groups, races, ethnicities, ages, and gender.

Each policy alternative carves out a more defined target population that may be deemed more or less deserving by policymakers and the general public. The group targeted by FMLA in 1993, when the legislation was initially passed, is most likely the same group targeted today, predominantly middle-class employees, suggesting that recipients will still be regarded as deserving. PLA, on the other hand, focuses on parents in the first half of the income distribution, primarily lower- to middle-income families. Historically, poor families have been regarded as less deserving than their middle class counterparts

for various reasons. While this is unfortunate, it is a political barrier that is overcome by targeting both groups simultaneously, as does PLA. By providing some level of financial assistance to both groups, PLA increases its overall political stability (Skocpol, 1995). The recipients of TCI are probably the most positively constructed group in that TCI is a universal policy available to all families who may need it at some point in time.

The second dimension of this benchmark is the level of stigmatization likely to be felt by recipients. Those who may benefit from the expansion of FMLA probably will experience a minimal amount of stigmatization in regard to employer and co-worker relations, but not necessarily from the greater society. This may be true for TCI as well, although the stigma may be slightly reduced in that all employees know that if the need for them to take leave should arise, they will benefit from equal wage replacement. Recipients of PLA are likely to feel the greatest level of stigmatization compared to the other two policies. By their nature, means-tested programs are more stigmatizing than universal programs. Given dimensions described the above, the expansion of FMLA gets a 4, PLA gets a 2, and TCI gets a 4.

Benchmark 7: Political stability of the item to be distributed is maximized.

Another aspect of political stability pertains to the item to be distributed, which in this case is financial assistance through some policy tool. The way in which financial assistance is provided to recipients will impact a policy's overall political stability. The expansion of FMLA provides financial assistance by mandating that companies provide employees with a minimum level of wage replacement. This indirect process may be more attractive to policymakers since costs appear strictly in the ledgers of private businesses. The level of financial assistance is tied to wages, which are likely to rise with inflation. However, powerful interest groups representing the private sector may oppose the new requirements and, if passed, are likely to work to have them reduced or removed later down the line. Thus, this policy gets a 4.

The item provided by PLA is a series of cash payments, the size of which depends on a family's total household income. This item will be less politically stable over time given that its costs are highly visible in the federal budget and that cash payments tend to generate controversial public debate. Therefore, this policy gets a 2 in relation to this benchmark.

TCI provides insurance against the risk of lost income due to the need to care for a newborn child. Some who pay into the system will be able to access benefits, while others will not. However, all participants will feel protected

against the potential risk of lost income. This policy is likely to be positively regarded by employees, policymakers, and the general public. TCI provides a socially acceptable item similar to that of Social Security warranting a 5 in relation this benchmark.

Summary

All three policy alternatives provide some level of financial assistance that will enable parents to stay home to care for a newborn child. The process or means of delivering financial assistance distinguishes one alternative from another. As shown in Table 1, TCI received the highest rating across all seven benchmarks followed by the expansion of FMLA and then PLA.

TABLE 1: MATRIX OF POLICY ALTERNATIVES

BENCHMARKS	FMLA	PLA	TCI
1) Equitable amounts of wage replacement	2	5	5
2) Equal access to benefits	5	5	5
3) Infringement on liberty of society is minimized	3	4	2
4) Number of families taking leave is maximized	2	3	4
5) Administrative complexity is low	4	1	3
6) Political stability of target population is maximized	4	2	4
7) Political stability of item to be distributed is maximized	4	2	5
TOTAL RATING	24	22	28

RECOMMENDATIONS

The social problem addressed throughout this paper is the imbalance between work and caregiving demands placed on families, particularly parents of new-

born children. The goals for remedying this problem include the provision of financial assistance so that both parents, whenever possible, are able to take leave from work to care for a newborn child and balance caregiving responsibilities. In the absence of wage replacement, many employees find taking leave to be impossible. Upon thoughtful consideration and evaluation of the three policy alternatives described above, the recommended approach for providing men and women with equal access to financial assistance so that they may stay home to care for a newborn child is through Temporary Caregiver Insurance (TCI).

The expansion of FMLA and Parental Leave Assistance (PLA) are attractive options, but they do not rate as highly as TCI in many key areas, including providing equitable amounts of wage replacement and maximizing the number of families taking full leave to care for newborns. The expansion of FMLA does particularly well in terms of providing equal access to benefits to mothers and fathers, administrative ease and potential political stability once passed. However, it does not provide equitable amounts of wage replacement or maximize the number of families able to take full leave to care for a newborn. PLA received the lowest rating on several benchmarks, except for providing equitable amounts of wage replacement and equal access to benefits. At a glance this policy alternative appears to be the least optimal choice, however, it warrants merit for providing financial assistance that is not necessarily tied to work. This is one of the limitations of the expansion of FMLA in that a small proportion of employees are covered to begin with.

TCI is the recommended policy approach, but it is not without weaknesses. This policy alternative does well in terms of providing an equitable amount of wage replacement and access to benefits, the highest number of families taking full leave to care for a newborn, and overall political stability regarding the item to be distributed and the recipient. Two primary areas in which this policy alternative may be improved include reducing its infringement on the liberty of society, particularly non-parent employees, and reducing the level of administrative complexity. The first issue concerns those employees who pay into the TCI system but never access benefits and are forced to provide coverage on the job for those who do. One way in which to address this matter would be the development of small, local management boards who oversee the process by which employees apply for temporary leave to care for a newborn and assign coverage of their work responsibilities. This will encourage employee oversight and involvement and create a forum in which they can express concerns or grievances. The level of administrative complexity is likely to be higher at the outset and eventually plateau. The

weaknesses of TCI are minor in comparison to the overall strengths of this policy, making it the better of the three alternatives at this time.

ADDENDUM

On Nov. 25, 2002, the United States Department of Labor (DOL) posted a notice of proposed rulemaking regarding the removal of the Birth and Adoption Unemployment Compensation (BAA-UC) regulation, more commonly known as the “Baby UI” rule. Written comments were to be submitted to DOL by Feb. 3, 2003. As of April 24, 2003, DOL has not yet issued a finding. The rescinding of BAA-UC would prevent the implementation of the policy alternative recommended in this paper. ■

REFERENCES

- Ackerman, Sherri (2002). Healthy Start introduces prenatal, child care initiative. *The Tampa Tribune*, Oct. 2, 2002, Metro Section, 1.
- Children’s Defense Fund (2001). *Child Care Basics*. http://www.chidrensdefense.org/cc_facts.htm
- Commission on Family and Medical Leave (1996). *A Workable Balance: Report to Congress on Family and Medical Leave Policies*, Washington, D.C. <http://www.dol.gov/asp/fmla/main.htm>
- Dube, A. & Kaplan, E. (2002). *Paid Family Leave in California: An Analysis of Costs and Benefits*.
- Goodman, E. (2002). The job of raising kids. *The Boston Globe*, Sept. 29, 2002, Third Edition, D11.
- Gornick, J. C. & Meyers, M. K. (2001). Support for working families: What the United States can learn from Europe. *American Prospect*, 12(1), 1-15.
- Heckman, J. J. (2000). *Fostering Human Capital*. www.ounceofprevention.org/publications/pdf/Fostering_Human_Capital.pdf
- Heymann, J. (2000). *The Widening Gap: Why America’s Working Families Are in Jeopardy and What Can Be Done About It*. New York: Basic Books.
- Heymann et al. (2002). *Work-family issues and low-income families*. www.lowincomeworkingfamilies.org
- Institute for Women’s Policy Research (2000). *Paid Family and Medical Leave: Essential Support for Working Women and Men*. Publication #A124.
- Kelly, E. & Dobbin, F. (1999). Civil rights law at work: Sex discrimination and the rise of maternity leave policies. *American Journal of Sociology*, 105(2), 455-492.
- Lambert, S. (1993). Workplace policies as social policy. *Social Service Review*, June 1993, 237-260.

- National Child Care Information Center (2002). *Quality Care for Infants and Children*.
<http://nccic.org/pubs/qcare-it.htm>
- National Partnership for Women and Families (2002). *Work and Family*.
<http://www.nationalpartnership.org/Content.cfm?L1=6>
- National Partnership for Women and Families (2001). *Family Leave Benefits: A Menu of Policy Models for State and Local Policy Leaders*. September 2001.
<http://www.nationalpartnership.org>
- Skocpol, T. (1995). Targeting within universalism: Politically viable policies to combat poverty in the United States. In Skocpol, T. *Social Policy in the United States: Future Possibilities in Historical Perspective*, 250-274. New Jersey: Princeton University Press.
- Stone, D. (1997). *Policy Paradox: The Art of Political Decision Making*. 2nd Edition. New York: Norton and Company.
- Vroman, W. (2001). *Compensating American Families for Births and Adoptions*. Revised addition, Washington D.C., Urban Institute. www.urban.org

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