CONTENTS

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EDITORIAL

Faith in the Faith-Based Initiative?

One of the first initiatives of the Bush presidency was the Faith-Based Community Development Initiative. Little of this new thrust has been spelled out beyond the purpose of promoting access to federal funds for religious-based organizations to provide social services. Furthermore, to date, only the faith-based aspect of the initiative has been talked about; hence, it can be called the Faith-Based Initiative, or FBI. John J. DiIulio, Jr., of the University of Pennsylvania's Center for Research on Religion and Urban Civil Society, who will head this effort, is best known for his discredited theory of predatory teenagers. The FBI has raised a flock of concerns: about First Amendment church-state relations; why it has been proposed; its impact on existing services; and what it portends for users of services, for social work, and for women.

Let us first look at some assumptions underlying this proposal:

1. Religiously sponsored organizations, by virtue of that religiosity, are more effective than existing programs in treating social problems and are cheaper.
2. The government is the worst choice of provider, and the federal government is the worst of all governmental choices.
3. Religious organizations are free of corruption, unlike governmental ones.
4. There is agreement on what constitutes an acceptable religion.
5. Funds for the initiative will come without the regulatory strings attached to other programs (limits on proselytizing, accountability for funds, the lack of bias in employment, the right to unionize, evidence of effectiveness, and so on).

6. All faiths are equally blessed with the know-how to apply, manage, deliver, and report on their activities in ways that are required for other federal grants.

With regard to the first assumption, Byron R. Johnson, a colleague of DiIulio from the Center for Research on Religion and Urban Civil Society, said that there are no data to support the belief that faith-based organizations (FBOs) are effective, never mind more effective, than other social services (Goodstein, 2001b, p. A12). Hence, this new policy is based only on faith. The absence of research is particularly crucial because it may be unconstitutional for the government to decide which religious programs to fund on any basis except proven success. Furthermore, both President Bush and DiIulio have repeatedly said that a record of effectiveness is the only basis on which to award funds to FBOs.

If FBOs are cheaper, it is probably because they use volunteers or less qualified staff to provide the services and pay less than the prevailing salaries, which pose a real threat to standards of expertise and quality. Or, perhaps the staffing will come from the Texas program for training licensed belief therapists, where for $90 you can learn to treat positional identity disorders, which include "not being a Christian" (Vicki Hansen, executive director of the National Association of Social Workers Texas chapter, personal communication, May 29, 2001).

The second assumption is purely ideological. It has long been an American tenet, based on the country's diversity, that the government must provide a basic network of services for all. Beyond that minimum, every group may offer what it wishes in the way that it wishes, using its own money. Social workers must be concerned when public funds for that basic level of provision are diverted to groups with little expertise and a predilection to proselytize. For example, Texas, which had a faith-based initiative under Governor Bush, gave an FBO state money for a job training program that required the participants to accept Jesus as their Savior (Goodstein, 2001c). Because the nearest alternative job training program was more than 60

miles away, in another county, did those who were required to enroll in such a program truly have access to one? The White House now says that funding religious programs like this is fine if they can show results and there is a secular alternative (Goodstein, 2001d). Testifying before a House subcommittee, Rev. John D. Castellani, president of Teen Challenge International, an evangelical drug treatment program, reported that whereas some Jewish clients returned to their Jewish faith, others had become "completed Jews" (meaning that they had accepted Jesus as their Savior) (Goodstein, 2001d, p. A14). Was there a secular alternative?

The third assumption is also erroneous. There have been many incidents of corruption by nonprofit and religiously based service providers. Tammy Faye Baker and her husband come to mind, as does the recent scandal in New Square, New York, where Orthodox Jews created a bogus school to receive federal money for the residents, as well as for Israeli citizens, from their impoverished town (Archibold & Gootman, 2001). Or the St. Francis of Assisi Foundation, "run by indicted Connecticut financier Martin Frankel, from which $50 million disappeared" (Missakian, 2001, pp. A3-A4).

With regard to the fourth assumption, if past statements by religious representatives are any indication, there is no agreement on what "faith" would be eligible for the faith-based initiative. Pat Robertson (cited in Interfaith Alliance, 2001a), for example, said, "You say you're supposed to be nice to the Episcopalians and the Presbyterians and the Methodists and this, that and the other thing. Nonsense, I don't have to be nice to the spirit of the Antichrist." The Anti-Defamation League of B'nai B'rith's objection to the Nation of Islam because of its history of anti-Semitism is another example, as are the protests over Scientology and the Unification Church.

In relation to the fifth assumption, what kinds of regulations will apply to the funded FBOs? In Texas, churches successfully used a First Amendment argument to avoid all regulations for the social services and educational programs they ran. Will hiring practices be based on practice or faith-based qualifications

or both? What about discrimination on the basis of gender, sexual orientation, or individual behavior?

With regard to the sixth assumption, one may question whether the numerous regulations, taxes, reporting, and so forth that nonprofit organizations must now meet can be managed by the FBOs. A number of ministers, such as Rev. Herbert B. Chambers, of the Young Memorial Church in Washington, D.C., have questioned the capacity of small churches, mosques, or synagogues to meet such obligations (Becker, 2001b, p. A11). Chambers has brought many millions of federal dollars to his community and knows full well how complex, rule encumbered, and difficult managing such efforts is. He recruits volunteer experts to ensure that he, expert though he is, makes no mistakes.

What about the role of the faith's ideology? Catholic hospitals, recipients of Medicare and Medicaid funds, do not provide contraceptive services or abortions or permit their staffs to refer patients to hospitals or clinics that provide such services and have imposed such policies on all hospitals in hospital networks that they seek to join, such networks being an increasingly common pattern of hospital organization. The impact of ideology on reproductive health services and their staffs is obvious. Ideology also has an impact on staff; for example, a highly esteemed and qualified staff person was fired by an FBO when a photograph of her at a demonstration for gay rights appeared in the local newspaper (Press, 2001). Will accepting federal money force FBOs to betray either their federal funder or their faith? And with what consequences for clients?

Furthermore, many religious groups take strong stands about the place of women in the home and in society, using the patriarchal family as the model, in which a woman's role is to marry, obey her husband, and take care of the children. As Robertson (cited in Interfaith Alliance, 2001b) said, for example,

> I know this is painful for the ladies to hear, but if you get married, you have accepted the headship of a man, your husband. Christ is the head of the household and the husband is the head of the wife and that's the way it is, period.

What kind of help would an FBO under such aegis provide a battered woman who was seeking shelter from her abusive husband?

Conservatives in Congress and the Christian Coalition have voiced their concern over the breakdown of marriage and have urged marriage-rewarding policies, such as giving scarce social services such as child care or low-cost housing first to married families, with only the leftovers going to single-parent families; lesbians would no doubt get no services. Nor are FBOs likely to hire divorced or single-parent mothers or lesbians. For example, Robertson (cited in Interfaith Alliance, 2001b) called for an end to the women's movement because "it encourages women to leave their husbands, kill their children, practice witchcraft, destroy capitalism and become Lesbians."

Another level of analysis suggests that the aim of the FBI is to woo votes from the Christian Coalition and from African Americans who have been wary of the Republican Party. Far from any new funds' being appropriated for the initiative, funding for social services has been cut, so that the FBOs will compete with currently funded agencies. Nevertheless, the publicity that the FBI has received should help the Bush bonafides with both groups. If the goal is to build a political machine for Republican votes, will the Black churches that have paid much attention to voter registration but little to public policy be able to survive the complexities they must deal with (Banks, 2001)? And will the seduction of new access to public funds work?

For social workers who are concerned with the quality and accessibility of social services, there are equal concerns. Both past practice and current voices hedge about the proselytizing aspects of religious social services. Bush has reiterated that charities will not have to suppress religious expression just because they are getting public funds (Becker, 2001a; Goodstein, 2001a). The bill allows religious groups to discriminate in favor of members of their own faith when hiring staff with federal funds—also a matter of concern. And the many high-quality sectarian social service programs, which have carefully separated religion and proselytizing from service

delivery, are likely to be replaced by free public funds for the FBI. In sum, a likely result of the FBI will be a highly uneven, varyingly accountable, unpredictable, and strongly ideological reduced array of services of dubious effectiveness, which are harshly judgmental about women, to replace our current service delivery system.

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Subjugated Knowledge in Gender-Integrated Social Work Education: Call for a Dialogue

Josefina Figueira-McDonough, F. Ellen Netting, and Ann Nichols-Casebolt

If social work education is truly committed to social justice and self-determination, it will have to liberate the knowledge of groups with which it works. To do so, it is necessary to recognize the unique role of practitioners in discovering and interpreting subjugated knowledge, which requires that academicians, practitioners, and consumers of services have opportunities to dialogue. Four strategies for freeing subjugated knowledge are proposed in this article. Dialogue that results from these strategies allows academicians and practitioners to focus on gaps between the practice theories they teach and the work they have to do and can contribute to curricular reformation.

> When you are playing tennis and the wind is blowing from your back, you may not be aware of the wind at all and think only that you are playing very well. All your shots go in swift and hard. It isn't until you change courts and the wind is blowing against you that you appreciate the force of the wind.
>
> ——P. Rose (1984, p. 268)

In *Parallel Lives*, P. Rose (1984) attempted to explain how men in a gender-stratified society are often unaware of the incredible advantages of their position and of their limited views of

reality. With regard to the quotation just cited, P. Rose would view the persons who conceptualized early social science theory as playing tennis with the wind blowing from their backs. Her allegory is enlightening in its simplicity. It is not surprising, then, that those persons who experience the adverse impact of the wind (such as women) have strongly reacted to the theories and models of practice that have been grounded in the dominant thinking of those who could be seen as playing tennis with the wind blowing from their backs.

For persons who are playing against the wind, the world looks different. Their knowledge is often subjugated, meaning that it is not taken seriously, is discounted, is ignored, and is even seen as irrelevant and unimportant by those who are positioned to influence what is considered "acceptable" knowledge. For example, the examination of historical and contextual evidence traces the origin of most social sciences to conceptualizations of Western, White, middle-class men. To the extent that theoretical explanations have an inductive basis, that is, that they use individual experiences to develop theoretical explanations (see, for example, Firestone, 1990; Harding, 1987; Little, 1991), these theories made sense within the reality of their male creators—a reality shaped by the experiences of those inhabiting a privileged social location within the gender, class, and ethnic structures of their society. This process of formulating knowledge narrows the legitimacy of the construction of knowledge to this privileged social stratum but is imposed as a universal explanation. Theories that are constructed in such circumstances can become highly influential, thus reinforcing the existing social structure (Gramsci, 1978) and subjugating the knowledge of others.

There is nothing new about recognizing that the views of diverse groups have been subjugated or that dominant theories have been used to squelch diverse perspectives. Reacting to dominant perspectives, critical and postmodern theorists have legitimated diverse sources of knowledge by accepting multiple approaches and embracing alternative ways of thinking. However, recognizing subjugated knowledge requires the

willingness of the dominant group to see reality through the lenses of the dominated group. Complicating the situation is that there are various types of subjugated knowledge. If critical and postmodern writers have taught anything, it is that theoretical interpretations are shaped by one's own experience. Therefore, the liberation of various types of knowledge requires opening one's mind to the views of many different persons throughout the social structure (Collins, 1999; Freire, 1973). This is not an easy thing to do.

Social work is not immune to discounting knowledge from some groups. Not only are the foundations of much of its knowledge based primarily on social science theories constructed by White, middle-class men, but even in constructing alternative theories, social workers often ignore the views of those with whom they work. In this article, we argue that if social work academicians are truly committed to social justice and self-determination, they must work with practitioners to liberate the knowledge of these ignored groups. To do so, they have to recognize the unique roles of practitioners and consumers of services in discovering and interpreting subjugated knowledge.

Because the profession is made up predominantly of women, is increasingly educated by women faculty, and serves a disproportional number of women consumers (Weick, 2000), we begin by examining how social work education contributes to the practice of gender stratification and the subjugation of women's ways of knowing. We then look at the importance of relationship building among academicians, practitioners, and consumers so that subjugated knowledge can be released. Last, we focus on strategies that can be used to connect academicians, students, practitioners, and consumers so that alternative ways of knowing can be infused into the social work curriculum. We argue that if social work academicians do not work with practitioners and consumers in developing knowledge, then the views of dominant groups will be taught as the only knowledge base for social work practice. The integration of the various forms of subjugated knowledge into the social work

curriculum is imperative if graduates are to be prepared to work within (and, it is hoped, transform) organizations that plan and deliver human services.

SOCIAL WORK EDUCATION AND SUBJUGATED KNOWLEDGE

The concept of the feminist standpoint is at the heart of efforts in all disciplines to uncover women's voices, as well as other voices that are often ignored. It includes the recognition that women have different experiences from men and therefore that both their worldviews and their interpretations of social facts differ (Bem, 1993; Flax, 1987; Gergen, 1988; Harding, 1986; Kramarae & Sender, 1992; Lorber, 1994; Newman, 1985; Nuccio & Sands, 1992; Stanley & Wise, 1983; Zalk & Gordon-Kelter, 1992). Knowledge gained from these experiences tends to be suppressed by patriarchal traditions.

In gender-stratified societies, academia is set in male culture, and thus, men enter this world without a sense of transition. In contrast, women who enter this male-constructed world need to undergo a transition from their own experiences. They are forced to accept the prevailing academic standards of thinking, the objectified knowledge that reflects society's stratified order, and to learn to speak in a borrowed language. They become, to a large extent, alienated from their own experiences in a gendered society. "Most are bilingual: moving fluently between their first and second languages with a generally appropriate application according to the situation" (Weick, 2000, p. 398). To recover their own experiential knowledge, women have to undergo a willful search of and nurture their voices. Their different experiences lead them necessarily to construct alternative knowledge that is based on realities previously unavailable to social study. They also have to recover the voices they lost in their own socialization process to academe, and their colleagues (male and female) may not always support them in their efforts to regain this "first" voice (Weick, 2000). These academicians are not only playing tennis facing the wind

but may face increased gale-force winds when entrenched, dominant perspectives are threatened.

The degree to which efforts to elevate subjugated knowledge have already taken place in the social sciences is notable, forcing a dialogue toward gender integration in the various disciplines. For example, critical contentions have addressed traditional biological accounts of women's nature (Hubbard, 1988), psychological and mental health interpretations (Kessler & McKenna, 1978; Parlee, 1992), theories of moral development (Gilligan, 1982), the image of women in gynecological medicine (Fisher, 1987; Scully & Bart, 1973), the invisibility of women in historical analysis (Scott, 1988; Smith, 1979), and the patriarchal frame of historical accounts (Jansen-Jurreit, 1982; Lerner, 1986). They have also discussed the failure to incorporate women's work in national and international economic statistics (Waring, 1990, 1992), the predominance of male metaphors in biological theorizing (Keller, 1985), the marginalization of women's issues in sociological theorizing (Farrell, 1992; Johnson & Frieze, 1978), and patriarchal family conceptions (Zinn, 1992). Likewise, they have addressed the restriction of definitions of political activity (Jaquette, 1992; Lewis, 1992; Macaulay, 1985), the gender-selective use of deviance and control (Figueira-McDonough & Sarri, 1987), the male-centric position in marital adjustment (Long Laws, 1972), the use of welfare policy to reinforce gender and racial stratification (Abramovitz, 1988; Dinerman & Faulkner, 2000; Quadagno, 1994), and the pervasive use of gender stereotypes in anthropology (diLeonardo, 1991). These efforts represent a theoretical revolution to bring gender democratization to the construction of knowledge.

In social work, academicians who are concerned about the inclusion of women's issues in social work curricula are probably familiar with the diverse visions of how to achieve it. Some authors have concentrated their efforts on designing more women-focused courses, others have argued for the insertion in all courses of sections dealing with women's issues, and some have argued for closer ties with women's studies departments (Bricker-Jenkins, Hooyman, & Gottlieb, 1991; Brook &

Davis, 1985; Davis, 1994; Hanmer & Stanham, 1988; Hooyman, 1994; Langan & Day, 1992). Still others have argued for the integration of gender across the social work curricula (Carter et al., 1994; Figueira-McDonough, Netting, & Nichols-Casebolt, 1998).

Although these writings address the same concern—the neglect of women's issues in social work education—the gender-integration group argues that to transform the curriculum to reflect the experiences of both women and men requires a paradigm shift (Bernard, 1987) in which the traditional body of knowledge that claims universality is contested. Simply adding special courses or special sections on women presents women's concerns as exceptions or deviant cases from the general theoretical and practice principles that are being taught and hence further marginalizes or ghettoizes women's knowledge. This ghettoization allows programs to retain the status quo in their curricula and to consider that the presentation of women's courses has achieved the mandate for including content on women. However, the theories and derived practice models are not altered, and women's issues become an addendum to the body of dominant knowledge (Smith, 1987). This state of affairs is untenable in view of the fact that more than half of humanity is female.

The integration of gender-centered studies in all courses, not as an addendum but as an alternative explanation, is the only way of expanding partial theories and critically evaluating their claims of universality. The process of gender integration through critical evaluation is intended not only to include women's ways of knowing, which are crucial to a world of female consumers, but to be a strategy for uncovering other forms of knowledge. To uncover these forms of knowledge, however, requires social work academicians to engage in an ongoing dialogue with practitioners whose voices have often been excluded from the construction of knowledge.

THE IMPORTANCE OF DIALOGUE

Practitioners can play a unique role in discovering and interpreting social work knowledge. Weick (1993) contrasted traditional views of a professional as a person who has "privileged and esoteric knowledge" to the concept of the practitioner as "one who seeks to activate, support and honor people's ability to know their own knowing" (p. 395). Unfortunately, there is often a disconnect between the models of change taught at both the micro level and macro level in schools of social work and the experiences of practitioners. Perusing social work practice textbooks, we were struck by the impressive number of taxonomies, graphs, and models they contained. This seemed to be a reasonable way of reducing complex realities so that social work students could begin to learn about the profession. However, reducing complex realities into manageable parts is dangerous when academicians present rarely tested ideal types or prototypes as descriptors of reality (Figueira-McDonough, 2001; Little, 1991).

To the extent that students acquire expertise by accepting models for assessing and intervening in problems, they may be encouraged to disregard or selectively use their experiential knowledge. They then become socialized to theoretical universals to the detriment of their own perceptions of practice realities. This process can leave recent graduates wondering why they just cannot seem to make theory fit their new positions, when what they are discovering and learning in practice can be as important as what they learned in the classroom. However, these newly educated practitioners have been taught not to trust their own experiences. In a sense, they have been socialized to formal educational views of the world and taught not to appreciate fully their own observations when these observations contradict formal teachings.

What an incredible dilemma this socialization causes for social work practice. Skilled practitioners have learned not to trust their own observations but to embrace dominant modes of thinking. Skilled academicians have engaged in the deception because they are committed to preparing students to be

formally grounded in established theories and practice models. Everyone's intentions are good, but collusion has occurred: Knowledge that comes from one's own experience is intentionally ignored so that one's practice can be theoretically driven. The disconnect between the application of often-irrelevant dominant knowledge to real-world situations leaves practitioners feeling a sense of awe for academicians who seem to understand a different world from the one in which they practice, when, in fact, both have conspired to ignore their own experiences and understanding. The skeptical practitioners eventually learn to go with their gut, couching what they do in appropriate social work language and often pretending to have applied established theories.

As we examined proposals of curricular gender integration, we noticed that the impulse to expand knowledge in curricular areas of practice often came from practitioners who were close to the real world and could better assess elements that were missing from their training. These practitioners began to see the discontinuities between what they had been taught as "true" and the realities they faced in practice. Consider, for example, that the innovative community organization material in gender integration was based on uncovered evidence of the extensive role of women in maintaining resistance and solidarity in local communities—what Naples (1998) called "activist mothering" and Stoutland (1997) labeled "stability strategies."

Both Naples and Stoutland are practitioners, one who worked in the War on Poverty and the other who works with a community development corporation. The evidence they uncovered revealed how the history of community organization and identification of change strategies had neglected and misunderstood the roles that women have played in community practice. Working closely with women in local communities, they were able to understand how local activism is shaped by gender location, involving an almost seamless response to work concerns, civic participation, and family obligations. Part of their argument is that women's motivation to participate in community activities is strongly shaped by their family concerns and that collective involvement is a natural extension of

such concerns (Weil, Gamble, & Williams, 1998). The invisibility of the strength of this motivation in poor neighborhoods is the result of a limited analysis that focuses mostly on formal political strategies and social action leadership, both defined within the male sphere. However, as Abramovitz (1996) documented, the history of women's resistance to domination is considerable and is linked to women's roles of defending their families.

Other practice theories and models are also replete with dominant thinking. In human service organizations, the traditional goal has been to transform consumers as raw material to be changed (Hasenfeld, 1992). Change is defined according to therapeutic models that reinforce socially sanctioned consumer roles. The expert defines what needs to be changed by defining (diagnosing) what is wrong with the consumer, interpreting and shaping the consumer's life toward socially desirable adaptation. Within this context, the consumer is expected to be "submissive, dependent and . . . feminine" (Threthewey, 1997, p. 282). To a large extent, organizational and professional discourses reinforce the powerless status of the consumers, labeling consumers as incompetent and compelling them to adapt to their marginal position (Cloward & Piven, 1974; Reisch & Wenocur, 1986).

This attempt to mold consumers is aptly illustrated in Threthewey's (1997) insightful description of a social service organization that was designed to assist low-income single parents in obtaining education and job training to become independent of welfare. Threthewey's analysis found evidence that in spite of the forces that denied consumers' self-determination, consumers actually displayed a variety of forms of resistance that did not necessarily deprive them of badly needed resources but allowed them to keep their affirmative identities and even modify their interactions with caseworkers. Consumers resisted the psychological interpretation of their lives, established boundaries to prevent the invasion of their privacy, chose modes of interaction, broke rules on the use of resources, used humor to reverse roles, and complained.

Threthewey's (1997) case study also highlighted the various levels of constraints that may distort professional performance from its own principles: (a) constraints set by the organizational structure and culture (see also Lipsky, 1980; Vinzant & Crothers, 1998) and (b) those set by practice models at the service of the organization's goals. Both types of constraints, in turn, are upheld by utilitarian purposes that are at odds with social work's core principles of self-determination and social justice. Utilitarian purposes may seem more efficient in getting things done, but in being efficient organizational leaders, they may begin to assume expert roles and not hear the diverse voices of line workers and consumers. Such principles as self-determination and social justice imply that diverse perspectives, needs, and experiences are recognized, which takes more time than just applying often-used models to every practice situation.

In all areas of the social work curriculum, there is likely to be evidence of how practitioners' insights could extend the development of social work knowledge. Although it could be argued that the Council on Social Work Education's requirement of 2 years of practice prior to teaching in a school of social work would serve to bring practice experience into the classroom, there are obvious limitations to this strategy. Even if all social work academicians have met this requirement, the experiential knowledge acquired will soon be dated. For example, the experiential learning of a professor who was tenured in 1999 is the social context of 1993, before welfare reform, the anti–affirmative action movement, the recent growth in underclass settlements (Jargowsky, 1997), and the restructuring of local politics (Schneider & Netting, 1999). The problem will be further aggravated for the professor whose practice experiences may date from the 1960s or 1970s. In sum, the context in which social workers work has to be continuously updated because a variety of dimensions affects the lives and interpretations of both practitioners and consumers.

It is in this context that we consider the contribution of practitioners to social work education. Academicians must be able

to hear what Weick (2000) called "hidden voices." Because academicians have chosen a

> dominant voice as the official voice of the profession, social work has let slip through its fingers the language that fills its veins with the fullest expression of human services and that most essentially gives social work its distinctive character as a profession. (p. 400)

STRATEGIES FOR FREEING SUBJUGATED KNOWLEDGE

Nichols-Casebolt, Figueira-McDonough, and Netting (2000) discussed a variety of strategies that are designed to effect change in social work curricula. Although their discussion is relevant in delineating processes for achieving gender integration in social work teaching, it did not specify the role of practitioners in the construction of professional knowledge. The academic world needs to understand the constraints of policies, organizations, and practice models on services to consumers as they are experienced and interpreted by practitioners. A dialogue must be established such that practitioners can share their experiences that may deviate from theoretical predictions and academics can use those experiences to correct or modify the theories and models. How can it be done?

Engaging Academicians and Practitioners as Coteachers

Academicians can develop meaningful roles for practitioners in the classroom. Certainly, inviting guest speakers into the classroom is not a new idea, but the point is that these practitioners can be viewed as colleagues in the learning process. For example, in a planning and administration course in a large urban university, practitioners who direct agencies in the local community are invited to serve on budgetary hearing panels. The students develop program plans, and practitioners are the audience to whom the students present their final products, arguing that their budgets are feasible and reasonable.

Practitioners serve on panels in which they use their real-life experiences to ask the students questions. They share the responsibility for grading the students with the instructor, provide written feedback to the students, and debrief the class about their impressions and experiences. For these sessions, they become coinstructors, and because there are typically four different panels of three persons each, as many as 12 practitioners share their knowledge and expertise with the students over two 3-hour class sessions.

In another example, faculty members at the same university were paired as coteachers with practitioners from the local area in a course on interdisciplinary teaming. The message this coteaching experience gave to the students was that both academicians' and practitioners' voices are important. Assignments also centered on observing and analyzing the interactions of members of interdisciplinary teams in various health care settings. Not only were these assignments grounded in practice environments, but the grading of the analyses revealed tremendous insights from the practitioner member of the teaching team that often challenged some of the models being taught in the course that had been developed by academicians. Therefore, the grading process itself became a learning experience for the instructors as well as for the students.

**Meeting Practitioners and
Consumers in Their Environments**

The concept of guest speaker has also been applied to consumers who are occasionally invited to share their struggles and personal journeys with a class, but this experience is often voyeuristic because students look on. To engage consumers fully in the classroom experience means that academicians and students are able to hear the messages and voices without interpreting them solely through the lens of dominant theories. Therefore, instead of always bringing consumers into the classroom, one strategy is to bring the classroom to consumers.

Several years ago, one of us brought her class to a mental health facility in the heart of the city, so the students could meet

consumers on their own turf. This proved to be a humbling experience as the students and academician experienced the environment in which the consumers spent their daily lives, met with staff members who felt comfortable in their own settings, and heard about how it feels to live and work in such a mental health institution. The environment was no longer academic, and the consumers' and staff members' words were couched not in academic language but in the language of their world.

Connecting Academicians, Students, and Field Instructors

The field practicum is an integral part of the social work curriculum. All schools of social work develop a network of field placements for their students in which the students are supervised by practitioners, and the local agencies eventually hire a large proportion of them after they graduate. Schools of social work are in a privileged position of having access to groups of practitioners. There are models of field instruction that can be used to facilitate the dialogue between practitioners and academicians. One such model is the use of faculty members as field liaisons, in which all faculty members carry a field load as part of their required teaching responsibilities. It has been our experience that this is an excellent way to connect academicians, students, and practitioners. When faculty members make field visits to local agencies, they are exposed to the cultures of these organizations, and because they are simultaneously teaching in the classroom, they can have candid conversations with field instructors and students about the fit between what is being taught and what is actually occurring in the practice setting. If faculty members can hear the voices of students and practitioners in the field, there is great potential to bring this subjugated knowledge into the social work classroom.

However, we contend that access to field agencies is not currently well used as a source of the type of knowledge expansion identified in this article. Links between schools of social work and practitioners appear to follow standard requirements of exposing students to certain practice experiences, of timely

supervision, and of evaluations of students' performance. Often, schools offer courses to students in the field to help them integrate their experiences with the practice models learned in class. Although these courses could constitute a great opportunity to engage in the critical evaluation of practice knowledge, a review of assignments suggests that the purpose is more likely to attempt to fit field experiences with practice models that are learned in class. In short, we suggest that if the fit does not work, alternative theories and practice models may need to be introduced into the curriculum. To a large extent, the disjunctures between students' experiences and practice theory and between supervisors' demands and students' training are not always taken as an opportunity for the critical assessment of different perspectives and possible insights for generating alternative forms of knowledge.

Increasing Practitioner-Academician Collaborations

We are encouraged by professional journals' attempts to give voice to practitioners. The October 2000 issue of *Social Work*, for example, featured a number of articles on how social workers struggled with the tensions between their formal education and what they encountered in actual practice with consumers (Kanuha, 2000; S. M. Rose, 2000; Sternbach, 2000). In addition, millennium projects reported in the *Journal of Social Work Education* underscored numerous ways to connect practitioners with academics. For instance, Dietz (2000) developed a curriculum outline that was designed to elevate subjugated knowledge in the clinical sequence. This trend is evident in interdisciplinary journals as well. For example, the entire March 2000 issue of the *Nonprofit and Voluntary Sector Quarterly* was devoted to "authority, legitimacy, voice, and the scholar-practice question." Feeney (2000), the guest editor, stated that the journal was attempting to "respond to practitioner outcries of marginalization and their pleas for understandable, accessible, and relevant research" (p. 5).

Another strategy, therefore, is for academicians and practitioners to collaborate beyond the classroom and field setting.

Engaging in joint research projects, developing conference presentations together, and coauthoring articles are all ways to learn from one another. It has been our experience that the learning that comes from having to put together an article or participate in a jointly inspired research project elicits numerous opportunities for colearning. Ultimately, types of action research in which consumers and practitioners join with researchers are additional ways in which the new knowledge can emerge as all the participants engage in collaborative learning. An excellent example of such a collaboration is the book on women's poverty *For Crying Out Loud*, edited by Dujon and Withorn (1996), which includes chapters by welfare recipients, former recipients, practitioners, and academicians.

CONCLUSION

We propose that the development of knowledge that will bring professional activity closer to professional principles must include the input of practitioners who deal with organization-therapy-consumer tensions. In relation to the academic world, practitioners fit the criteria of double vision defined by Collins (1991). They have been trained in the dominant social work knowledge and, at the same time, have to deal with a world that does not quite fit the models of intervention they have learned. In fact, they are often in a contradictory position in which, given their low organizational position, their knowledge is being subjugated, while as experts they may, in turn, be subjugating the knowledge of their consumers.

An open dialogue among practitioners and academicians in related fields that focuses on the gaps they perceive between the practice theories taught to students and the work they have to do may contribute to curricular reform. Such a dialogue may also expand professional definitions, interpretations of problems, and alternative interventions for practitioners. The possible outcome would be a two-way learning process, in which academicians may consider new elements that have not been integrated into the theories they teach or the research they are

pursuing and practitioners may imagine new forms of intervention or the need to change the constraints to their work. Because practitioners are in direct contact with consumers, especially those who share the same gender and minority backgrounds, they may be able to transmit consumers' interpretations of their situations and the forms of resistance the consumers use. Insights into consumers' interpretations and resistance can inform alternatives for social work intervention. In this process, it is important to recognize that the most subjugated knowledge of all belongs to consumers, for even practitioners and academicians who attempt to listen to what consumers have to say may not fully recognize the import of the underlying messages. Central to this process of critical mutual influence is that whichever models of teaching and action emerge, they must meet the standards of client self-determination and social justice. As Wakefield (1988) argued, it is these social work principles of self-determination and social justice, rather than specific modes of intervention, that differentiate social work from other human service professions.

Our call for the inclusion of practitioners' "ways of knowing" in the construction of social work knowledge does not assume that practitioners automatically can contribute insights that will expand social work knowledge. In fact, we know many female practitioners who have internalized the male model of "efficiency," the dominant construction of standards, and the distrust of explanations derived from subjugated knowledge. However, we also know that many practitioners, both female and male, agonize in their everyday work about the contradictions of professional means and ends and often bend rules that go counter to their interpretation of consumers' needs.

We hope by now that we have convinced the reader that there is a need to increase the dialogue between academicians and practitioners so that both can contribute to the education of future generations of social workers. As academicians, we recognize that academia has contributed to the subjugation of women's knowledge and that academicians need assistance from practitioners to uncover this subjugation as it occurs in the

policy, organization, and community arenas in which they practice daily.

However, social work academicians need to do more than fit women's realities in academe with diverse realities among women practitioners and consumers. They need to recognize the context of practice. A starting point is to reexamine the nature of how academicians interact with the incredible resources of practitioners who are at their fingertips—current and future field instructors. Faculty members have often looked to these practitioners to test the winds of policy change (how managed care is being implemented, what is happening in welfare reform, how a particular population group is faring, and so forth), but they have not always looked to practitioners as colleagues to help in the critical examination of the theories and models that are taught and to collaborate on research and writing projects.

Does what academicians teach fit with the lived experiences of consumers? With the experiences of seasoned professionals in the field? For true integration into the curriculum and for continuing integration into the practice lives of the next generation, academicians need to hear the voices of consumers and practitioners. Only then can they change the curriculum in a way that prepares future generations for gender-sensitive social work practice. Only then can they join in facing the strong force of the wind (P. Rose, 1984) that subjugates what women know.

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A Wolf in Sheep's Clothes?
How Welfare Reform May Threaten
Domestic Violence Services

Susan E. Smith

The 1996 welfare reform law threatens the independence and integrity of domestic violence agencies for two reasons: (a) The "work-first" approach may distort their primary mission, especially because victims of domestic violence are at great risk in the workplace, and (b) these agencies can be considered feminist organizations. To protect the agencies' organizational integrity and quality of services, administrators, advocates, and researchers need to work toward three goals: to legislate the primacy of the safety goal, reevaluate available funding streams, and minimize competition and maximize collaboration and participation.

Although the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 makes more federal money available to providers of domestic violence services, the money comes with strings attached. Before advocates and service providers count their marbles and go home, the benefits of federal financial support must be weighed against two potential costs—devolved spending and organizational integrity. The first concern is related to devolution in general, whereas the second concern is tied to the particular impact of devolved funding streams on domestic violence, and all women-centered, service providers.

This article considers the consequences of PRWORA for providers of domestic violence services. The term *welfare reform* refers to three important changes. First, states now receive grants of a fixed amount and are allowed more latitude in designing particular sets of programs to meet caseload-reduction goals. Second, most adult recipients are subject to time-limited benefits and are compelled to work. The third change is related to the first two: Additional federal money can be used, at a state's option, to offer recipients supportive services to overcome barriers to work. These barriers are categorized by three service areas: mental health, substance abuse, and family violence.

As the first families reach the time limits set for their receipt of welfare, the holes in the safety net beneath them are becoming acutely obvious. Much research is under way to determine the consequences of policy changes on the lives of women and their children. A less discussed area of study, with a substantial impact on the most disadvantaged families, concerns the effect of the changes on the organizations that deliver direct services in communities. Agencies that provide services to poor women and their children are expected not only to fill the gaps left by the withdrawal of federal entitlements but to help women overcome their own barriers to work.

For many women, poverty is caused, exacerbated, or prolonged by violence (Davis, 1999). Work is often difficult for women in current or recent violent relationships because violence is associated with tardiness and frequent absences and because victims suffer from low self-esteem, depression, and anger (Sachs, 1999). Providers of domestic violence services have traditionally functioned to protect women in violent relationships by offering temporary housing, legal advice, emotional support, and often public-assistance referrals for temporary financial support. Many service providers are expanding their services to include job placement and work-readiness training because welfare departments now contract with domestic violence agencies as part of welfare reform, with the

aim of helping victims of domestic violence become economically self-sufficient.

In the area of domestic violence services, nonprofit agencies had been operating without federal support, and many without state or local support, for most of their histories. It was not until the passage of the Violence Against Women Act of 1994 that most emergency shelters or other service centers received federal support. Shelters were typically funded by a combination of support from foundations, local government grants, private donations, and user fees. These agencies, formed primarily by coalitions of women who were tied to feminist organizations, were able to maintain less formalized, more consensual organizational styles than traditional service agencies. The 1994 legislation provided federal and state money to offset the costs of shelters and services. Then, under pressure from women's advocates, the 1996 welfare reform bill was amended (the Wellstone-Murray amendment) to enable states to keep women and children safe during the welfare-to-work process by allowing battered women who receive Temporary Assistance to Needy Families (TANF) more time and specialized services (Brandwein, 1999). Since 1999, hundreds more agencies have entered into governmental contracts as a result of the Wellstone-Murray amendment to PRWORA. Each state must decide whether to accept the family violence option (FVO) funding. In California, counties may also decide whether to make use of FVO funding. The state of California and Los Angeles County opted to accept the option, but nine counties in California do not assess TANF recipients for the risk of family violence.

This new funding does not simply fund existing services; it requires something new from agencies: welfare-to-work training. In addition, agencies that choose to contract with public welfare organizations to make use of federal welfare-to-work money may be forced to formalize and centralize particular functions. These potential changes are the concern of the remainder of this article.

DEVOLVED SPENDING

Devolved spending refers to a change in the funding stream and is related, in substance and theory, to the privatization of services. In traditional patterns of funding, legislated in 1935 by the Social Security Act, funds went from the federal government to the states and then to the appropriate regional or county departments.

Devolved spending, redefined as PRWORA, replaced the Social Security Act as the legislative authority over welfare, reducing the role of the federal government while increasing the oversight function of states and localities and adding the local agency to the funding stream. Thus, funds now go from the federal government to the state government to the designated department to the local agency.

The assumption behind this shift is that private agencies are better equipped than are public agencies to offer responsive services. Overall spending is reduced because private agencies are expected to be capable of providing better services at a lower cost. It is not simply that funding details and programmatic discretion are devolved to states and counties; open entitlement to social programs is no longer federally guaranteed. If a state has greater human need than it can support, the state has the responsibility (or opportunity) to develop innovative programs to manage the problem. Federal mandates are loosened to allow states and localities to use discretion and innovation to address their particular economic and social circumstances.

DEVOLUTION MEETS THE FEMINIST ORGANIZATION

Nonprofit agencies now serve as "third-party government," delivering the majority of services that are administered by states or counties and funded by the federal government (Salamon, 1994). This interdependence reflects both the reliance of nonprofit agencies on governmental support and how disadvantaged people in this country depend on the programs

and services of these agencies. A cut in governmental spending is, by definition, a cut in funding to the nonprofit sector. The government and nonprofit agencies are not in competition; their responsibilities are separate. They grow or shrink, evolve or devolve, together.

Agencies that provide domestic violence services are no different from other nonprofit agencies, except that they have historically been funded more by localities than by the federal government. Cities, as funders, require less formality and accountability; the funding process is less time consuming and outcome driven. As a result, the woman-centered, consensual structure of battered women's shelters has not been as threatened by the formalizing pressure of external funding as has the structure of other nonprofit agencies (Leidner, 1991).

There are two reasons why welfare reform threatens the independence and integrity of providers of domestic violence services. First, these agencies may have difficulty maintaining their primary focus on the safety of women while being subject to welfare-related work requirements. The "work-first" approach of counties and states may distort the primary mission of service providers, especially because victims of domestic violence are at a great risk in the workplace (Freudenheim, 1988; Gelles & Cornell, 1985; Raphael, 1996; Zorza, 1996). For example, one study (Moore & Selkowe, 1999) found that more than half the battered women had been threatened to the point that they were afraid to go to work or school.

Prior to welfare reform, agencies would have evaluated themselves on one principal outcome—protecting women from violence. Adding the component of work requires agencies to integrate the goal of moving women into jobs. Because the safety of battered women is compromised in the workplace, the goal of moving women to work may actually contradict the principal functions of agencies.

The second reason it is particularly important to study agencies that provide domestic violence services is that many of these agencies stem from nonhierarchical traditions. Battered women's shelters, like rape crisis centers, grew out of the women's movement of the 1970s and proliferated in the 1980s.

The number of shelters increased as awareness about battering heightened. These organizations form the seminal foundation of knowledge on nonhierarchical, feminist organizations. Although other types of service providers were formalizing during the 1980s and 1990s in response to more complicated funding mandates, these woman-run organizations maintained more consensual-model organizational structures in spite of external pressures to formalize.

Providers of domestic violence services should be concerned about their potential vulnerability to the mandates involved in receiving federal funds. The success of advocates in getting the FVO option attached to welfare reform is beyond reproach. Certainly, women who are raising children in violent homes need public help to move to safety. This help should rightly include additional time to prepare for work, as well as individualized services to promote the women's safety. Without the Wellstone-Murray amendment, domestic violence survivors who needed welfare would be moved directly into job searches with no accommodations for their physical or emotional needs. Still, implementation of the FVO option raises two important concerns for women-centered organizations. The first pertains to the work-first bias of welfare reform, and the second is a consequence of the inherent competition in the structure of devolved funding streams.

Safety Versus Work

How will organizations and their employees adapt to the welfare-to-work activities mandated by the PRWORA? Organizational theorists have devoted much thought to the strain posed by ambiguous or conflicting goals on the functioning of systems. Unclear objectives have particularly plagued public agencies that are struggling to respond to multiple and conflicting mandates. Some theorists have gone as far as to credit ambiguous goals with discrediting the institutions that provide the majority of public services in social work, corrections, and mental health (Lipsky, 1980).

Every new layer of funding modifies (at best) or adds (at worst) goals and objectives. If these new outcomes are inconsistent with those that already exist, conflict or ambiguity can result. Providers of domestic violence services should be particularly wary of this risk, considering the substantial contradiction between the goals of protection and work. Success in achieving the work goal could derail the protection goal, considering the danger that battered women face at work. Whereas the FVO option actually allows women in violent relationships more time before work is required, service agencies that are under contract with counties or states to offer services must begin work-centered activities immediately.

Early in the legislative process, advocates for women were actively involved in minimizing the negative consequences of welfare-to-work mandates on domestic violence survivors. These women often lack work experience; for example, one study found that one third of the women who were surveyed reported that their batterers had prevented them from working (Shepard & Pence, 1988). Advocates also feared for women's safety in the workplace; for instance, Raphael (1996) found that more than 70% of employed battered women reported that their abusers harassed them at work.

The most critical aspect of ambiguous goals is related to evaluation. For domestic violence service agencies, funders have primarily been concerned with the number of women served and the nature of programs offered. For agencies that are now offering services under public contract, an added focus of accountability is the successful movement of women into work. Federal support, unlike funding from less formal sources, includes a mandatory evaluation component. The lesson from child welfare and family support is that this mandatory evaluation must encompass measurable outcomes. Gathering data on these outcomes requires the fuel of bureaucracy, hierarchy, and additional paperwork. As Hawley (1968) stated years ago, in classic organizational theory "organizations receiving resources tend to mimic the structures of the organizations from which the resources come" (p. 334).

Conflicting goals and nonrational bureaucratization put agencies at risk of having problems implementing new programs. According to Lipsky (1980), "One can expect a distinct degree of noncompliance if lower-level workers' *interests* differ from the interests of those at higher levels, and the incentives and sanctions available to higher levels are not sufficient to prevail" (p. 17). Although administrators may be compelled to change forms and formalize procedures to avoid losing their public contract, frontline workers in an agency who are implementing the changes may feel differently. The administrators may require the workers to make appropriate referrals for skills training and mental health services, but the workers need to believe that these services are in the best interest of their clients.

The internal conflict that may result from the formalization associated with public funding is particularly relevant to feminist organizations that are rooted in a cooperative, consensual tradition. These organizations, with a tradition of fluid authority, ethics-based rules, and personal social relations, feel the impact of formalization and centralization more profoundly than do hierarchical agencies (Iannello, 1992). The cost to workers and to the climate of the organization as a whole must be weighed against the benefits of having a relatively stable funding source.

Collaboration or Competition?

Devolved spending threatens feminist models of organizational functioning by increasing the extent to which all nonprofit agencies must rely on, and compete for, external funding. Even without welfare reform, the funding climate has affected providers of domestic violence services. PRWORA may have particularly dire consequences for these agencies and for many poor women in violent relationships. Although more money is now available to selected service providers, tight-knit referral networks may be threatened by competition between agencies over scarce funds, coupled with the increased demand for services by battered women as welfare funds shrink.

Collaborative structures have already shown strain in Los Angeles County. Prior to the competitive process for obtaining California's welfare-to-work (California Work Opportunity and Responsibility to Kids [CalWORKS]) FVO money, 25 emergency shelters for women operated in the county. These shelters maintained shared referral networks, served on a common task force, and were the most effective lobbying group in ensuring that family violence services were funded by the state and county. Because not all the original 25 agencies were funded by the county, relations within and among organizations became strained. What was once a collaborative network that functioned for the good of clients became fragmented and competitive.

This strain was also evident in a study of the impact of welfare reform on the functioning of service agencies in Los Angeles (Smith, Patti, & Absey, 2000). The agencies reported that although collaborative activity was up, so was competition. Many more agencies had staff involved in task forces and collaborative activities, yet they also thought that information was not shared equally and that funding opportunities were not equally available. The agencies benefited from lobbying efforts in opposition to welfare reform in the mid-1990s, in that their representatives met those of other service providers and worked toward a common goal, but the structure of devolved funding has put them in much more direct competition with their colleagues.

STRUCTURE, NOT IDEOLOGY

Although this discussion assumes that organizations that provide domestic violence services are rooted in feminist theory, an organization need not be feminist for the arguments presented here to apply. What is more important is that the agency operates from some derivative of a consensual model. How devolved spending, such as the case of welfare reform, is potentially threatening to consensual organizations, feminist or not, is explored later in this article. The connection is that domestic

violence agencies are likely to be consensual because they are feminist and are likely to be involved in welfare reform because the FVO option exists.

Most, though not all, organizational theorists consider a consensual, democratic structure to be indicative of feminist organizations. Although feminist organizations may not be inherently nonbureaucratic, feminist theory dictates a cooperative workplace with shared power (Leidner, 1991). There are multiple definitions of a feminist organization, but they share core concepts. A feminist organization is prowoman, political, and socially transformational. It is an organization in which the work that is done in one way or another builds and strengthens the women's movement—leading to fundamental changes in the society (Freeman & MacMillan, 1981). Yancey Martin (1990) recognized greater variance in defining a feminist organization by identifying five diagnostic criteria. According to her definition, an organization is feminist if it has any one of the following attributes—(a) a feminist ideology, (b) feminist guiding values, (c) feminist goals, or (d) feminist outcomes—or if it was founded as part of the women's movement. By this definition, most, if not all, domestic violence organizations can be considered feminist organizations.

Some agencies provide services that are related, but not fundamental, to domestic violence, such as mental health services, substance abuse treatment, legal or housing assistance, and skills training. Others may be inherently non–woman centered, such as those that treat batterers. These agencies will experience different benefits and costs from welfare reform, compared with woman-centered agencies that were founded and operate from a feminist perspective (or any other agency that is structured according to a consensual model). The impact of welfare reform, though, is particularly pernicious for organizations that are defined by their nonhierarchical structure. These organizations are most distanced from bureaucratized, competitive operations.

Since Weber (1957) first discussed organizations by defining hierarchy in terms of bureaucracy, the definition of a hierarchical organization has been expanded to include three other

dimensions: the degree of specialization in the division of labor, the extent to which communication is centralized, and the presence of nonegalitarian leadership (Iannello, 1992; Scott, 1981).

Conversely, consensual organizations can be defined across seven dimensions (Iannello, 1992):

1. Authority is fluid, temporary, and negotiable.
2. Rules are minimal and based on ethics.
3. Social control is not an issue because of the homogeneity of the employees.
4. Recruitment and advancement are achieved via friendship networks.
5. Money is secondary in the incentive structure.
6. Social stratification is egalitarian.
7. Differentiation between jobs is minimal.

The extent to which an organization is consensual, whether or not it is feminist, is likely to portend its vulnerability to competitive, devolved contracted funding.

Organizations should be advised to assess their own potential "handicap" in the face of devolved TANF funding streams. Organizations that are characterized by all seven dimensions of consensual organizations face the greatest costs in accepting this new money. Those that offer domestic violence services but have few characteristics of consensual organizations will be less threatened by the new funding climate. But, warning organizations that are at the greatest risk is not enough; changes in federal, state, local, and organizational policy are required. Some specific proposals follow.

MAKING IT RIGHT

As service providers navigate the bureaucratic landscape of welfare reform, their attention is focused on understanding immediate mandates and expectations. With input from those who administer programs, as well as street-level workers, advocates, policy makers, and researchers are positioned to

turn their attention to reforming the current system to protect nonprofit agencies and their clients. Four areas require attention.

The most immediate area is the need to legislate the primacy of the safety goal. Although the Wellstone-Murray amendment allows states to exempt individuals from most welfare-to-work mandates for as long as necessary, it does not require states to comply with this exemption. States are free not to offer special considerations to welfare recipients who have been victims of domestic abuse. By the end of 1999, 11 states made no provision for domestic violence (Sachs, 1999). Even within states, counties may decide not to assess recipients' risk of violence.

Women's safety in the workplace is directly linked to welfare-to-work mandates. Regulating the work attachment of women is a common aspect of violent relationships. Batterers are more likely than not to harass their partners who do work. Furthermore, welfare has traditionally been a tool that women have used to transition from their violent homes to safety. Research on women, violence, and welfare has made clear that it is necessary to screen women for safety before they are compelled to work or do community service.

In addition to the concern for women's safety, legislating the primacy of protection from violence benefits organizations. The goals and objectives of domestic violence service agencies must be consistent with their providers' missions. The agencies' commitment to protecting women is compromised by a stringent work mandate—a conflict that has negative consequences for both the agencies and for individual workers. Researchers can aid administrators by determining whether domestic violence service agencies with public welfare-to-work contracts become more centralized after contracts are initiated. It is also necessary to understand the consequences of centralization and other structural changes on the climate and services of agencies.

Until agencies are able to ensure the safety of battered women, administrators may be wise to reevaluate available funding streams. Although the Wellstone-Murray amendment makes available much-needed resources, the cost for agencies

may be too high. Agencies that opt to take advantage of federal support must pay special attention to potential changes in their goals and objectives. Because street-level workers may be in the best position to determine how new procedures should be implemented, the failure to seek input from them may jeopardize the implementation of any changes. Administrators should be particularly sensitive to their reliance on frontline workers to gather new data. The goals of these workers must be consistent with those of the administrators if implementation and evaluation are to be successful.

The decision whether to seek or continue a public contract should be based, at least in part, on what the contract requires the agency to evaluate. Will the contract require the agency to evaluate its success on an outcome that is inconsistent with its service objectives? For instance, instead of measuring the number of clients served, will the agency move toward counting successful job placements? These types of changes guide the day-to-day functioning of an agency, from the volume and complexity of the paperwork to the ways in which the staff are evaluated and promoted.

Finally, community networks can be structured to minimize competition and maximize collaboration and participation. The standard model for funding privatized, devolved programs is for the federal government to pay a state, which then pays a county. Then, local agencies respond to the county's request for proposals by opening the process to competitive bidding. The best way for agencies to control this process is for them to organize into collaboratives and decide among themselves how funding should be distributed. In economic development, this technique has been used by community development agencies to divide funds from Community Development Block Grants. Agencies may decide to divide their county into service areas, with each agency serving a particular area. They may share an evaluator, use common forms, and take advantage of their particular strengths to offer expanded services. The county can then negotiate with the collaborative, so that the agencies are not positioned in opposition to each other.

The positive side of devolution is that communities may have expanded authority and flexibility in dealing with their particular struggles. Local responsiveness can enhance, instead of threaten, the cohesiveness of communities as long as community institutions are not pitted against each other in competition for scarce resources. A key to the empowerment of communities is for the agenda to be controlled at the local level. Nonprofit agencies can assist in this effort by making sure that their internal goals and objectives are driven by their missions, instead of in response to funding opportunities. Providers of domestic violence services, in particular, are part of a social movement as well as the nonprofit community. Their commitment is rooted in the realignment of power. The era of welfare reform offers particular challenges, some of which may be disguised as opportunities. The wolf may be well disguised.

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"Sitting With the Sick": African American Women's Philanthropy

**Iris Carlton-LaNey, Jill Hamilton,
Dorothy Ruiz, and Sandra Carlton Alexander**

This article traces the historical development of informal and, to a lesser extent, formal health caregiving among African American women from slavery to the Great Depression. "Sitting with the sick," a metaphor for myriad services, including preparing meals for, housekeeping for, feeding, bathing, and generally visiting with people who are mentally or physically ill, injured, or grieving, has been an important aspect of social support among African American women for centuries. Implications are presented for practice and ways to enhance the health caregiving role using the historical record as a guide.

African American women have historically contributed an abundance of rich resources to meet the health care needs of their communities. "Philanthropy among friends" was the central theme of their work. Although they gave money, when possible, the usual large-scale financial contributions do not adequately incorporate the range of their philanthropy. Specifically, early African American mutual aid, a reflection of the philanthropic spirit, involved services to widows, orphans, the aged, and the sick. "Sitting with the sick," a metaphor for myriad services, including preparing meals for, housekeeping for, feeding, bathing, and generally visiting with individuals who are mentally or physically ill, injured, or grieving, has been

an important aspect of social support among African American women for centuries.

Aspects of the benevolent act of sitting with the sick changed throughout the years as African Americans became better educated; migrated to urban centers; and gained more economic, social, and political power. Although the services provided became more sophisticated, comprehensive, and focused, the basic tenets of sitting with the sick changed little. Although women in the community continued their individual practice of visiting and serving the sick, they further developed and fine-tuned their efforts through group activities such as hospital auxiliaries, mission societies, church organizations, and women's club projects. Essentially, sitting with the sick was women's work, and women of all socioeconomic classes took an active role in caring for their sick family members and neighbors (Salem, 1990).

Moreover, African American women's philanthropy and self-determination encompassed a sense of social responsibility, which was inspired by religious devotion and the need for group survival. This sense of social responsibility embraces what Brown (1993) called a "womanist theology." The term *womanist* is based on the African American cultural expression "womanish." It is unlikely that the women discussed here would have referred to themselves as feminist, but they may have embraced womanism as "God's will" and as a better way to identify their commitment to the community. A womanist theology attempts to articulate "the significance of God's movement in human history from the vantage point of Black women struggling for survival and freedom" (Brown, 1993, p. 1276) and is a theology of survival and liberation. According to Brown, it identifies the wisdom, values, and traditions that these women have passed down as they have worked to foster the physical, psychological, spiritual, and emotional health of their communities.

This womanist theology highlights African American women's lives as the primary caretakers and transmitters of religion and cultural values (Brown, 1993). Circumscribed by a womanist theology, this article traces the historical

development of informal and, to a lesser extent, formal health caregiving among African American women from the early years in America to the Great Depression. It concludes by discussing implications for practice and ways to enhance the health caregiving role using the historical record as a guide.

SOURCES OF VALUES

Although nurses and physicians were valuable professional resources, lay helpers were highly prized and spent quality time with the sick, significantly increasing the available health care resources in the African American community. Humanistic values and life circumstances helped to shape and concretize these women's roles as community health care providers. These particular humanistic values, which McCray (1980) characterized as the "extended caring" role, can be traced to several sources, including (a) the African cultural heritage, (b) strong religious beliefs, (c) the "caring roles" created by social and economic situations, and (d) a tradition of mutual aid necessary for group survival.

The African tradition of collective responsibility, a cultural phenomenon that survived the Middle Passage, is fundamental to the African American caregiving role. DuBois (1909, p. 9) called attention to this African prominence when he wrote that "there is a distinct nexus between Africa and America" that the careful student should not neglect. Similarly, Sudarkasa (1988) noted that commitment to the collectivity is a product of the African culture that enslaved people recreated in America. She further noted that although the family offered a network of security, it also imposed a burden of obligations—qualities that were critical to group survival.

Emphases on group survival and economic necessity led to the practice of mutual aid, which was a form of resistance for the enslaved, as well as for the free men and women. Contemporary Afrocentric scholars, such as Asante (1988) and Akbar (1979), have said that recognition of African history, culture, and worldview provides the context for understanding African

Americans; from this perspective, the individual cannot be understood apart from others in the social group. Finally, Mbiti (1988) noted that the cardinal point of the African view of men and women can be summarized with the following tautology, "I am because we are and since we are, therefore, I am" (p. 108).

The religious belief system is another critical element that influenced the caregiving behavior of these women. From their strong religious commitment, one of the most pervasive cultural strengths of African Americans (Hill, 1997), has come the impetus for loving and caring for neighbors. J. Jones (1985) noted that newly emancipated African American women wielded a tremendous influence over their neighbors' spiritual lives outside the confines of formal religious organizations. For example, both women and men often eagerly consulted the elder conjurer women and herb doctors whose pronouncements and incantations were believed to be divinely inspired gifts from God.

Economic necessity also contributed to the development and growth of the indispensable roles these women played. Throughout history, health care professionals have been inaccessible or too costly to meet the needs of the African American community. This inaccessibility has often been manifest in an unwillingness to serve African American patients or in a lower level of care than that provided to White patients. The inability to gain access to the better quality care provided to Whites has seriously impaired African Americans' health.

The caregiving role created by economic and social necessity is so fundamental to African American life that it is often reflected in fictional literature. Images of African American women caring for and sitting with the sick can be seen in numerous works and reflect the womanist theology. Two such characters are Big Mama, in Taylor's (1976, p. 5) *Roll of Thunder, Hear My Cry*, set in a small Depression-era rural Mississippi community, the family matriarch who "was good at medicines and people often called her instead of a doctor when they were sick"; and Miss Mattie Jones, an elderly African American woman, in Taylor's (1981) sequel, *Let the Circle Be Unbroken*, the

prototype of the strategic healing woman who nurses two boys who are ill with "the fever" and have been unjustly jailed.

Other fictional characters who take care of the sick appear in works by Naylor. The main character in *Mama Day* (Naylor, 1988) is a conjurer woman with a great deal of community status, who uses her gift mainly for healing. Miss Mattie Michael, the central figure in *The Women of Brewster Place* (Naylor, 1982), helps a woman deal with the grief of her abortion and the electrocution of her young daughter—care that illustrates the multiple roles inherent in sitting with the sick and broadens the definition of *sick* to include the "sick at heart," in this case, those who are grieving.

Finally, as McCray (1980) noted, a tradition of mutual aid and communal spirit is evident in the extended caring role and has provided a powerful impetus for caregiving in the African American community. The communal spirit that existed in slave communities was an enlarged manifestation of kin relationships, a blend of blood ties and "fictive kin" (J. Jones, 1985) that formed and defined patterns of mutual obligation among the slaves. These fictive kin networks shared such resources as folk medicines and healers—conjurers, root workers, herb doctors, midwives, and those said to have "healing hands," as well as ordinary women in the community who understood their interdependence, embraced the concept of mutual sharing, and hence assumed responsibility for sitting with the sick.

SLAVERY AND THE ANTEBELLUM PERIOD

During slavery, the importance of helping others and caring for the sick was tied to the close sisterly bond among slave women, fostered by close residence and life circumstances—a relationship that continues today. Slave women, according to White (1984), formed networks of female cooperation and interdependence. For example, during childbirth and convalescence, they depended on slave midwives or "doctor women," who also treated other members of the slave community. Although

male slaves and professionally trained White physicians some-
times provided health care to ailing slaves, doctor women were
the most popular among the slave community (White, 1984),
and young White women of the plantations sometimes refused
the White physicians' prescriptions, insisting that the doctor
women provide remedies (Fox-Genovese, 1988). These doctor
women commonly began their careers while young, gaining
firsthand experience and knowledge from other slave women
to develop their expertise in the art of healing using a variety of
herbs and roots to ease pain and treat sicknesses
(Fox-Genovese, 1988).

According to slave narratives recorded by the Works Prog-
ress Administration (WPA), during the Great Depression, a
woman who had served as a "nurse" during slavery recalled
being summoned after emancipation to "tend to" her former
mistress who had fallen ill. The former slave recalled that she
did not want to go because the mistress had been so "mean" but
consented because she realized that her skills were needed
(Hurmence, 1984). Believing that their skills were a gift from
God, these healers felt obligated to help those in need. Yet, slave
owners were suspicious that midwives sometimes conspired
with their patients to bring about abortions and infanticides
rather than to see their babies born into the "peculiar institu-
tion" of slavery (White, 1984).

During slavery, some slaveholders kept their slaves in fairly
good health, in an effort to protect their investments (E. Jones,
1923/1978). After emancipation, however, this meager health
care system, which included White physicians and an indige-
nous network of slave healers and midwives, was no longer
available to the newly emancipated African Americans. There-
fore, African American women continued to aid and be aided
by family, friends, neighbors, and fictive kin (J. Jones, 1985).
Essentially, a new system of care, consisting of benevolent and
secret societies of women, rapidly replaced the old one. For
example, in 1875, a sisterhood of African American women, the
United Order of Tents, was formed with the purpose of caring
for the sick and burying the dead (Reaves, 1998). The pro-

pensity of many African American women to organize for the delivery of social services carried over to the Progressive Era.

THE PROGRESSIVE ERA

Although termed the *Progressive Era*, the years 1890 to 1915 were anything but progressive for most African Americans who still resided in the rural South. During this time, segregation laws negatively affected the living conditions and health status of most African Americans. The "Black codes" or "Jim Crow" laws promoted disenfranchisement, restricted access to public accommodations and retail establishments, and severely limited access to health care (Rouse, 1989). The small percentage of African Americans who moved to urban areas in the South and North in search of better jobs and living conditions generally did not fare any better than did their counterparts who remained behind on farms and in country towns (J. Jones, 1985). In rural areas, as in urban areas, the living conditions of the majority of African Americans were affected by their low-wage jobs as domestics and field hands.

Some White Americans believed that the poor living conditions and high morbidity and mortality rates of African Americans were the result of immoral lifestyles and the lack of attention to cleanliness and personal hygiene (Gamble, 1989). In reality, however, these risk factors made African Americans more vulnerable to disease. Illnesses, such as pneumonia, pellagra, tuberculosis, and syphilis, increased mortality rates among African Americans and supported the notion that they were racially and biologically inferior and, as one insurance company predicted, likely to be extinct by the year 2000 (Byrd & Clayton, 1992; Gamble, 1989).

With life expectancy rates as low as 32 years for African Americans, compared with 49 for Whites in 1900 (Byrd & Clayton, 1992), the future probably did appear grim for African Americans, especially because few health care resources were provided to them as part of public policy. In addition, some

White physicians refused to treat African Americans when they became ill, holding tenaciously to the idea that their biological inferiority made such treatment futile (Gamble, 1989). Moreover, the medical establishment limited the number of African American physicians and nurses who could have provided health care to this population by denying African Americans access to medical and nursing schools (Smith, 1995).

In response to the poverty, racism, and inadequate or nonexistent health care for the majority of African Americans during this period, the system of informal support continued. In addition to the support provided by a network of extended kin and nonkin, African Americans pooled the resources of their neighborhoods and communities in an effort to survive. According to J. Jones (1985), in the rural areas where African Americans worked in the cotton fields, African American women and men usually stayed together in family units as they migrated from plantation to plantation to sustain themselves economically. In these kinship clusters, family members cared for each other and shared their material resources to ensure the group's survival. Lacking access to formal health care services, they taught themselves the art of healing and administered home remedies to their sick relatives.

African Americans in urban areas continued the caring and sharing that were characteristic of the small rural communities. For example, those who migrated to Cleveland during this time embraced the "patterns of visiting, reciprocity and familiarity of Southern households," eagerly welcoming visitors from the South (Phillips, 1996, p. 401). Furthermore, surrogate families were created when blood relatives were not available. Older women were easily absorbed into households as fictive grandmothers, godmothers, and aunts to help care for children and the sick. A network of blood relatives also provided support with migration to the cities. The blood ties of these family clans went beyond residential proximity and included the retention of Southern values and kinship traditions and obligations. Moreover, these family networks continued to take care of each other's needs and joined the same churches and social

organizations or secret orders, all of which were necessary to adjust to life in the North and retain ties to the South.

In urban areas such as Chicago's "Black Belt," Williams (1905) noted that secret orders were second only to the church in affecting the social lives of the African American community. She observed that these organizations, which claimed large memberships, took "care of the sick and provide[d] for the dead with a promptness, fidelity and abundance of sympathy that [was] not to be found in any other form of society amongst us" (p. 42). Essentially, "lodges" reflected the sentiments of those communities in their programs, activities, and services.

Numerous women's clubs also made health work their priority (Gordon, 1991). For example, the Colored YWCA in Washington, D.C., built a program around visiting the sick, and the Indianapolis Women's Improvement Club centered its work on the tuberculosis crisis after the Indianapolis board of health, the city hospital, and the Marion County tuberculosis society denied services to African Americans.

Other organizations, such as the controversial but powerful Universal Negro Improvement Association (UNIA), led by Marcus Garvey, embraced care of the sick as part of their benefits to members. The Garvey movement also established the Black Cross Nurses, a female auxiliary of the UNIA, to care for its members and to stand ready to support those who were victims of racist violence (Hill, 1983; Smith, 1995).

Still other examples include African American women's roles in hospital work. For instance, in the early 1890s, the Hospital of the Good Samaritan in Charlotte, North Carolina, was served by the beneficence of poor and middle-class African American women in the community (Carlton-LaNey, 2000). Whereas White women played a key role in founding the hospital and in the regular oversight of its daily workings, African American women assumed the tasks of providing a range of personal services to the sick, such as providing home-cooked meals, a church-sponsored newspaper, canned and preserved fruits and vegetables, and assistance with bathing and feeding.

In addition, visiting nurses provided valuable services in both rural and urban areas. Sleet (1905), a visiting nurse with

the New York Charity Organization Society, observed the importance of visiting the sick in their own homes, describing these visits as "a great opportunity for doing good." Sleet noted that the visits gave her an opportunity to administer to the wants of the patients and "to get in close touch with almost every member of the family" (p. 74).

Girls were trained early in the role of serving the sick. Often, young women who migrated to cities in the North were employed as live-in nurses, which gave them both affordable housing and experience in the informal care of the sick (Phillips, 1996). The church also played a key role in this training. The Epworth League of New York's St. Mark's Methodist Episcopal Church, for example, was composed of girls, aged 7 to 14, who regularly "visited the sick taking them flowers and delicacies" (Griffin, 1905, p. 75).

Churches also provided "old folks'" homes for their sick and needy elders who had no one to care for them, and African American club women were actively involved in establishing many of these homes during the Progressive Era. The club women's involvement ranged from administering the homes to making annual donations of food and money to sponsoring canning day (an annual event to preserve and can enough food to feed the residents through the winter months). The women often assessed themselves annual fees and designated times to visit and "sit with" the inmates of the homes (Carlton-LaNey, 1989b). Whether through formal organizations or individual initiatives, African American women continued the activity of sitting with the sick into the Depression years.

THE GREAT DEPRESSION

Attention to African Americans' health continued to be largely the role of the private voluntary sector during the 1930s. If the federal government assumed a role, it was simply to supplement these voluntary efforts. Thus, African American women created their own " 'new deal' for Black health through community activism" (Smith, 1995, p. 58). Even with African

American women's exhaustive work to improve the health of the African American community, however, the general health conditions of this group remained dire.

In his seminal work *Shadow of the Plantation*, Johnson (1934) stated that the disease-ridden African American community suffered from a number of maladies, including heart disease, stillbirths, tuberculosis, influenza, nephritis, cancer, pellagra, and malaria. He further noted that no list could be complete or accurate because diseases were not adequately diagnosed for several reasons: (a) the poor and insufficient doctor-patient relationships, (b) the general ignorance of disease, (c) the reliance on folk diagnoses and cures, and (d) the high rate of venereal diseases. The inaccessibility of professional health care providers left families in the hands of informal community agencies for handling both sickness and death. These informal agencies and laywomen took their jobs seriously, tenaciously and dutifully caring for their sick family members, neighbors, and fictive kin.

In 1936, Pinky Pilcher, an exasperated southern African American woman, wrote to President Franklin D. Roosevelt seeking WPA-sponsored employment to care for the sick. She said, "I visit my sick people because I feel like it is my duty" (Pilcher, 1936/1972, p. 402). She also wrote that African Americans should visit their sick and Whites should visit theirs. Pilcher was especially perturbed that Whites, who easily claimed all the WPA jobs for themselves, seemed to be overseeing African Americans' visits to their sick, "writeing [*sic*] down how many people visit the sick room and what they brought" (p. 403).

Professional nurses supported Pilcher's idea of the significance of African American women sitting with the sick. Eunice Rivers, the nurse who oversaw the daily operation of the Tuskegee Syphilis Experiment for the Public Health Service, has been severely criticized for her role in this heinous 40-year experiment. Yet, her visits with the men who were subjects of the study were highly praised by the men and their families. Rivers's home visits were an important part of her follow-up work, and through them, she got to know the men and their

families well. In addition to visiting men who were ill most often, Rivers went to all the funerals, sitting with the deceased men's families (J. Jones, 1981).

The Alpha Kappa Alpha (AKA) Mississippi Health Project, financed and conducted by the sorority's middle- and upper-middle-class members during the summers from 1935 to 1942, operated on the principles of taking health care to the sick. The sorority women who served on the first team included one physician, two nurses, and several teachers and social workers. These sorority women, mostly from the urban North, traveled to Mississippi to work with and for the sharecroppers who had no other access to health care. In some cases, small African American churches were the clinic sites, but in other cases, the sorority women turned their cars into mobile clinics and drove to each plantation. Ultimately, the sorority women realized that their success in reaching those in need depended on the support of indigenous healers such as midwives and ministers.

The AKA workers were not paid for their work with the project. Essentially, the spirit of sitting with the sick, which included racial uplift, service to the less fortunate of the race, and an air of noblesse oblige, was fundamental to the sorority's health caregiving. The fact that the women coordinated their private project with state and local government officials also helped to ensure the success of their efforts (Smith, 1995).

Rural African American women in North Carolina, reminiscing about the Depression years, recalled that their sharing, caring, and reciprocity were the greatest strengths of their community life and that their efforts to care for sick neighbors were some of their most memorable and rewarding times (Carlton-LaNey, 1989a). One woman said that she would like to be remembered for the life she lived and the service she had given to others, especially the sick. She also recalled that she "always helped the sick people in any way" possible and that her sense of worth came from "caring for other people" (Carlton-LaNey, 1989a, p. 4). At the time the study was conducted, she had an elderly, blind, nonkin woman living in her home who "had nobody to look after her" (Carlton-LaNey,

1989a, p. 4). Another woman recalled the time that a neighbor was sick with tuberculosis, and rather than shun him for fear of contagion, she would "fan [him] with a piece of paper and carry him food" and simply "sit with him" (Carlton-LaNey, 1989a, p. 22).

IMPLICATIONS FOR SOCIAL WORK PRACTICE

Sitting with the sick, a time-honored way of caring for sick neighbors, family members, and friends, has permeated African Americans' health caregiving since slavery. From the slave doctor women to the old folks' homes to the AKA Mississippi Health Project, the care of the sick has come from both formal and informal initiatives and has changed its emphasis over time from providing for the sick to preventive health care.

Social workers, nurses, home health care service providers, and others can learn valuable lessons from this descriptive history of one form of African American women's philanthropy and the quiet, but essential, role that those who sat with the sick played for individuals who were beneficiaries of their services. In understanding what these women have done, social work practitioners and educators can

- fill in some gaps and make corrections in social welfare history;
- dispel myths of African American pathology;
- identify the problem-solving commitment in the African American community;
- identify elements of self-help that have historically permeated the African American community;
- help professionals identify strengths, rather than deficits, in the African American community; and
- help to promote culturally competent contemporary practice.

Correcting the Historical Record

In the past two decades, social welfare historians have begun to interpret and write African American social welfare history.

Their work has begun to address what Gordon (1991, p. 560) called "white-centered" standard social welfare history. Furthermore, information on African American women's history has increased greatly in the past two decades because of the work of several noted historians, including Darlene Clark Hine, Stephanie Shaw, Deborah Gray White, Wanda Hendricks, and Roslyn Terborg-Penn. These scholars' writings, however, have not generally been included in the social work literature or curriculum. On the other hand, many social work historians have also begun to contribute to this scholarship in recent years. Scholars such as Wilma Peebles-Wilkins, Yolanda Burwell, Susan Chandler, Tawana Sabbath, and Lawrence Gary have brought historical pioneers, social issues, and social welfare practice interventions out of obscurity and have begun to make some needed corrections to the historical record.

According to Fisher and Dybicz (1999), historical research is "critical to the self-understanding of a profession" (p. 117). Leaving the history of social work to scholars outside the profession limits the historical record, largely because these scholars lack insight in and knowledge of the profession. Essentially, many social work scholars (Carlton-LaNey, 1999; Fisher & Dybicz, 1999; Reisch, 1988) firmly believe that historical research needs and deserves a place in social work education and practice.

Dispelling Myths of African American Pathology

African Americans are often presented in the contemporary literature as dependent and problem ridden. Governmental spending on social programs often supports the notion of hopelessness and inadequacy among these families. In response to policy makers' puzzlement at the worsening circumstances of low-income African American families during the 1970s and 1980s, at a time when levels of governmental spending were high, Hill (1993) stated that many of these policy makers used the deficit model to analyze these circumstances, ultimately blaming the victims. He suggested that a holistic perspective is the most effective way to understand and address the concerns

of these families. The holistic framework, according to Hill (1993), identifies significant issues that need attention to increase understanding of the nature, causes, and remedies of problems that African Americans experience. Sitting with the sick is one of those remedies that has become an institutionalized part of African American culture. Those who sat with the sick were natural and, to a lesser extent, professional helpers who did not rely on formal systems to provide health care to their families and communities. Rather, they developed a system of care with the resources to which they had access. Furthermore, they knew that they had to rely on themselves because formal systems of discrimination excluded them from alternative resources. Policy makers and practitioners are often unaware of and fail to acknowledge the informal practices that support and strengthen African American communities.

Identifying Self-Help Elements in the Community

Self-help is critical to the survival of the African American community. The need to develop self-help efforts, however, may suggest to social workers that they have somehow failed in their practice (Simon, 1994). In discussing self-help movements, Riessman (1986) said that self-help connotes a three-tiered reservoir that includes one's own indigenous strengths, those of the immediate group of supporters, and those of the larger community of fellow "survivors," all of whom have first-hand experience and have undergone similar life traumas. Although self-help in the African American community has been both formal and informal, Riessman's three-tiered reservoir nonetheless applies. Initiated by their own indigenous strengths, African American women who sat with the sick began the effort and continued it through an ethos of mutual aid. The mutual aid aspect of this practice galvanized a group of immediate supporters, as well as those of the larger community. In addition, many institutions and organizations supported individual efforts that reflected family and community values. Church groups, women's clubs, lodges, and other social groups all began to formalize sitting with the sick as part of their

service component and in recognition of African Americans' exclusion from or differential treatment by the larger society. The result has been a "mutual aid-oriented response" (Peebles-Wilkins, 1995) to social service delivery in the African American community.

**Identifying the Problem-Solving
Commitment in the Community**

By examining the historical record and analyzing the strategies that African Americans used to interact successfully with their environment, one can identify a strong problem-solving commitment in these communities. Harper (1990) presented the following profile of the historical relationship between African Americans and health care delivery:

- Blacks have always cared for the sick at home, yet it was never labeled "home care."
- Blacks have been dying at home and receiving care in the process, yet it was never called "hospice care."
- Blacks have relieved each other from the caring and curing processes, yet it was never seen as "respite care."
- Blacks have cared for each other in their homes, in their neighborhoods, and throughout their communities, yet it was never referred to as "volunteerism." (p. 240)

Harper's profile gives contemporary labels to the practice of sitting with the sick and edifies a history of indigenous community problem solving.

Identifying Strengths in the African American Community

This article suggests to professionals that the most effective intervention is not necessarily the one that they select. Instead, professionals must be skilled in a significantly broad range of methods if they are to answer the "diverse calls that clients and client groups from historically disempowered communities have made" (Simon, 1994, p. 27). For example, African

American elders rely heavily on informal supports that include the practice of sitting with the sick (Gibson & Jackson, 1989). Many African American churches have a "sick and shut-in ministry" in which congregants regularly select from a list of sick or disabled church members and visit them in their homes or long-term care facilities. The visits are partly to assess service needs, but a greater part of the ministry is to provide the human contact of a visit (A. Roberts, assistant professor, School of Social Work, University of North Carolina at Chapel Hill, personal communication, September 23, 2000). The church members may spend several hours providing no function other than sitting with the sick. The skilled professional who views this activity from a strengths-based perspective understands the importance of maintaining this service and building on it, when possible.

Promoting Culturally Competent Practice

Social workers need to be culturally competent to work successfully with diverse groups. That is, they must not only have knowledge of customs and history but be sensitive to and understand the impact of discrimination, oppression, and stereotyping on practice (Poole, 1999). Therefore, it is critical that professional service providers be aware of the importance of assessing a patient's cultural orientation as part of their service plan. Taking into account the fact that affordable and accessible modern medical care continues to elude many African Americans, they must be knowledgeable about and respectful of indigenous practices that have sustained these communities. One such practice is sitting with the sick, which continues to be practiced and valued in the African American community.

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Women of War: Emotional Needs of Ethnic Albanians in Refugee Camps

René Drumm, Sharon Pittman, and Shelly Perry

This qualitative study identified the emotional needs of female Kosovar refugees in southern Albania in May 1999, about 1 month following their flight from Kosovo. Common themes that emerged from the interviews included dealing with trauma, anxiety, and boredom and maintaining the hope that they would return home. On the basis of the findings, along with feminist theories as guiding concepts, the authors offer recommendations for the prevention of further trauma and treatment options for women in refugee camps.

Women around the world struggle to make their voices heard and their visions known, but in times of war, "women's voices and visions are pushed aside, shunted off to the margins" (Evangelista, 1997, p. 38). What may women need to survive the traumas they experience as war refugees? Relief agencies have historically been involved in offering basic food, shelter, and medical assistance to refugees. Although these efforts are undoubtedly beneficial and life sustaining, the decisions of what types of help to offer invariably come from people other than the refugees themselves. How would the help that is offered change if refugee women could express their needs and desires directly?

Feminist theories and helping approaches call for clients to be active participants in the helping process with the goal of

467

empowerment (Bricker-Jenkins, Hooyman, & Gottlieb, 1991; Hartman, 1993; Worell & Remer, 1992). In addition, feminist values focus on clients' strengths, creating social networks, and understanding the meaning of events from the clients' perspectives (Hanmer & Statham, 1989; Laidlaw & Malmo, 1990; Lewis, 1992). In the tradition of qualitative research, this article reports on a study of the voices of women who are caught in the difficult circumstances of refugee life. Specifically, it addresses the emotional needs of Kosovar women in refugee camps in Albania following their flight from Kosovo in 1999. We focus on women's needs as refugees and, using feminist perspectives as guiding concepts, present suggestions for lessening the resulting trauma through prevention and treatment efforts in war-torn areas.

THE REFUGEE EXPERIENCE

By definition, a refugee is an outcast, fugitive, or escapee. Refugees' experiences often begin years prior to exile, with ethnic or religious discrimination escalating to harassment and persecution (Gorst-Unsworth & Goldenberg, 1998). Refugees flee their homes and countries to save their lives and the lives of their children. "If given a choice, most refugees would prefer to stay in their countries and not seek shelter in strange foreign lands, where they can be isolated, ostracized, and impoverished" (Williams & Berry, 1991, p. 632).

The refugee experience is marked by stress, loss, uprooting, trauma, and isolation (Stein, 1986). It is not surprising, therefore, that research has found "higher rates of symptoms and mental disorders in refugees, compared with the general population" (Williams & Berry, 1991, p. 632). Whenever war causes refugees to flee, it is often women and children who are the refugees. Men usually remain in the country fighting the enemy, and women are assigned to take care of the children and flee.

This change in family structure to women-headed households often leaves women with new social roles with which to contend and adds to the stress of dislocation (Russell & Stage,

1996; Wali, 1999). Besides the difficulties they face as new heads of households, women often experience a change in employment status. For example, Rasekh, Bauer, Manos, and Lacopino (1998) found that although 62% of the women studied were employed before their flight as refugees, only 20% were employed afterward. This shift in gender roles contributes to psychological distress that should be addressed through mental health interventions (Chung, Bemak, & Wong, 2000). In addition, today, as in the past, women are subjected to rape and other forms of sexual abuse by the enemy and military personnel (Chelala, 1998; Epp, 1997; Pelka, 1995; Salzman, 1998; Swiss & Jennings, 1998) that traumatize them and require both medical and mental health interventions.

EMOTIONAL NEEDS OF REFUGEE WOMEN

The age-old debate of nature versus nurture endures even among scholars of the recovery of refugees. Thus, scholars have debated the question, Which contributes more to difficulties among refugees, the traumas they have suffered (nature) or their experiences surrounding the trauma (nurture)? Researchers who adopt the nature perspective have linked poor emotional outcomes to the amount of trauma (Almqvist & Brandell-Forsberg, 1997; Herkov & Biernat, 1997; Mollica, McInnes, Poole, & Tor, 1998). For example, Almqvist and Brandell-Forsberg (1997) concluded that the amount of "traumatic exposure is of major importance for future post-traumatic symptomatology among preschool children, as well as in older children and adults" (p. 363). Researchers have also investigated the personal characteristics of survivors of trauma, concluding that genetics plays a role in the survivors' outcomes. As Roscoe, Ackerman, and Joseph (1997) noted, "It is furthermore assumed that PTSD [post-traumatic stress disorder] will not occur in the absence of a genetic susceptibility that may vary from zero to absolute certainty" (p. 9).

Researchers who hold the nurture perspective view the refugees' environments to be as important as the trauma itself or as

more indicative of future emotional difficulties
(Gorst-Unsworth & Goldenberg, 1998; Llabre & Hadi, 1997;
Silove, Sinnerbrink, & Field, 1997). According to
Gorst-Unsworth & Goldenberg (1998), "Poor social support is a
stronger predictor of depressive morbidity than [are] trauma
factors" (p. 90).

In addition to general social support, the immediate family
environment affects mental health outcomes. One study found
that "refugee children exhibited a significantly higher inci-
dence of stress reactions if their mothers had difficulty coping
with the stress of displacement" (Ajduković & Ajduković, 1993,
p. 843). The converse is also true. When parents maintain their
typical pattern of caregiving in spite of war, they are more apt to
shield their children from the negative aftereffects of trauma
(Macksoud & Aber, 1996). This type of caring and involved
response from parents is an important mediating factor in chil-
dren's future adjustment (Garbarino, Kostelny, & Dubrow,
1991). The same may be true for women. In a qualitative study
of women refugees from Southeast Asia, Davis (2000) con-
cluded that the "stories told by the women in this study portray
an extraordinary resilience of the human spirit, which is forti-
fied through strong family and community affiliations" (p. 166).
On the other hand, Aroian and Norris (2000) found that
although resilience protected women against depression, it
was not helpful for general distress in their lives as immigrants.

Although disputes among researchers abound, scholars
agree that people who suffer traumatic events, such as refu-
gees, are at a high risk of emotional difficulties that require
mental health intervention (Ajduković & Ajduković, 1993;
Almqvist & Brandell-Forsberg, 1997; Mollica et al., 1998; Wil-
liams & Berry, 1991). The sooner the intervention is available,
the better. In discussing the mental conditions of trauma vic-
tims, Amir, Kaplan, and Kotler (1996) concluded that "the lon-
ger a person remains ill, the worse his or her situation becomes,
regardless of the nature of the original trauma" (p. 346).

Knowing that many refugees are women and children who
are at a high risk of emotional difficulties, it is vital that social
work researchers examine these needs in a more systematic and

timely way. The more risk factors that accrue without protective relief, the more likely it is that psychological damage will occur (Garbarino et al., 1991). Thus, preventing increased risk factors and providing expanded opportunities for resilience should be part of a research and practice agenda for women in social work today. This article discusses the emotional needs of Kosovar refugee women in four camps in southern Albania. From the findings, guided by feminist principles, we suggest both prevention interventions and treatment initiatives that may contribute to more positive emotional outcomes.

METHOD

Our qualitative study was undertaken at the request of the Adventist Development and Relief Agency (ADRA), a nongovernmental organization, to assess the emotional needs of refugees under its purview. The research team, consisting of the authors, three female social work professors, had experience conducting needs assessments, using qualitative methodology, and performing crisis intervention.

Participants and Procedures

We interviewed 53 Kosovar refugees individually and conducted eight focus groups with an additional 56 refugees. We also interacted with approximately 40 children, both in groups and individually. The participants ranged in age from 7 to 81. All but 3 or 4 of the adult participants were female, but among the child participants, there was a fairly even mix of boys and girls.

We interviewed the refugees at four camps in the southern region of Albania chosen by ADRA. The interviews were conducted through interpreters hired by ADRA, two of whom were Albanian and one of whom was a Kosovar refugee. The Kosovar interpreter, a nurse, had been identified and hired previously by ADRA to act as an interpreter for its international staff.

We selected the participants by approaching refugees and asking them, through the interpreters, if they would like to talk. The interpreters explained to the refugees that the purpose of the talk was to find out about the emotional needs of the people in the camp. All the refugees whom we approached were eager to volunteer and, in some cases, sought us out.

The interviews ranged from short, 5-minute conversations to full 1-hour interviews. The majority of the data-gathering sessions lasted approximately 20 to 30 minutes and were conducted on 1 day. The interviews took place primarily in tents, warehouses, or dormitories housing the refugees or outdoors.

Data Analysis

In qualitative research, data collection and analysis occur simultaneously (Lofland & Lofland, 1995). Therefore, after interviewing at each camp, we debriefed by discussing the major themes and findings before we started the next set of interviews. In this way, we could be aware of emerging themes that would lead to common directions in investigation. For example, in the first camp, the Kosovar refugees did not participate in the camp operations, which limited opportunities for meaningful activity among them. Thus, the participation of Kosovar refugees in the camp operations became an issue to ask specifically about at the next camp.

We held a lengthy debriefing session at the end of the day to identify several predominant themes that were common among the participants and reported these themes to the ADRA officials at a session following our return from the camps. This type of debriefing, known as peer debriefing (Lincoln & Guba, 1985), offers an external check on the study process. Using peer debriefers, we were able to confirm and clarify the emerging findings through insiders who had been associated with the camps from the beginning.

The data were initially processed using the computer program Ethnograph to assist in coding the emerging themes. Codes are "labels that classify items of information pertinent to a topic, question, answer, or whatever" (Lofland & Lofland,

1995, p. 186) and permit researchers to organize, categorize, sort, and identify the data. Because coding is the primary connection between the data and their theoretical interpretation, it is a crucial step in developing the analysis (Lofland & Lofland, 1995).

As coding continued in the analytic process, we discussed specific incidences of the codes to clarify similarities and differences. Discussing differences offered the opportunity to gain a clear understanding of each category and its relationship to other categories. Using the constant comparative method (Glaser & Strauss, 1967), we generated both descriptive and explanatory categories. This process led to interpretive insights as we began to recognize and record the emerging themes. The Findings section summarizes the major themes that emerged in analyzing the data.

Limitations of the Study

This study offers an initial direction for further inquiry into the refugee women's emotional needs. It was limited in several ways. First, we were unable to communicate with the participants directly because of the language barrier and hence used translators to help bridge that communication gap. To increase the translators' effectiveness, we followed several recommendations by Amodeo, Grigg-Saito, and Rogg (1997): (a) We met with the interpreters as a group before we left for the refugee camps; (b) we explained to the interpreters the goal of our mission and what we hoped to accomplish; (c) we took the time to clarify specific terms, such as *emotional needs*, *trauma*, and *counseling*; and (d) we discussed the role of the interpreters and were clear about how important they were to the success of the mission.

In spite of the appropriate precautions, there were some difficulties. First, the interpreters differed in their proficiency both in English and in communicating with the Kosovar refugees. For the two Albanian interpreters, the dialects were different enough that they had difficulty communicating with confidence. Second, it appeared that some of the Kosovar partici-

pants distrusted the Albanian interpreters. The Kosovar interpreter pointed out that the participants would not likely be as open with the Albanian interpreters as they were with her. Whether this situation was true is unknown; however, ethnicity may be an important consideration in choosing interpreters.

Another limitation was the small sample size. We were able to spend only 1 day in the refugee camps, and although we contacted more than 100 participants, more in-depth work is needed to gain a comprehensive view of the refugees' emotional needs.

FINDINGS

Physical Needs

Using Maslow's (1954) hierarchy of needs as a guiding principle, we hypothesized that if there were crucial unmet physical needs, it would be difficult to find out about the refugees' emotional needs. Maslow postulated that people strive to meet their needs to "self-actualize," or become the persons they were meant to be. He believed that human needs drive human behavior and that these needs ascend along a hierarchy. That is, people need to fulfill certain basic needs, such as for food and water, before they can move up to more complex needs, such as belonging and self-esteem. Therefore, our first objective was to assess the camp conditions for satisfactory food and water supplies, as well as the adequacy of other basic necessities.

In general, the participants thought that the camp conditions met their basic physical needs and did not report being hungry, thirsty, or in need of sleeping space. However, they did complain about the limited choice of foods. One focus group member said, "We are only getting bread and cheese and tea. Sometimes we have beans or potatoes. The cooking is not good here." Another participant continued, "We can't cook here at the camp. They send us away when we offer to help. The food is tasteless. There's no salt or pepper. There's not enough bread. There is a water shortage sometimes."

Besides the limited choice of food and other supplies, the primary complaint was the lack of sanitation. A refugee from one camp pointed out, "There are 300 of us here and only two bathrooms." In another camp, there were approximately 2,000 refugees with only six toilets. One interpreter pointed out that two of the toilets were locked and could not be used. The camp manager was not available for us to ask about the situation.

Emotional Needs and Issues

After we concluded that the refugees' basic physical needs were being met, we examined the refugees' emotional needs and issues. Several clear themes emerged in this regard: pervasive trauma to the refugees before their flight to Albania, high anxiety accompanied by physical symptoms, the boredom of camp life, and the need for hope that they would return to Kosovo.

Trauma

All the participants told of some form of trauma prior to their arrival at the camp. The primary type of trauma was from military violence resulting in the deaths of family members, friends, and other fellow Kosovars. Secondarily, the participants experienced trauma throughout their flight from home.

Military violence and death. Military violence was rampant in Kosovo, causing hundreds of thousands of civilians to flee their homes and seek refuge in neighboring countries. Most of the participants shared stories of the trauma they either experienced or witnessed, including murder; torture; rape; theft; and the destruction of homes, property, and animals. What follows is a sample of the experiences that they disclosed. The first experience was recounted by a 15-year-old girl:

> One time a soldier from the army came to our house and said, "Give me money or I'll kill you right now." The soldiers lined us up and asked for money. We didn't have any, so we gave them

jewelry. We were scared. We said, "Don't kill us, please; we don't have any more money." The soldiers put the women and children in one room and told us to give them money. They thought we were hiding money from them. The soldiers beat all the men. Then the soldiers took me out of the room of women and children and my uncle and his son out of the room with the men. They told me they were going to kill us now. Then they gave me the gun and ordered me to kill my uncle and cousin. I was crying and told them, "You'll have to kill me and kill us all because I won't kill them." After 2 hours the soldiers left. I did not have to kill my uncle and cousin. My family fled to the mountains, and I saw my village being burned as we left. Just as we were leaving, I remember watching our neighbors running away, and one of them was killed.

Although rape was not a predominant theme in the data and no one disclosed a firsthand account of rape, a few participants told us of others whom they believed had been raped. For example, a woman in her 20s said,

Rape is a big problem. One of my cousins was raped in front of her father. Being raped in front of one's father is the worst thing that can happen to a person. Because the soldier raped her, he didn't kill the father.

Research reminds us that religious and cultural beliefs "may differentially influence the meaning and subjective experience of trauma" (Marsella & Friedman, 1996, p. 24). Therefore, the circumstances under which the rape occurred may be as important as the act itself.

Evacuation of refugees. The refugees were further distressed by their forced evacuation from Kosovo. The participants recounted their experiences of escaping from their home country, emphasizing that the evacuation experience itself was not only difficult but traumatizing. As a 20-year-old woman said,

My family drove for 5 days from our town to the border [of Albania]. There were 80 family members traveling together. We started out in five cars and a truck. On the way, the Serbs took the cars and all our money. The soldiers said, "You have to stop here, and we'll kill you if you don't give us money." They took

our cars, so 80 of us piled on top of each other in the truck to cross into Albania. The dead lined the roads on the way out of Kosovo. We saw maybe 50 or 100 dead bodies the Serbs left to scare us.

Another woman in her 20s recalled,

The children were crying during the trip. There was nothing to eat. I was worried for my three children because they had nothing to eat. My youngest is 3 months, and I was not able to change her diaper. All day my child had to keep it on no matter what it was. It was 5 days and 5 nights for the whole trip.

Anxiety and Physical Symptoms

Anxiety among the refugees was nearly as pervasive as trauma. The anxiety theme from the data was consistent and strong. The primary condition leading to anxiety was the lack of information about their family members still in Kosovo. One participant said,

We don't know what's going on. We don't have enough information. It's been 2 months, and we still haven't heard anything. We've been here 6 weeks and 2 weeks in the mountains in Kosovo. We can't eat or sleep because of worry. I have a husband and son who is 15 years old, and I don't know anything about how they're doing.

An elderly woman reiterated the theme, "I am the only woman from my family that is here. I don't know anything about my seven sons, daughters-in-law, and grandchildren."

The participants reported physical symptoms associated with anxiety, such as difficulty eating and sleeping, high blood pressure, and digestive problems. One participant reflected a common theme when she said, "We are all worrying a lot about our family members in Kosovo. We fear for their safety and well-being. When I eat, I wonder if they have something to eat." "I am experiencing a nervous stomach," one participant stated as she tried to explain the difference between a symptom's being emotionally based versus a physical illness. She realized

the toll the anxiety was having on her health. Another partici-
pant said, "I have a lot of brothers and sisters in Kosovo that I
don't know about. I have high blood pressure because of all the
worry about them."

Boredom

The participants indicated that in the refugee camps, the lack of
meaningful activities led to feelings of boredom—a problem
that has been documented in the research literature (Russell &
Stage, 1996). Without activities and the ability to use their skills
and talents, the refugees had more time to think about their
missing family members, which, in turn, increased their anxi-
ety. "We need newspapers, books, and magazines to spend
time and take our minds off suffering," one participant said.
The participants shared their concerns about the lack of activi-
ties for the children. As a 19-year-old man put it, "There is noth-
ing for the children to do and there is no school for them here.
The kids play ball with a stone." And a 24-year-old man said,
"The children need activities. They need balls and some toys.
There are no TVs, radios, videos, paper, pencils, or crayons to
keep the children occupied."

   In addition to not having activities to pass the time, the par-
ticipants were concerned that their talents were not being used.
The focus-group members clearly stated that they would wel-
come the opportunity to use their individual skills in the camp.
Two members said, "Working would help us survive here. We
would like to fix hair." Another said, "I finished a course in
sewing and would like to sew clothing for the children."

Need for Hope About Returning Home

Returning to their homeland was a primary objective for the
Kosovar refugees. When asked how conditions at the camp
were for the young people, one 19-year-old woman said, "They
are very bad." When asked, "What makes it so bad?" she
replied, "Because we want to go back to Kosovo." Other than

wanting family members to be safe, going home was what the refugees longed for most.

The desire to go home served as a source of strength for enduring the hardships of refugee life. A 15-year-old girl reported that she was "getting crazy" from thinking about the trauma she suffered in Kosovo. When asked, "Why aren't you crazy now? What's kept you from going crazy?" she replied, "Hope. I have hope that I'll be able to go home. I'm afraid I'll lose hope. I don't know how I'll do it [stay hopeful]."

Although some refugees were able to keep alive the hope of going back, they voiced the need to hear messages of hope from others. When asked about the need for counselors, a 23-year-old woman answered, "We want them to come. We want to hear from counselors that everything will be all right and we can go to Kosovo. It's like a mother telling her child that it will be all right."

RECOMMENDATIONS

When women become refugees, their emotional health is at risk on many levels. These findings suggest several areas of concern that could be addressed through preventive interventions as well as treatment initiatives. This section presents ideas that bridge the findings with feminist perspectives to propose interventions that may be helpful in future work with refugees.

Preventive Interventions

Primary prevention refers to the efforts made to target normal or at-risk populations in a universal way to ward off future problems. When high-risk populations are involved, these interventions are usually referred to as selective interventions (Durlak, 1998). From a feminist perspective, preventive efforts are essential because social and economic action is an important part of the helping process (Breton, 1999; Weil, 1986; Zippay, 1995). Because many of the interventions discussed

here require the mobilization of resources, advocacy with funding agencies would be required for implementation. The primary preventive interventions that we suggest are managing the flow of information into the camps, developing local capacity, and providing planned activities for individuals and groups.

Managing information. As the participants all noted, when they were uninformed about their family members who were still in Kosovo and heard nothing about the progress of the war, their anxiety increased. Therefore, increasing the flow of information into refugee camps would be a form of primary prevention.

Although the participants reported that family-tracing databases were being developed, none was evident. Relief agencies need to develop databases of camp residents that could be posted to a shared network to allow for the wide dissemination of information. If family members could know that one of their missing members was safe in another location, they would feel greatly relieved.

One camp we visited provided a television set for the residents that was centrally located, and we noted that the camp residents were steadily watching it. This camp lent itself to this type of intervention because of its available electric supply and proximity to a small city; however, these types of interventions could be approximated in more remote areas on a smaller scale through the use of radios.

Developing local (within-camp) capacity. Recognizing the strengths and talents that people bring to a difficult situation helps to develop those strengths and capacities. It is important for relief agencies to tap into refugees' talents and skills, giving them the message that they have abilities that can contribute to their own and others' well-being. One way to do so is to discover the natural leaders in the camp and delegate capacity-building tasks to them. For example, these leaders could form task groups, interviewing each refugee and screening for strengths and talents they may contribute to the camp. Skills such as teaching, nursing, cooking, community organizing, and

being proficient in foreign languages may be useful to camp life. Focusing on the strengths of the refugees and helping them to use their abilities may lead to more positive outcomes.

Providing planned activities. Boredom in the refugee camps contributed to low morale and increased anxiety. This finding supports the findings of other studies that have linked boredom with anxiety and depression (see Silove et al., 1997). Introducing planned activities, both individual and group, into the camps would be a primary preventive intervention to help reduce boredom. Relief agencies, of course, must be aware of cultural preferences in planning activities. Therefore, someone who is knowledgeable about the refugees' culture must be consulted before group activities are planned. As one expatriate worker suggested, "It would be easy to get the ladies to do something like knit. Lots of them knit and would do so if knitting needles and yarn were provided."

Mental Health Treatment Initiatives

Assessing emotional trauma. To prevent further traumatization, relief agencies should be prepared to assess and deal effectively and promptly with refugees' emotional trauma. However, from our research observations, no coordinated treatment initiatives were under way in the camps we visited. Offering mental health treatment may seem like an impossible task because of the refugees' overwhelming physical needs. However, in an age of multitasking, while one relief crew is working on food, shelter, and water supplies, another crew could be assessing the refugees' emotional needs. The idea of providing mental health support during the emergency phase of refugee work is supported in the literature (Jong & Ford, 1999). Researchers have called for "cultural workers who, alongside the water and sanitation experts, logistics personnel, protection officers, and health workers, negotiate, communicate, and collaborate with those affected" (Hyndman, 1998, p. 256).

Because people deal with trauma, loss, and grief differently, it is not surprising to find a wide spectrum of emotional states, ranging from active crisis to moderate coping. This wide variation in emotional coping calls for appropriate assessment in the early stages of people's lives as refugees, with ongoing assessment throughout the time the refugees are in the camps and beyond. From a feminist perspective, this assessment should include some qualitative components if clinicians are to hear women's unique voices (Bloom, 1996; Giblin & Chan, 1995; Lindsey, 1997; Summerfield, 1991). If left to standardized assessment instruments alone, the primary voice heard from the resulting assessment may be that of the tool's developers (Walters & Denton, 1997). The interpretation of the results of the assessment may also be in question. Because many assessment tools are culturally validated, feminists and researchers argue for the cautious use of standardized assessment instruments on which to base large-scale treatment initiatives (Cariceo, 1998; Davis, 2000; Jimenez, 1997; Norman & Wheeler, 1996). We concur with these cautions and recommend that women in refugee camps be involved in the assessment process from the beginning. For example, researchers and clinicians could ask women, "If you were going to try and find out who needed what types of emotional help, how would you go about it in this camp?" Then, program developers should use the women's answers to direct assessment efforts.

Following the assessments, professional mental health workers may be needed, particularly if indicators of PTSD or trauma, such as rape, are present. In our needs assessment, one female refugee said, "When I am thinking about what happened, many times I cry. I get nightmares at night. I see houses burned. When I hear airplanes, I am afraid. It's the same noise as when they were bombing Kosovo." This refugee appeared to be in the beginning stages of posttraumatic stress because she discussed reliving her experiences through nightmares and feelings of danger. She also had symptoms of increased arousal, such as an increased startle response. With early intervention, this woman might have been better prepared to begin the healing process.

In the case just cited, professional mental health interventions were clearly needed. At the same time, feminist clinicians remind practitioners to involve women in their treatment, to form partnerships with them, and to ask women what may be most helpful (Ballou, 1995; Bricker-Jenkins et al., 1991; Giblin & Chan, 1995; Van Den Bergh & Cooper, 1986). "Feminism and postmodernism view the client as the expert in her own life and work toward creating a collaborative and egalitarian therapeutic system" (Biever, Fuentes, Cashion, & Franklin, 1998, p. 172). In our needs assessment, we asked, "What has helped you cope with your trauma?" From the participants' responses, we learned that in addition to professional clinicians, trained listeners or peer helpers may be an important service. A 20-year-old woman responded, "Talking helps. Talking to someone from outside my country. We [Kosovars] don't talk to each other because everyone has had the same experience. To talk to someone else is better." Just talking to an interested party seems to be something the refugees view as potentially helpful. In one focus group, a member said, "It's a relief to talk to someone. We believe in you. You came here for us. You came to help us. [We know this] because you are talking to us." Initial research on training refugees in counseling techniques to supplement professional therapies appears to have positive outcomes (Kanyangale & MacLachlan, 1995). Nonprofessionals, whether refugees or volunteers who are trained as skillful listeners, could provide some relief to the refugees.

In terms of the types of treatment to initiate, we again recommend an empowerment approach that involves engaging women in their own treatment paths. Women could be informed about various treatment approaches that have been found to be helpful to other women (Hanna & Hanna, 1998). Some of these treatments include psychoeducational groups (Allen & Kelly, 1997; Lubin & Loris, 1998), facilitated self-help groups (Tribe & De Silva, 1999), support groups (Nicholson & Kay, 1999), the Wits trauma intervention model (Eagle, 1998), eye movement desensitization and reprocessing treatments (Rothbaum, 1997), exposure and cognitive restructuring

groups (Echeburua & Zaretta, 1997), and cognitive-behavioral interventions (Foy, 1992; Scott, 1997).

Feminist social workers are uniquely positioned to initiate new directions for women who have been caught in the by-products of war, such as women who are living in refugee camps. Whereas traditional help for refugees has come from the top down, social workers should insist on an inclusive, empowering, mutual process that invites women who are refugees to have a voice that affects their living and healing conditions.

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Where Do You Go When It's 40 Below? Domestic Violence Among Rural Alaska Native Women

Judy Shepherd

Although domestic violence is now recognized as a serious prob-lem in American society, little information is available on this problem in rural indigenous communities. This article, which is derived from in-depth interviews with 9 rural Alaska Native women who have been in abusive relationships, explores the environmental and cultural context of domestic violence in a remote Alaska Native community and the adaptations that such a context requires for the provision of culturally appropriate services.

Domestic violence is a leading cause of injury and death for women throughout the United States. Browne (cited in Stout & McPhail, l998), who reviewed studies on the prevalence of domestic violence in l993, found "that between 2l% and 34% of women in the US will be battered by a male partner" (p. 213). Furthermore, Harlow (l99l, cited in Stout & McPhail, l998, p. 213) indicated that women are 6 times more likely than men to be victimized by their partners or ex-partners.

Few studies have been undertaken on the context of, or response to, domestic violence in indigenous rural populations. As Norton and Manson (l997), who studied a domestic violence intervention program in a western, urban, American Indian health center, noted, "Despite the increasing recognition of domestic violence in American Indian communities, the literature on domestic violence interventions in this special population is almost non-existent" (p. 33l). Similarly, there have been only a few studies on the occurrence of or interventions for domestic violence in rural areas.

Isolation; few, if any, law enforcement officials; the lack of transportation; and severe climate, as well as extended family networks, generational ties to the land, cultural history, and language barriers, are important considerations in understanding domestic violence in this context and in developing appropriate intervention strategies. In addition, the loss of traditional culture in indigenous populations in the United States because of historic and current state and national policies has had an impact on the domestic violence problem. In many indigenous American cultures, the alarming rise in social problems, such as alcoholism, suicide, child abuse, and domestic violence, has coincided with the loss of traditional culture, including the loss of land, language, customs, and traditional roles (Napoleon, l99l).

DOMESTIC VIOLENCE IN ALASKA NATIVE COMMUNITIES

The statistics on the incidence of domestic violence in Alaska, in general, and in the Alaska Native population, in particular, are disturbing. According to the Council on Domestic Violence and Sexual Assault (l997),

> Women in Alaska face a much higher rate of homicide than women nationwide. Non-Native Alaskan women are killed l.5 times more often (6.2 per l00,000) than the average U.S. woman (4.2 per l00,000) according to the University of Alaska

> Anchorage's Institute of Social and Economic Research. Native women are killed 4.5 times more often (l9.l per l00,000). Native Alaskans in small communities see more violent deaths than in other Alaskan communities, and at rates as much as six times the national average. In l990, 50% of female murder victims in Alaska were killed by their husbands or boyfriends. In l995, 80% of homicides in Alaska were domestic violence related. In l996, 4 of the l6 domestic violence related deaths in Alaska were children. (p. 5)

In addition, Shinkwin (l983, p. 86) noted that domestic violence that resulted in severe injury or death was 4 to l0 times higher in the three rural Yupik villages in Alaska that she studied than in the general population.

Domestic violence is not commonly believed to have been a part of traditional Alaska Native culture. The saying "domestic violence is not traditional" is commonly heard in Alaskan villages, and Shinkwin (l983) concluded that "claims by older people in the region that domestic violence was exceedingly rare in their youth are easily believed" (p. 94). The onset of domestic violence and other social problems, such as suicide, alcohol abuse, and child abuse, in Alaska Native villages is believed to have occurred after Native communities in Alaska experienced massive social upheaval, including innumerable deaths from disease, the removal of children by child protection workers, forced assimilation through social institutions and boarding schools, and the introduction of alcohol and other drugs. An example of an event that resulted in social upheaval and cultural change was the "Great Death" (small-pox, measles, chicken pox, and flu-cold epidemics), which resulted in the deaths of 60% of the Alaska Native population in the early l900s (Napoleon, l99l). In addition, from the 1930s to the 1970s, many Alaska Native children were sent to boarding schools in the lower 48 states or in urban areas in Alaska that were far from their home villages because of the policy of assimilation that was prevalent at that time. These schools were known for their harsh discipline and for forbidding students to speak their Native language or practice Native cultural activities. In a study of the boarding school experience of Alaska

Native children at three high schools in the early l970s, Kleinfeld (l973) concluded,

> When I began this study three years ago, it was not my intention to show that boarding home programs and regional high schools were helping to destroy a generation of village children. . . . But as I saw what actually happened to the l97l-72 class of village students who entered representative high school programs, I was compelled to give up these initial views. In all of these programs, the majority of village children were developing serious social and emotional problems as a result of their high school experiences. Our follow-up study of graduates from these school programs suggested that in many cases, the school experience had left these students with a set of self defeating ways of dealing with the world. . . . The damage is done [to village children] primarily through a total system which separates children from their families at a critical developmental period and places them in unhealthy environments for growing up. (pp. vii-viii)

One 46-year-old woman who was interviewed for my study on domestic violence recounted the treatment of students in her village elementary school: "I spoke Inupiaq as a child. At school they wouldn't let kids speak Inupiaq. They slapped us. I don't know Inupiaq anymore." Another woman spoke of her boarding school experience this way:

> I went to boarding school when I was l4 in Oregon and stayed nine months. Then I was sent to boarding school in Nome. I stayed there two years. I was by myself. It was exciting at first, lonely later. There were Natives from the lower 48 there. . . . Before I left, I could speak Inupiaq, cut up seal and fish. When I came back, I didn't remember those things.

Also, prior to the enactment of the Indian Child Welfare Act of l97l, many Alaska Native children were removed from their families and villages by child protection workers and placed in foster homes or adoptive homes with non-Native families in Alaska or in the lower 48 states. Most of these children were lost to their villages and were never reunited with their families.

This recent history of loss and trauma in Alaska Native culture is thus important in understanding current social problems in Alaskan villages. In regard to the history of domestic violence in Alaska Native communities, Shinkwin (l983) noted,

> The growth of the custom of beating one's wife is more properly associated with the introduction of western institutions that disrupted the traditional structure of relationships between men and women as well as traditional mechanisms of social control. Review of the history of institutions relating to marriage, the family and male-female interactions highlight the association of western beliefs and social arrangements with abuse of women in a domestic setting. (p. 94)

THE REGION

It is important to note that rurality in Alaska differs from other states in that many villages are not on a road system and are accessible only by plane, boat, snow machine, or dog sled. There are more than 626,000 people in the state (more than half of whom reside in one urban center) (L. Walters, Alaska Department of Community and Economic Development, personal communication, June 21, 2001), dispersed over a land mass of 656,424 square miles (*World Almanac*, l996). Of the state's 119,241 Alaska Natives, 63,674 live in rural areas and are widely scattered among 256 rural communities. Of the 322 communities in Alaska, 217 are not connected by roads, and approximately 40% of them lack water and sewer systems (L. Walters, personal communication, June 21, 2001). In the villages, subsistence activities, such as hunting, fishing, and gathering of plants, remain an important part of life.

The regional center in which this exploratory study took place is an Arctic community of more than 3,000 people that serves as a hub for 11 Alaska Native villages. The populations of the villages in this region range from 80 to 750, and the total population of the region is about 6,000 people. The regional center is approximately 80% Alaska Native. The surrounding small villages are Alaska Native communities. Subsistence

activities in the area include fishing; hunting of bearded seal, caribou, moose, and other fur-bearing mammals; and whaling in the northwest corner. The sharing of food among individuals and villages is customary. The physical environment in this region is considered harsh by many because winter temperatures can drop to 60° below 0 and the winter months are characterized by little daylight.

METHOD

I conducted this exploratory study on domestic violence in l997-1998. At that time, I visited and stayed at a shelter for battered women in a rural regional center on several occasions and conducted in-depth qualitative interviews during two of these visits with 9 staff members or clients of the shelter regarding their experiences with and feelings about domestic violence in their community.

This study was initiated after I visited the shelter for battered women and met with its coordinator. After this visit, I discussed my research interests with the shelter coordinator, who helped me develop a research proposal and format. The coordinator, however, made it clear that I was to stay at the shelter, not with local professionals, during visits and to stay a long time or come several times if the study was to be of any value. On the evening of my first stay at the shelter, the coordinator held a potluck dinner for the shelter staff during which I was introduced and the research was explained. The staff members were also told that they could use time during their shifts at the shelter to participate in the interviews. During this first visit, I stayed 6 days and interviewed 7 individuals. I also visited a safe-home provider in a small village, helped with staff training, reviewed case files and policy notebooks, and assisted the shelter coordinator and staff in daily activities. Since the first visit, I have returned to this region on several occasions, always staying at or visiting the shelter and assisting staff in whatever ways possible.

During the second stay at the shelter, I interviewed 2 other women (only one of the interviews was included in the study because the other woman did not have personal experience with domestic violence) and reviewed documents at the shelter. Because this shelter had virtually no staff turnover during the 4 years of my continuing involvement, my relationships with the staff are ongoing. I conducted one additional interview in my office in Fairbanks with an individual from the region who felt more comfortable in that setting.

The interviews with the staff and clients used a semistructured format and lasted approximately 1 to 2 hours. All the women who were asked to participate agreed to do so, and almost all stated that they would be happy to participate if the results would help other battered women. Before they were interviewed, the women read and signed consent forms and were informed that they could choose not to answer any question, to stop the interview at any time, and to decide at any point not to be included in the study. In addition, the women were asked if their interviews could be tape-recorded. Five women consented to taping and four did not. During both the taped and untaped interviews, I took notes, asked demographic and clarifying questions, and listened to the stories the women told of their experiences. Four of the interviews took place at the shelter, three in the offices of social service agencies, one at the home of the safe-home provider, and one in my office. The taped interviews were later transcribed, and my notes from the taped and untaped interviews were reviewed for common themes regarding domestic violence. Suggestions for organizing the article were made by the shelter coordinator.

All nine women who were interviewed were Alaska Native women who were residing in the region. The shelter where the interviews took place is unique in that all staff except relief counselors are Alaska Native women, and thus it provided an ideal setting for learning both about domestic violence from an Alaska Native perspective and about culturally appropriate interventions. Of the nine women, eight were in their late 30s to

40s, and one was older than 70. Five of the women were shelter staff who had personally experienced domestic violence in the past, and four were past or present clients of the shelter. Of the nine women, seven had three to seven children each. At the time of the interviews, six of the women were in nonabusive relationships, and three had recently left abusive relationships. Furthermore, of the nine women, only three had come from families where they had witnessed domestic violence as children; however, all but one said that the male partners who had abused them had witnessed their fathers beating their mothers. None of the women had bachelor's degrees, and all but one were either employed at the shelter or in other social service agencies as aides or counselors at the time of their interviews.

It is important to note that even though this study took place in a predominantly Alaska Native community and the women who were interviewed were all Alaska Natives who were residing in the region, the men who abused the women included non-Native men living in the region currently or in the past and Native men from this and other regions. If this study had been conducted in an Alaska Native village instead of a regional center, the backgrounds of the abusers might not have been so diverse, but because the focus of this study was on the nature of domestic violence that Alaska Native women face in a remote region, the diversity of the abusers' backgrounds was not significant.

When I undertook this study, my goal was to learn about domestic violence in rural Alaska. However, as the women told their stories, it became apparent that they were providing information not only about domestic violence today but about the past context of domestic violence and about the strengths of women who left horrendous situations when few supports were available. Almost all the women were currently in nonabusive relationships and were working in jobs where they now assisted other battered women or members of the community.

FINDINGS

The following description of the environmental and cultural context of domestic violence in this Arctic region is based on the information provided by the women who were interviewed.

Environmental Context

Women who experience domestic violence in rural Alaskan villages face many of the same obstacles when seeking help or trying to escape their abusive situations as do rural women in other areas of the United States, except that the obstacles to assistance are more formidable because many villages are not on a road system and because the weather in the Arctic is generally severe in the winter. As one shelter worker noted, "When it's 40° below 0 and dark and you have several kids, what are you going to do? Where are you going to go?"

The main environmental factors that affected living in and leaving abusive situations were as follows:

1. the isolation of communities;
2. severe weather;
3. the lack of adequate law enforcement;
4. the prevalence of alcohol and other drugs;
5. the prevalence of weapons;
6. the absence of many basic public services, such as low-income housing and transportation;
7. the lack of jobs and dependence on public assistance; and
8. infrequent visits by mental health professionals and the lack of treatment programs for abusers.

These conditions are comparable with those described by Websdale (l998) in his study of rural battered women in Kentucky:

> From battered women's perspective, a mosaic of problems exist when it comes to the state's delivering various services to rural women. Some of the difficulties stem from the remoteness of the region and the sociopolitical and physical isolation of women.

> Other problems emerge because of the lack of privacy in rural areas and the interconnections between those who provide services and those who consume them. Still more problems arise from the generalized dearth of state services in rural communities brought about by a combination of factors including the inability of the state to infiltrate or access rural communities. (p. xxx)

One of the biggest environmental constraints in this region for domestic violence assistance is the isolation of the villages. As one woman put it, "Often it's 90 miles by air, and you have to call for the troopers and wait for help to come. A lot can happen in the time it takes for a plane to come." Although the homes in the villages are often close together, the villages themselves are long distances from each other and the regional center. Thus, a woman who wants to leave a dangerous situation has to telephone the troopers, hide out until the troopers arrive, and then hurry to the plane with her children in tow. In most villages, planes come once a day if the weather conditions are good. A woman who plans to leave prior to a crisis involving troopers incurs considerable expenses because the round-trip airfare from a village to the regional center costs about $l20 and from a village to an urban center, $500 to $600. If the woman takes her children with her, this cost is multiplied. One woman in a small village described her escape this way:

> I didn't go to the clinic because I didn't want to cause trouble. He knew I wanted out. If I left for good, I knew I'd get the beating of all beatings. I could watch him working on his boat. I called the state troopers. How I got the courage to call was I could watch him on his boat. The troopers had a whole plan. Go to a safe home; we'll call her, you wait there.

This woman had to run to a safe-home provider and hide out with her children until the state troopers flew in from the regional center and arrested her abuser. Often, the abuser is also in hiding, and the troopers cannot find him because almost everyone in the village knows when planes are coming and most people know when the troopers are searching for someone.

Inclement weather can also compound the difficulty of leaving an abusive situation. Here is one woman's poignant account of trying to escape with her four young children:

> They were like little ducklings following right behind me. One time he was drunk, and when he doesn't hit me and passes out, then we will sneak out because I know he will wake up in a bad mood and start drinking again. We would crawl through a bathroom window. I would run out first, when we were fighting. I would try to find some way to get out. I knew he would fight me. After he would pass out, I would come back to the house because I couldn't leave the kids there . . . because he already locked the door and jammed it, and the kids couldn't open it. So I would say, "Go to the window." And I'd pull [them] through the bathroom window. Let them step on the honey bucket [a bucket kept in the house for bathroom use and later emptied] and go out through the window. Get them out and get to the women's shelter. About 2 or 3 in the morning. It was cold, stormy sometimes. We all stuck together.

The isolation of the villages is compounded by the lack of law enforcement officers. In the villages, there are no police or state troopers, only village public safety officers (VPSOs), local residents who are trained to monitor safety in the village but do not carry guns. Unfortunately, this position is poorly paid and often not highly respected in the villages (because it means monitoring and reporting on friends and relatives), and so the turnover is high. At the time I visited this region, 3 of the 11 villages had no VPSO, which means no local law enforcement at all. One woman described the VPSOs this way: "They are more like security guards. They walk around town at night. Make sure stores are locked. They don't know how to handle a major crime. If we do get a good VPSO, they get burned out and quit." One woman noted how difficult it was for her to get help in the regional center in the past.

> See my husband abused me. My face was all bloody and everything. And he hit me. He wouldn't let me out the door and, you know, tore all my clothes off. I was scared because he was pounding my face. So I got away from him somehow, and I

grabbed a sheet hanging up around the honey bucket. I tore the sheet off and ran out, and I ran into the preacher's house across the street. And I just ran in his house, I didn't even knock. I [said], "Can you help me?" I was all bloody and everything. Then [the preacher] called the police. Then they said we can't do anything because nobody saw. . . . So then the police just took me home. And I says I've had enough. Because I took l5 years of being knifed, hammered, shot at, hit in the head with hammers, I was scared of him, and I knew he would get away with it because the town is small, and he keeps saying this is his town. Every time I [called] the police when I [had] a restraining order, he would be at the door, and he would break in. And I would be scared of him. And he [said], "If you tell the police anything, I'll kill you." And I felt that he would.

Another criticism of law enforcement was leveled at the practice of "third partying," by which a perpetrator is released by the police into the custody of a friend who is supposed to watch the perpetrator at all times. One woman described this practice as follows:

At the time when he would get in trouble, and he would end up in jail . . . you know, they would automatically bail him out, but they had to be in ear range. . . . [They had to be able to] see him or hear him at all times. But that never happened because nobody could enforce that. Families do that all the time. They will do a third party, and then you will see the guy driving around drunk a few weeks later. . . . When I got shot at, within hours his parents third partied him.

One woman said how it was hard in the past in her village to stay at someone's house because others were afraid of her husband. She described her abuser's past this way:

When he was young, he saw . . . his dad beat up his mom. Things like his mom crawling out the window and running. Or his mom hiding, you know, at the neighbor's house. He saw that. In the village . . . it is expected that wives run and hide from their husbands now and then. And people just take it as a matter of fact. "Oh where is she? Oh, she's hiding from her husband. How's the weather? Oh, pretty nice."

She then said that sometimes friends would not let her in when she ran to their houses.

> Some are afraid of their husbands and boyfriends and say no you can't come in. You might come here with a gun. Because most of the time when I lived in—there was no VPSO or law. I mean anyone, anywhere, at anytime, could kick in your door. And that's true today in many villages.

Complicating the absence or inadequacy of law enforcement in many villages is the preponderance of weapons. Because almost all families in this region subsistence hunt and fish, guns, knives, and other weapons are commonplace. Unfortunately, for a woman in an abusive situation, the abuser's easy access to weapons can make a violent episode lethal, and many women carry scars from their past abuse. One woman noted that a lot of abusers get third partied to relatives even when weapons are involved. She stated, "I had a lot of weapons, a lot of knives, a lot of things thrown at me. A lot of guns." When asked if weapons were commonly used in her village during domestic violence episodes, she responded,

> Oh yeah, everybody is dragging a gun or knife or going to get a gun or knife. "I'm gonna go get a gun, gee whiz!" They would shoot around, and you would get a bullet hole coming through your wall. Oh, better lay low, and who you gonna call. You could call —, and it would take a couple of hours for him to get down there. By then [the abuser] is probably passed out.

Although all the villages in this area are dry (no alcohol is allowed to be brought into the villages) and the regional center is damp (alcohol can be purchased only for personal consumption), bootleggers bring alcohol and drugs in, and inhalants are available. The combination of the prevalence of alcohol and weapons, the lack of law enforcement, and isolation puts women in abusive relationships in dangerous situations and likely accounts for both the severity of wife abuse and the high death rate of Native rural women from abuse.

Alcohol is seen as a major factor in much of the family violence in the region, though not necessarily a causative factor. As one woman stated,

> All our families have been touched by alcohol abuse. Some of the families healed the best they could. I see a lot of healing now. See all ages healing. During a certain decade, there was so much drinking here. Whole families had to flee in the middle of the night and go to relatives' houses.

In her study of three Yupik villages, Shinkwin (l983) noted, "In this study, 95% of abusers are problem drinkers and respondents insist that wife beating incidents are alcohol related. We found a strong statistical association of male problem drinking in couples with spouse abuse" (p. 90). Although the women in my study discussed alcohol abuse often, most said that their husbands or boyfriends also abused them when they were not drunk. In addition, the women recounted the effects on their children of witnessing the abuse, waiting for the abuser to fall asleep, or lying awake listening to the abuser who had been drinking rant and rave. One woman recalled how her children learned to deal with their father's drinking and abuse:

> They'd get scared [when he was drinking]. They'd . . . find someone to spend the night with when they got a little older—sleep over at their house. Sometimes they would hide with me. I'd be hiding too. . . . When I got to know him better, and I knew if he had the first drink, I'd take the kids and go to the women's shelter.

The other similarity that rural village Alaska has with other areas of rural America is the lack of many basic services and an inadequate housing stock. In most villages, housing is at a premium, with many family members crowded into small houses. To build housing in this region, building materials must be transported by barge during the summer months, and all construction must be done during that time; thus, only a few houses, if any, are added to the housing stock each year. It is not uncommon in some regional villages to have 13 or 14 people

living in one small house. One woman who was a shelter employee had this to say about the availability of affordable housing:

> I'll probably never own my own house in my whole life. It must be nice not having to keep your kids quiet and being able to have a pet. I can't get ahead no matter how hard I try. I'm in a rut.

Also, many houses do not have indoor plumbing. In some villages, people obtain water from a community spigot or chop and melt ice for a water source. Honey buckets are used in many homes, both in the regional center and in the villages, and at the shelter, many staff members take showers and do laundry at work because of the availability of water. As one person stated, "Water is a pure luxury, especially in the winter." This lack of basic services can make life hard and stressful for those who are living close to or below the poverty level, with crowded housing only adding to family stress.

In this region, jobs are few and the reliance on public assistance is common. According to the Alaska Census Region Labor Market Information (Fried, 1994),

> Finding a wage or salary job in rural Alaska is often a daunting task. Only 66% of rural adults participate in the labor force, versus 75.8% in the rest of the state. . . . In some areas, labor force participation rates barely exceed 50%. (p. 1)

The Arctic borough under study had an unemployment rate of 20.3% in the 1990 census, which was the highest in the state. In 1994, 18.5% of the population of this borough were living in poverty. As one woman in the regional center stated, "Sure we have a technical school, training, but there are no jobs. Some part-time work, but to get a job you have to wait till someone retires. The only jobs are busboys, waitresses, and taxi drivers."

Furthermore, many managerial and professional jobs in the health and education fields are filled by imported labor.

> Statewide 11% of the labor force are Alaska Natives; they account for 7% of the managerial and professional occupations. . . . In the

> Nome census area 60% of the labor pool are Alaska Natives but they hold only 39% of the managerial and professional jobs. (Fried, l994, p. 2)

In the regional center at the time of this study, all the medical personnel at the hospital, all but one of the counselors at the mental health center, all but two of the teachers in the schools, all but one of the teachers at the extended college campus, and all the lawyers and judges were non-Natives who had moved to the area, thus creating a distinct dichotomy between the non-Native professional class and the local Native population. The women who were interviewed noted the difference between the local Native and non-Native perceptions of problems and social circles and voiced frustration with the non-Native professionals who move temporarily into their community, drawing high salaries and staying only for a brief period. As one woman from a village stated,

> White professionals try to help, but it's like they do it with a 10-foot pole. There is a real difference in how they see the problems and how Natives see it. A real difference in where they live and who they associate with.

This dichotomy between non-Native professionals and the local Native population was further commented on by one shelter employee, who stated, "They have the best houses but still you hear them in the grocery store complaining about how hard it is to live here."

The lack of social services and treatment for abusers is also a problem. In the regional center, a residential alcohol treatment program and an Alcoholics Anonymous (AA) group are available, but in the surrounding villages, mental health counselors visit villages for a few days a month or every 2 months, and there are no AA support groups. An anger management class is periodically offered in the regional center that some abusers are court mandated to attend, but such services are not available in the villages. The absence of programs for batterers was noted by one shelter employee, who stated,

Perpetrators don't get help. The court might appoint them to go to counseling. No one goes. No one checks up on them. Perpetrators are still drinking. The courts will appoint it and write it on a piece of paper, but perpetrators think it's funny. . . . There's no follow-up on what perpetrators are ordered to do.

Shinkwin (1983) noted a similar problem:

The study demonstrates that victims have the primary responsibility for "managing" their abuse. Their primary response is to run away. This action protects the wife but it obviously has little effect on the husband since many of these women have been beaten for years. . . . Village women are embarrassed to run constantly to relatives and relatives tire of housing victims. At the same time, relatives seem reluctant to directly intervene in domestic violence. (p. 104)

CULTURAL CONTEXT

Every culture has its own values, norms, and traditions that must be incorporated into social services if they are to be accepted and utilized. In the Inupiat culture, the value of respect and cooperation are important. Inupiat values are listed on the business cards of all shelter employees. These cards state,

Every Inupiat is responsible to all other Inupiat for the survival of our cultural spirit, and the values and traditions through which it survives. Through our extended family we retain, teach and live our Inupiat way. With guidance and support from Elders, we must teach our children Inupiat values—Knowledge of Language, Respect for Culture, Cooperation, Respect for Elders, Love for Children, Hard Work, Knowledge of Family Tree, Avoidance of Conflict, Respect for Nature, Spirituality, Humor, Family Roles, Hunter Success, Domestic Skills, Humility, Responsibility to Tribe. Our Understanding of our universe and our place in it is a belief in God and a respect for His creations.

This statement underscores the importance of family, community, tradition, and respect in the Inupiat culture.

The strong value placed on family, however, can make it difficult for abused women to seek help. Often, women do not want to see their partners go to jail or to anger their abusers' parents, siblings, or friends. Also, a VPSO or police officer is likely to be related to or a friend of the abuser. As one interviewee noted, "I was afraid to call 'cause I knew they wouldn't do anything and it would only make him madder. They all said he was such a nice, funny guy." Another woman stated, "There's a norm against causing trouble. People say [you're] a troublemaker when you put someone in jail. Women are very conscious of their options. They try to resolve things without pressing charges." A village health aide said, "We don't see many battered women at the clinic because health aides have to report to the state troopers, and they will come and arrest the man, even if the woman doesn't press charges."

A woman's ability to obtain services is further hampered if she and her husband are residing in the husband's village, which increases what Gelles and Loseke (1993) called gender inequality. Because it is his village with his relatives, the woman's confidence in getting help is minimized. As one woman recalled, "He was always saying it was his village and I should leave. He said he'll go to the village council and get them to give me a blue card so I could never return to the village." In addition, children are highly valued, and many families are large, which sometimes makes fleeing and finding shelter a difficult task.

For many Alaska Native women, drawing attention to themselves and causing conflict are the last things they want to do. By reporting an incident of domestic violence, they believe, they will start a family quarrel, and they are at the center of the controversy. As one woman stated, "I would never want to send my boyfriend to jail. I just want him to stop beating me. I think that's why a lot of women don't want to call for help." Another woman said, "His father beat his mom, but no one ever talks about it out of respect."

Of course, family has also provided a source of strength and help for battered women in Alaska Native villages. Shinkwin (1983) found that women always fled to the homes of other

women when being abused, and one woman who was interviewed, who was not originally from the village where she was abused, said that other women stood up for her when she had her boyfriend arrested. There is also a strong tradition of taking others in and helping out, so when women flee, they usually find a relative or friend who will give them shelter. Every village has at least one safe-home provider to whom a woman who is being abused can go with her children and stay for a short time until it is safe to return home or until she must leave for another area. As one woman stated, "People here care; if someone is battered or drinking or in trouble, they would never just leave them alone. When I was living in Anchorage, people would avoid a person. Here people are concerned; they try to help."

Another significant factor in seeking assistance for domestic violence in villages is that battered women often do not want to leave their home villages, even if their relationships are dangerous. Traveling to the regional center or to an urban area with a shelter may be not only overwhelming and costly but undesirable. A village is the home of family, friends, and traditions. Also, for many older Alaska Native women, English is not their first language, so they have difficulty communicating when they travel to other regions, and if shelter employees in other areas do not understand and respect their cultural values, it is unlikely that the women would stay for a significant time.

DISCUSSION

Limitations

The main limitations of this exploratory study were the small sample size and the uniqueness of the region under study. It is important to note, however, that many of the environmental obstacles noted by Alaska Native women are similar to those faced by the women in Websdale's study (1998) of domestic violence in rural Kentucky and thus are likely to be experienced by women in other rural regions of the country as well. This study

thus underscores the need for future research on the occurrence of and interventions for domestic violence in rural areas and with Native American and other minority populations.

Implications

It is apparent that domestic violence is a serious issue in rural Alaska, one that is compounded by the obstacles present in many rural environments. The absence of an adequate number of law enforcement officials; the isolation of villages; the lack of many social services; and the widespread availability of weapons, alcohol, and drugs all add to the lethal nature of domestic violence in the region.

On the basis of the comments of the women who were interviewed, three main areas for intervention for and research on domestic violence are apparent, all of which are premised on the societal need to acknowledge the severity and importance of this problem.

First, the safety of women in abusive situations must be ensured. To do so requires funding for an adequate number of law enforcement officials in rural areas and specific training in the area of family violence for these officers, as well as money for women and children to travel to get out of dangerous situations and unhealthy environments. In addition, support for locally based and culturally appropriate safe houses and shelters where women feel comfortable staying temporarily is crucial. As was noted previously, the importance of family, community, and culture makes it unlikely that a battered woman would choose to leave her home community or region to escape an abusive situation. The shelter visited for this study provided an excellent example of a culturally appropriate model. All the permanent staff members were Native women; traditional foods were provided to the residents, and one employee's job description included subsistence hunting and fishing for the shelter; the shelter outreach worker spoke the Native language; a fish camp was built for the residents to spend time at in the summer; safe-home providers were usually elders whom the community members respected; and cultural healing and

strengthening of families was an underlying philosophy of the shelter. The shelter coordinator had this to say about the addition of a fish camp:

> We got a fish camp because we had to. We needed it for the kids. If women have something to do, it's healing. Natives know there are other ways to heal than just to talk in an office. Cleaning fish and talking and just spending time together is healing. In the old days, people could take long walks on the tundra.

In terms of the shelter philosophy, she stated, "We need our hunters. We don't want to divide. If we divide our families, it will be one more part of cultural breakdown. We all need to heal."

Such locally based and culturally appropriate services are crucial if services are to be supported by the community and used by local women for temporary safety and support. In addition, governmental funding for low-income housing and job training programs is necessary for women who choose to leave their abusive situations. Without housing and employment opportunities, women's ability to leave unhealthy situations is limited.

Second, more social services in villages and rural areas are needed, especially services for batterers. Mandated anger management classes that include a component on basic belief systems regarding male-female relationships are important, as are access to alcohol and drug treatment programs and follow-up and general family counseling to strengthen families. Providing such services in rural and remote regions is, of course, extremely difficult because of the vast distances and considerable cost. Therefore, educational programs in the social services delivered through distance education and other innovative means that give site-bound students in rural regions access to mental health training should be strongly encouraged. Such programs could increase the number of culturally sensitive practitioners in rural regions.

Finally, educational programs in schools and communities are needed in such areas as healthy relationships, sexual

respect, and the effects of alcohol and drugs on families and communities. These programs should also include historical information on the treatment of indigenous people in the United States and the onset of current social problems. As Klein, Campbell, Soler, and Ghez (l997), who studied domestic violence in minority communities, noted, "Effective strategies in all communities of color must address the values in transition in these communities—historical perspectives, the impact of racism . . . and develop strategies that include leadership from within the communities themselves" (p. 64).

One shelter employee who was asked what she thought would help decrease domestic violence in the region stated,

> One thing—and it's just one thing—the bringing back of the cultural beliefs would help a lot. Because it's not traditional, it's not part of the culture, it's not part of the ancient culture to be violent in the family. You know, you really try to stay together, work together. It was an economic support. You talk to little old ladies, and there is no word for domestic violence or wife beating. It's just not there. Just like Levi's. There is just no word for Levi's. So bringing back the culture would help. People would be ashamed and wouldn't want to do it.

The strengths model, as defined by Saleeby (l996), which emphasizes resilience and membership, fits this rural Native community well. Resilience is the belief that individuals and communities can rebound and recover from devastating events in the past. As Dossey (cited in Saleeby, l996) stated, "To believe in the naturally selected hardiness and wisdom of the body is to believe in the possibility of any individual or group surmounting difficulty" (p. 301). Similarly, the theme of membership fits with Alaska Native communities that have struggled over the years to overcome cultural upheaval. According to Saleeby,

> As people begin to realize and use their assets and abilities, collectively and individually, as they begin to discover the pride in having survived and overcome their difficulties, more and more of their capacities come into the work and play of daily life. These build on each other exponentially, reflecting a kind of synergy. The same synergetic phenomenon seems true of

communities and groups as well. In both instances, one might suggest that there are no known limits to individual and collective capacities. (p. 299)

Thus, as was noted by the women who were interviewed, domestic violence interventions should include both a consideration of the constraints and specific needs present in a remote environment and an acknowledgment of the importance of individual and communal efforts to strengthen families and communities.

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BOOK REVIEWS

Under Attack, Fighting Back: Women and Welfare in the United States (2nd ed.). By Mimi Abramovitz. New York: Monthly Review Press, 2000, 182 pp., $15.00 (paper).

Abramovitz, a celebrated scholar of gender and social welfare, continues to scrutinize the welfare state from a feminist perspective in the second edition of this book, which presents a concise historical and political analysis of the landmark 1996 welfare reform law. Following the central argument of her first book (Abramovitz, 1988), she draws connections between labor economics and welfare state policies, emphasizing the welfare state's role in regulating low-income women's production and reproduction. Abramovitz argues that the perennial fear that welfare will become more attractive than work has thwarted attempts to improve benefits or services for low-income single mothers. She relates the welfare reform efforts that began in the early 1980s to politicians' desire to establish their conservative credentials and to corporatists' fear that welfare programs would compete for their supply of low-wage labor. The book offers ample historical and theoretical background to understand the dismantling of Aid to Families With Dependent Children in the 1990s and its replacement with the time limitations, work requirements, and other punitive components of Temporary Assistance to Needy Families.

The book is divided into four sections. Part 1, rewritten for this edition, examines the 1996 welfare reform law in the context of major welfare state retrenchment that began in the conservative Reagan era. Part 2 provides a wider historical background for understanding the recent law. It reads almost as a summary of her first book (Abramovitz, 1988) yet focuses specifically on attacks on women's welfare programs from the

1820s to the present. Part 3 critiques gender-neutral welfare state theories and presents several feminist analyses of welfare state policies and programs. Part 4 discusses working- and middle-class women's political activism in the arenas of suffrage, the labor and civil rights movements, and welfare rights organizing. This part is updated to include women's activist response to the 1996 welfare reform law. Although none of these four topics is covered in depth, the book makes several key points that are backed with useful historical and contemporary examples.

Perhaps the major piece missing from this book is an orientation to the future. The early predictions Abramovitz makes about the implications of welfare reform are coming to pass. As time limits are reached and many states cut services to the poor, families are running out of resources. States are scrambling to pass extensions and other provisions that will prevent many families from being homeless and economically destitute. Women's grassroots activism has a long history, but as welfare programs are dismantled and hardship increases, will activism persist, or will the struggle for survival supersede efforts to reform the welfare laws? Where do we go from here?

In conclusion, this book is an excellent choice for a social policy class or for individuals who know little about the welfare state and who want to know more. It is short, easy to read, and full of useful insights. Readers who are highly familiar with this subject matter may find the book more of a review. However, the gender-based analysis and orientation to activism are refreshing in an era of conservative political backlash and negative public opinion about low-income women on welfare.

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Abramovitz, M. (1988). *Regulating the lives of women: Women and social welfare from colonial times to the present*. Boston: South End.

Women and the Criminal Justice System. By Katherine Stuart van Wormer and Clemens Bartollas. Boston: Allyn & Bacon, 2000, 244 pp., $33 (paper).

As the number of adults under correctional control has swelled in the United States (Beck & Karberg, 2001), it has become crucial for social workers to have a working knowledge of the criminal justice system. Using a feminist lens that recognizes how gender, race, and class intersect to contribute to the choices women make and the consequences they suffer; and an empowerment perspective for promoting possibilities for change, this book focuses on women who both affect and are affected by crime and the criminal justice system.

The authors build on previous work in this genre (Feinman, 1994; Price & Sokoloff, 1995) that presents more of the objective overview of these issues from a broader historical and criminological standpoint. They provide updated information on the current status of women in all aspects of the U.S. criminal justice system. In the section on incarcerated women, they draw from the important Amnesty International report that documented sexual harassment and assault against women prisoners by correctional employees in the United States, as well as progressive trends in the treatment of women prisoners in Canada and Western European countries.

The section on women as victims and survivors presents a useful summary of the issues of violence against women and the movements in the past 20 years that have secured improved responses in the criminal justice system and in crisis centers and shelters. The authors acknowledge, however, the costs of the greater choices for women of color in pursuing charges when the race of the perpetrator (and in the case of rape, the victim) is a predictable factor for conviction and sanctions. One growing area of alarm that the authors call attention to is the

increased documentation of the use of rape and torture in international situations of armed conflict when attempts to seek justice in extreme cases meet with official silence or indifference.

The final section on women professionals in the male-dominated legal, law enforcement, and correctional fields discusses the many layers of discrimination and sexual harassment that women face in both entering these professions and challenging the status quo of authoritarian domination and inequality.

A distinguishing feature of the book is the use of personal narratives, original interviews, vignettes, and illustrative sidebars. This subjective voice lends an authentic tone to the book that is consistent with its empowerment orientation.

The book is a useful tool for bringing the issues of women's struggles and agency front and center in courses in criminal justice programs. It may be less useful for social workers because it does not address the many locations where they are most likely to see women who are involved with the criminal justice system as offenders, particularly in probation or parole. Although the authors discuss the driving forces of drug enforcement and sentencing policies in the increasing flow of convicted women on drug charges, they do not discuss the intersection of the resulting correctional control and incarceration with recently adopted policies of child welfare and welfare reform. It is at this intersection that the weight of involvement in the system, even as a victim, can result in multiple losses of housing, public aid, and children. Although the authors' description of the causes of crime may provide a useful backdrop to understanding what brought women to the attention of the criminal justice system, it does not facilitate practitioners' knowledge of the many resources that former prisoners, activists, and academics have developed to support recovery and reintegration.

Finally, the authors provide a list of "future trends" that references improvements in conviction rates for rapists and the potential of women's political influence in the criminal justice system. They neglect, however, to provide a much-needed summary of recent efforts to create strategies to provide gender-specific alternatives to incarceration that address some of the

complexities of women's involvement in crime, including issues of victimization, relational issues, parenting, addiction, and self-empowerment. In addition, there is slight attention to the evolving restorative justice movement, which provides some promise for doing justice differently for offenders, victims, and communities.

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Feinman, C. (1994). *Women in the criminal justice system*. Westport, CT: Praeger.
Price, B. R., & Sokoloff, N. J. (Eds.). (1995). *The criminal justice system and women: Offenders, victims, and workers*. New York: McGraw-Hill.

A Woman's Guide to Menopause and Hormone Replacement Therapy. Edited by Lorraine Dennerstein and Julia Shelley. Washington, DC: American Psychiatric Press, 1998, 160 pp., $26.95 (hardbound).

The major contribution of this book, divided into 10 chapters, each written by authors from a variety of disciplines, is that its primary focus is on the detriments and benefits of hormone replacement therapy (HRT). The editors admit in the preface that they did not attempt to remove overlap or contradictions among the chapters because they wanted to impress on the reader that there still exists much controversy over the most appropriate "treatment" of menopause. Although this approach is understandable, the resulting redundancy may be annoying to the reader.

The book does a good job of providing basic information about the function of hormones and effectively argues against the perception of menopause as an "estrogen deficiency

disease." The authors review what has been acknowledged as the more universal symptoms of many midlife women but present some fascinating data from cross-cultural studies that underscore the vast differences in how women experience this midlife transition.

One of the most informative chapters is "Why Hormone Therapy Is a Social Issue." The author not only questions whether medicine is overestimating the benefits of HRT for heart disease and underestimating its effect on breast cancer but examines the "social agenda" that may be behind the medicalization of menopause. In fact, several of the authors examine the stigma of aging for women and discuss the ways in which many cultures serve to reinforce that stigma, thus making women themselves clamor for a "cure" to this natural aging process.

The authors also examine the psychosocial aspects of menopause and conclude that there are many variables that shape how women emotionally approach this phase of life. One of the major changes in women's lives in developed countries has been the increasing number of women in the workforce. Because of this trend, women's identity is, in many cases, no longer directly tied to their reproductive capacity. Although this experience varies with social class, the option for paid work during and after women's childbearing years seems to have lessened the significance of this developmental stage. These developments have served to deconstruct the old models that conceptualized menopause as a time of loss, mourning, and regret.

Although the chapter on the positive role of exercise and diet in midlife is informative, it does not contain much new information. In addition, the chapter on natural therapies is too technical and therefore not practical.

This book is an easy-to-read guide that would be most useful to those who have read little on the subject of menopause. Its greatest strengths are its examination of the pros and cons of HRT and its framing of menopause within the context of cultural values surrounding the aging process for women. The information contained in this text could greatly enhance the

quality of the dialogue that women in midlife should be having with their health care providers.

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INDEX

to

AFFILIA

JOURNAL OF WOMEN

AND SOCIAL WORK

Volume 16

Number 1 (Spring 2001) pp. 1-128
Number 2 (Summer 2001) pp. 129-256
Number 3 (Fall 2001) pp. 257-400
Number 4 (Winter 2001) pp. 401-524

Authors:

Articles

Book Reviews

Editorials

Poetry

"Circle Broken," Soule, 102.
"The First Home Visit," Bevernitz, 105.
"The Kitchen," Coss, 100.
"Still Not Funny," Soule, 104.

INFORMATION FOR AUTHORS

The Editorial Board of *Affilia: Journal of Women and Social Work* invites the submission of manuscripts, poetry, articles, reports, essays, and literary pieces that relate to its mission: to the discussion and development of feminist values, theories, and knowledge as they relate to social work and social welfare research, education, and practice. All forms of writing and analysis will be considered and a range of feminist perspectives will be encouraged. The intent of *Affilia* is to bring insight and knowledge to the task of eliminating discrimination and oppression, especially with respect to gender, race, ethnicity, class, age, disability, and sexual and affectional preference. The editors seek manuscripts from people both in and outside the field of social work that offer a critical analysis of the condition of women in this and other societies, apply these ideas to social welfare purposes, and work toward the empowerment of women in an equitable society.

Manuscripts should be submitted in quadruplicate, typewritten and double-spaced in 12-point font. Maximum length of a manuscript for an article is 20 pages (25 pages for manuscripts reporting on qualitative research), including text, tables, references, and all else. Authors are requested to submit manuscripts in the reference style specified in the *Publication Manual of the American Psychological Association* (4th ed.). Authors should supply a separate cover sheet with name of the author(s) and other identifying information. An abstract of fewer than 100 words should accompany the manuscript. It is assumed that manuscripts are submitted for exclusive consideration of *Affilia* and have not been simultaneously submitted elsewhere. Submit manuscripts to Miriam Dinerman, Editor-in-Chief, AFFILIA, School of Social Work, Yeshiva University, 2495 Amsterdam Avenue, New York, NY 10033.

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DEADLINES EXTENDED

Request for Proposals
for a
Feminist History of AFFILIA

SUMMARY: The Corporate Board of Women and Social Work, Inc., which publishes *Affilia Journal of Women and Social Work*, is offering a $10,000 cash stipend for a history of the origins and development of *Affilia* in the context of the values and politics of the women's movement in social work and social work education.

BACKGROUND: *Affilia*, the first feminist social work journal, is a result of the ferment in social work education in the 1970s and 1980s regarding the role and status of women, people of color, and lesbians and gays in social work. Dissatisfaction regarding curriculum content, salary inequities, and unequal opportunities for promotion, tenure, and publication provided the impetus for creating this journal. The journal will celebrate its 20th anniversary in 2005 and the history of its origins should be ready for dissemination at that time.

PRODUCT: We desire an accessible history of the journal in several possible forms: an article submitted for publication in *Affilia*, a free-standing document published by Women & Social Work, Inc. for wide dissemination, a videotape, CD-ROM, Web site, graphic recording, and so forth.

PROCESS AND METHODOLOGY: The history must be thoroughly researched, and may be in the form of a dissertation. Any product published by Women & Social Work, Inc. would not infringe on the author's intellectual property rights should he or she later wish to publish the work as a book. Applicants should include in the submission a proposed methodology for the study.

QUALIFICATIONS: Familiarity with the larger women's movement, demonstrated research skills, and competence in feminist analysis are expected. If this is part of a doctoral dissertation, the student's doctoral chair should have competence in feminist analysis as well.

AWARD: A stipend of $10,000 will be awarded over 2 years in three installments, contingent on satisfactory progress and the final installment with completion no later than January 31, 2004.

TIMELINES: New deadline for submission is December 31, 2001, with award notification by March 31, 2001. Completed project must be submitted no later than March 31, 2004, for publication in the 20th Anniversary Year of *Affilia* in 2005. Eight copies of the application must be submitted with a curriculum vita. If this is a doctoral dissertation, eight copies of the Chair's CV must also be submitted. Applications will be reviewed and decided by the Corporate Board of Women & Social Work, Inc.

Proposals should be mailed to

Dr. Betty Sancier, President of Women & Social Work, Inc.
2715 East Park Place, Milwaukee, WI 53211