The mission of the Journal of Student Social Work is to provide a forum for the exchange of innovative ideas that integrate social work practice, education, research, and theory from the perspective of social work students. First published by students at the Columbia University School of Social Work in 2003, this academic journal provides an opportunity for students in the field of social work to share their unique experiences and perspectives with fellow students, faculty, and the larger social work community.
# Table of Contents

Editorial Introduction ........................................................................................................ Page 4

Editorial Board .................................................................................................................. Page 5

Advisory Board .................................................................................................................. Page 6

The Battle for Effective Sexuality Education

*by Jennifer Friedman* ....................................................................................................... Page 7

A Brief Review of Issues in PTSD Research Following the September 11 Tragedies

*by Sarah S. Jeon & Terra K. Marroquin* ........................................................................ Page 17

The Use of Play Therapy with Child Victims of Sexual Abuse

*by Jamie D. Aarons* ......................................................................................................... Page 27

Rescuing the Self from Selflessness:
How We Can be Better at Helping Others by Helping Ourselves

*by Steve Salee & Jonathan Sibley* .................................................................................. Page 35

Paradigm of Rural Homelessness:
A Case Study of Clinton County, New York

*by Jessica Spissinger* ...................................................................................................... Page 46

Reflections of Racial Consciousness in Social Work

*by Jamie Favaro* ............................................................................................................. Page 53

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Cover Design by John LeBaron, CUSSW '05
Welcome to the second volume of the *Columbia University Journal of Student Social Work*.

This academic journal strives to be a forum for students of social work to critically analyze the existing structures within which we practice and learn. It is the belief of the Editorial Board that both the content and process of social work practice must be continuously examined in order to promote effective interventions and outcomes. By publishing a student social work journal, we are challenging future practitioners to begin a social work career dedicated to such exploration through professional publication.

In order to uphold the Code of Ethics of the National Association of Social Workers, an awareness of all aspects of social work, gained through self-exploration and continuous learning, must be entwined in one’s practice knowledge. As clinicians, advocates, researchers, and administrators, social workers occupy an increasingly diverse set of roles, beginning in graduate social work school. This *Journal* encompasses that diversity from the fresh perspective of the field’s newest professionals.

In this volume, Jeon & Marroquin remind us of the need to be discriminating contributors to and consumers of social work research. Spissinger reflects on the cautions of applying interventions for the homeless without consideration of specific community needs. Salee & Sibley and Favaro encourage social work students to enhance their use and understanding of self in practice, be it through an examination of racial identity or self-care techniques. Aarons presents a critical analysis of clinical practice with sexually abused children. Finally, Friedman critiques the policy implications and the role that values play in sexuality education for adolescents.

As change agents for the individuals, communities, and systems we serve, social workers have an obligation to seek out knowledge. This *Journal* is just one forum for students to learn from their fellow peers, participate in the discourse, and ultimately contribute to the social work profession.

We hope you enjoy the second volume of the *Columbia University Journal of Student Social Work*.

2004 Editorial Board
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THE BATTLE FOR EFFECTIVE SEXUALITY EDUCATION

Jennifer Friedman

Sexuality education for young people is no longer confined to awkward family discussions or whispered conversations in the school hallway. The rise in teenage pregnancy, legalization of abortion, and the spread of HIV thrust adolescent sexual behavior into the realm of policy makers and government officials. Sexuality education emerged as a potential mechanism for targeting these public health issues; however, a divisive battle over appropriate content and structure has led to inconsistent implementation of sexuality education programs for American youth. While the programs seek to curb teenage pregnancy and prevent the transmission of sexually transmitted diseases (STDs), the debate over what kind of sexuality education best achieves this goal illuminates crucial issues regarding the role of values and personal behavior regulation in social welfare policy.

This article will cover historical trends in sexuality education, the current federal policy and alternatives, and discuss the limitations and subsequent consequences for future policy. Additionally, this article will highlight the important implications of the sexuality education debate for the social work profession. In response to a growing decline in the health status of adolescents in the United States, the National Association of Social Workers (NASW) has called for an increased focus on adolescent health issues and comprehensive prevention services, particularly around adolescent sexual behavior (NASW, 2004). In light of social work’s commitment to self-determination and access to reproductive health resources, the NASW recently declared...
its intentions to co-sponsor the March for Women’s Lives in April 2004 (NASW, 2004). Given the increasing role that reproductive health and sexuality will play in the upcoming political arena, it is essential that social workers be informed about sexuality education policy and effective interventions.

The sexuality education debate is complicated, as it includes concern over the impact of sexuality education on youth sexual behavior and the efficacy of such programs in preventing pregnancy and HIV/STDs. The concerns are important: one in five adolescents have had sex prior to age 15, half of all 17 year olds are sexually active, and nearly 850,000 teenagers become pregnant each year (Health Education Advocate, 2003). Since the Progressive era, sex education has mainly been a function of schools; 89% of public school students will take sex education sometime between grades seven to 12 (Luker, 1996; Kaiser Family Foundation, 2000). But the policy debate also affects secular and religious organizations that provide sex education and stretches beyond moral and social prerogatives; nearly $100 million in government funding is available to schools and community-based organizations that implement federally-approved sex education programming. Current policy dictates that available funding must be used for abstinence-only education programs, which seek to prevent premarital sexual activity and convey the message that abstaining from sexual activity until marriage is the “morally correct option” (Advocates for Youth, 2001, p.7). The policy focus on abstinence and the increase in funding has impacted the nature of sex education; in 1999, 23% of secondary schools taught abstinence compared to 2% in 1988 (Darroch, Landry, & Singh, 2000).

Schools and organizations that do not receive federal funding are free to pursue alternatives to abstinence education, frequently described as comprehensive sexuality education. In 1990, the Sexuality Information and Education Council of the United States (SIECUS) developed guidelines that cover the six main concepts of comprehensive sexuality education: human development, relationships, personal skills, sexual behavior, sexual health, and society and culture (SEICUS, 1996). Comprehensive programs emphasize abstinence, but also provide information about contraception and disease prevention in addition to education on adolescent development, relationships, sexual orientation, and other life issues. A 1999 survey conducted by SEICUS and Advocates for Youth found that 93% of Americans supported comprehensive sexuality education (Advocates for Youth, 2001).

**History and Policy Development**

The current sex education policy battle and conflict over funding reflects the historical ambiguity of American attitudes toward teenage sexual behavior. Over the last thirty years, the growing awareness of teen pregnancy, the abortion controversy, and the reemergence of po-
litical and religious conservatism have significantly impacted sexual-
ity education politics (Goodson & Edmundson, 1994; Wilcox, 1999).

Teen Sexual Behavior Moves to the Forefront in the 1970s

In the 1970s, the rates of abortion increased, as did the numbers of
women having children outside of marriage. While adolescents repre-
sented a small percentage of these trends, the combination brought teen
sexual behavior into the forefront. A 1976 report by the Alan Guttmacher
Institute further heightened awareness around adolescent sexuality and
the “epidemic” of teenage pregnancy (Wilcox, 1999; Luker, 1996). The
policy approach in the 1970s embraced the provision of family planning
services and contraception; in 1970, Congress passed the Family Planning
Services and Population Research Act under Title X of the Public Health
Services Act. The act did not originally target adolescents, but as a result
of the growing awareness of teen sexual activity, Congress specified that
adolescents should receive targeted family planning services under Title
X. The support for family planning also stemmed from a political con-
sensus that preventing adolescent pregnancy and childbirth would aid ef-
forts to prevent poverty and decrease welfare expenditure (Wilcox, 1999).

Focus Shifts to Abstinence Education in the 1980s

Support for increasing adolescents’ access to contraception and family
planning resources was short-lived. By the early 1980s, a more conservative
administration and a growing anti-abortion movement shifted the focus to
abstinence education. Opponents of the family planning approach claimed
that support for contraceptive services encouraged sexual promiscuity and
thus sought to replace these services with programs that would prevent sex-
al activity (Luker, 1996). Furthermore, proponents of abstinence education
argued that the prescriptive nature of abstinence programs would place sex
within the context of committed, monogamous relationships (Goodson &
Edmundson, 1994; Olsen, Weed, Nielsen, & Jensen, 1992). In 1981, the
first full-fledged federal policy mandating abstinence education was passed.

The Adolescent Family Life Act (AFLA) was passed in an effort to
create programs that develop “strong family values” and promote “self-
discipline” (Title XX, as cited in the Office of Population Affairs, 2003b).
The AFLA supports demonstration projects that develop and implement
abstinence curricula, or provide support services for pregnant and par-
eting adolescents to “ameliorate the effects of too-early-childbearing
for teen parents” (Office of Population Affairs, 2003a). The act promotes
adoption as the preferred option for pregnant teens and prohibits funding
for programs that provide abortions or abortion counseling/referral (Ti-
tle XX as cited in the Office of Population Affairs, 2003b). While fund-
ing for AFLA decreased during the Clinton administration, the program
has seen a revival during recent years. In 2000, the AFLA received $19 million — three times the funding it received in 1994 (Brindis, 2002).

The AFLA has faced significant challenges, most notably the lawsuit filed in 1983 by the American Civil Liberties Union (ACLU). The ACLU argued that the AFLA was a violation of the separation of church and state, as much of the initial funding was used to support religious-based programs that explicitly promoted religious values (Saul, 1998). A U.S. District judge found in favor of the ACLU, but the U.S. Supreme court reversed the decision in 1988. The court however, remanded the case for further fact-finding, which uncovered constitutional violations in the AFLA’s administration. As a result, in 1993, a five-year settlement reformed the grant administration process and required all AFLA grantees to submit curricula for review of the material’s content and accuracy (Saul, 1998).

**Increased Funding for Abstinence Education in the 1990s**

In spite of constitutional concerns over the AFLA and abstinence programs, the legislature continues to increase funding for abstinence education. The 1996 welfare reform legislation contains a specific entitlement program for abstinence-only-until-marriage education, allocating $50 million per year for five years beginning in 1998. States receiving funds are required to match every four federal dollars with three nonfederal dollars, thus creating a total of nearly $500 million in spending for abstinence education (General Accounting Office, 1998; Wilcox, 1999). The legislation dictates the parameters of acceptable abstinence-only programming using a strict eight-point definition, which includes teaching that non-marital sexual activity is likely to have harmful psychological and physical effects (Advocates for Youth, 2001). Wilcox notes that the legislation did not originally allocate any funds for evaluation; after reproductive health advocates protested, Congress allotted an additional $6 million for evaluation purposes.

The funding provided under the welfare reform act is having a significant impact on the nature of sexuality education. In its first year of funding, all fifty states applied for grants under the abstinence-only-until-marriage provision (Advocates for Youth, 2001). Some states reported concern over the restrictive nature of the abstinence programs, and difficulty in matching federal funds without decreasing funding for existing comprehensive programs (General Accounting Office, 1998). Despite these concerns, funding for the program was reauthorized in 2002 (Smith, 2002). States channel these funds for programs in school districts, community-based organizations, and faith-based institutions (Advocates for Youth, 2001). While these programs have a range of messages and some are also privately funded, many have religious affiliations and include material that directly refers to specific religious beliefs (Trevor, 2001). The influence of religious values on sexuality education policy is frequently debated; Good-
son and Edmundson (1994) argue that abstinence-only approaches were promoted in response to concern over the “value-free” character of previous sexuality education approaches. The intersection between religious values and approaches to sexuality education raise powerful questions about whether adolescent sexuality is a public health issue or a moral concern.

Support for Comprehensive Sexuality Education

In spite of the government’s success in promoting abstinence education, there are many who feel abstinence-only programs are fundamentally flawed and support alternative ways to promote responsible sexual behavior among youth. Supporters of comprehensive approaches to sexuality education argue that abstinence-only education programs promote a specific set of values, use fear and shame to influence young people’s sexual behavior, and contain biased information about family structure, sexual orientation, and abortion (Advocates for Youth, 2001; Trevor, 2001). Supporters also point to European approaches and policies towards sexuality education. Darroch, Frost, and Singh (2001) report that countries such as Sweden, France, and the Netherlands have significantly lower rates of teenage pregnancy and abortion, despite similar levels of sexual activity among youth.

Unlike the U.S., however, these countries mandate comprehensive sexuality education. In France and Sweden, research has shown that positive attitudes about sexuality and clear expectations for behavior in sexual relationships contribute to more responsible teenage sexual behavior. In addition, adolescents in Europe have greater access to contraceptive services and the media is used to promote positive sexual behavior. Despite limited support in the United States government, promoters of comprehensive sexuality education often refer to the Surgeon General’s 2001 Call to Action, which states that adolescents need accurate information about contraceptive methods and that providing sexuality education in the schools is crucial for providing youth with a basic understanding of sexuality (Office of the Surgeon General, 2001).

In light of these alternatives, The Family Life Education Act (H.R. 3469, 2001) was introduced to the 107th Congress in December 2001. The Act called for the appropriation of $100 million each year for five years to fund block grants to eligible states for family life education programs, “including education on both abstinence and contraception for the prevention of teenage pregnancy and sexually transmitted diseases, including HIV/AIDS” (H.R. 3469, 2001). The requirements for the program stated that funding could not be used to teach or promote religion and that information on adolescent development, healthy life skills, and interpersonal skills must be included in program content. In addition, the bill stipulates an extensive evaluation procedure including a national evaluation of sample family life programs as well as state evaluation (H.R. 3469, 2001). The bill currently has 89 sponsors in the House,
but remains in the Subcommittee on Health (Advocates for Youth, 2003).

**Limitations of Current Policy**

The current policies regarding sexuality education in the U.S. are problematic. First, despite the implementation of federal funding and policy for abstinence education, there is no coherent agenda for sexuality education. Most education policy remains under the jurisdiction of state and local governments; as a result, states may have multiple policies governing sex education, leading to tremendous variation in the structure and content of programs. Sex education programs may also vary among communities depending on local preferences, values, and policies, particularly in schools (General Accounting Office, 1998; Kaiser Family Foundation, 2000). Geographic location also dictates young people’s access to information and resources pertaining to sexuality.

Second, federal sexuality education policy has been implemented with little debate and away from the spotlight. Both the AFLA and abstinence education provision of the welfare reform legislation passed without extensive discussion (Saul, 1998). Such legislative tactics may be necessary to the success of the legislation, as recent polls show that only 18% of Americans support teaching only abstinence until marriage (Kaiser Family Foundation, 2002). Advocates for comprehensive sexuality education found there was increased discussion about sexuality education during the recent welfare legislation reauthorization process; however, open public discussion is necessary for a more informed debate (Smith, 2002).

Lastly, the effectiveness of sexuality education is still open to debate among health and social service professionals and policy makers, largely as a result of limited evaluation efforts. In summary of the World Health Organization’s review of program effectiveness, Grunseit and Aggleton (1998) state that the success of HIV and sexuality education programs hinges on whether the programs have the capacity to change behavior, whether the programs cause unintended or negative outcomes, and whether the programs have been adequately evaluated so that outcomes can be relied upon. There is an overall need for increased evaluation funding and sound evaluation methodologies, particularly for abstinence education programs (Kirby, 2002; Grunseit & Aggleton, 1998). The General Accounting Office (1998) report on teen pregnancy prevention programs found that evaluation was often focused on process rather than outcome; state evaluations measured changes in knowledge, attitude, and behavioral intentions rather than sexual and contraceptive behavior.

In spite of these limitations, research has shown that comprehensive sexuality and HIV education programs do not increase the sexual activity of young people, nor do they hasten the onset of sexual behavior. In fact, the literature demonstrates that some programs increase condom
or contraceptive use among sexually active youth and may even delay sexual activity for some youth (Grunseit & Aggleton, 1998; Kaiser Family Foundation, 2002; Kirby, 2002). Kirby also identified ten characteristics of curricula effective at reducing unprotected sex, which included, among others, using theoretical approaches to behavior change, incorporating clear messages about sexual activity and contraceptive use, and providing modeling and practice of communication skills.

Given the available research on comprehensive sexuality education and the limited information on the efficacy of abstinence education, it is significant that current federal policy solely supports abstinence-only-until-marriage programs. Such policy positions raise questions over the government agenda and whether intentions are to reduce teen pregnancy or to regulate behavior and “legislate morality” (Ehrhardt, 1996, p.1524). Among states receiving federal funds for abstinence programs, the lack of evidence-based research was cited as a concern (General Accounting Office, 1998). A report by the National Campaign to Prevent Teen Pregnancy found only three published evaluations of abstinence-only programs that were rigorous enough to be included in its literature review (Kaiser Family Foundation, 2002). Kirby (2002) cautions that the lack of evidence should not be taken as a generalization about the effectiveness of abstinence-based education; there are a diverse range of abstinence-only programs and further evaluation could demonstrate an impact on youth sexual behavior. However, until more comprehensive research efforts are completed, it is essential that programs be based on accurate information and realistic notions of adolescent sexuality (Ehrhardt, 1996).

Conclusion

In general, concerns over the effectiveness of sexuality education programs are largely focused on behavior – what will adolescents do as a result of receiving such education (Grunseit & Aggleton, 1998). For supporters of abstinence-only education, the desired aim is the prevention of sexual activity until marriage. As an alternative to this limited scope, Michelle Fine (1988) argues that sexuality education should offer an “empowering context in which we listen to and work with the meanings and experiences of gender and sexuality revealed by the adolescents themselves” (p.36). This would include providing a safe space for exploring sexuality and discourse on desire (Fine, 1988). Ehrhardt (1996) adds that adolescent sexuality is always presented in the context of risk behavior, rather than focusing on positive notions of sexual behavior and feelings as part of normal human development. As in other areas of educational policy, the goal should be to help young people become sexually competent individuals (Ehrhardt, 1996). This emphasis is important for social workers since the profession’s values promote the importance of human relation-
ships and enhancing an individual’s ability to meet his or her own needs. As practitioners, social workers can effectively provide a safe space for adolescents to explore issues of sexuality and make informed choices.

While the future of sexuality education in the U.S. rests largely on improved evaluation methods and demonstration of effectiveness, the values debate cannot be ignored. The ability to demonstrate effectiveness can help guide policy decisions towards evidence-based programming rather than value-laden agendas; however, even evaluation efforts are rarely value-free. In addition to evaluation, it is also important to examine the underlying goals of social welfare policy — is the goal of sexuality education policy to prevent and educate or to restrict personal behavior? As social workers, we must understand the impact of such policies and work to support policies that promote self-determination and individual well-being. Rather than regulating and dictating behavior through abstinence only programs, comprehensive sexuality education programs seek to educate and empower young people and increase their access to resources. In this light, it is imperative that social workers advocate for comprehensive approaches to sexuality education, both by staying informed about local and community policies and lobbying national legislators to support comprehensive approaches to sexuality education such as the Family Life Education Act.

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of sex education programs advocating abstinence. Adolescence, 27(106), 369-380.

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A BRIEF REVIEW OF ISSUES IN PTSD RESEARCH FOLLOWING THE SEPTEMBER 11 TRAGEDIES

Sarah S. Jeon & Terra K. Marroquin

The attacks on the World Trade Center (WTC) on September 11, 2001 resulted in the largest loss of life due to terrorism that the United States has ever encountered. Terrorism often results in pronounced numbers of Post Traumatic Stress Disorder (PTSD) cases. Following the September 11 attacks, many research studies reported increases in PTSD, Post Traumatic Stress Symptoms (PTSS), and stress reactions; however, the inconsistency in the methods used to gather and analyze data poses problems in comparing and interpreting these results. A brief review of the methods used in trauma-related research following September 11 is presented. Guidelines for interpreting this research are also presented.

The attacks on the World Trade Center (WTC) on September 11, 2001 were devastating, killing 2,797 people (American Red Cross, 2003). Concerns over widespread trauma both nationally and internationally have been at the forefront of the mental health agenda since that time. Ongoing research regarding the short- and long-term effects of traumatic events is crucial for evidence-based social work practice and the provision of mental health services. However, a critical analysis of the methodologies used in research studies is needed before conclusions regarding the prevalence of Post Traumatic Stress Disorder (PTSD) or other mental health outcomes can be made.

Currently no common methodology for studying reactions to wide-scale disasters exists, making it difficult to compare studies and establish the validity of research results (North & Pfefferbaum, 2002). In this paper, the use and interpretation of trauma questionnaires as well as the terminology used in describing PTSD symptomatology will be explored so that researchers and clinicians alike may be more informed consumers of trauma-related literature.

Social workers, other mental health professionals, and researchers need to be able to differentially identify and properly diagnose PTSD. In the first two weeks of the World Trade Center Health Registry, more than 10,000 people worldwide enrolled for assessment through a health survey gauging the mental and physical health problems resulting from the September 11 attacks (New York City Department of Health and Mental Hygiene, 2001). This response indicated the large number of persons impacted by the disaster. The American Red Cross (2003) reports that
their organization provided as many as 240,000 mental health contacts immediately following the attacks. It was critical, therefore, that mental health professionals were able to identify persons who were likely to develop PTSD so as to offer appropriate treatment to these large populations.

**Diagnosing PTSD**

According to The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (American Psychiatric Association [APA], 2000), a diagnosis of PTSD is dependent upon exposure to an event that involves “actual or threatened death or serious injury” to one’s self or loved one or the witnessing of such an event which causes a sense of “intense fear, helplessness, or horror” (APA, p. 464). Symptoms, including re-experiencing the event, avoidance and numbing, and increased arousal, must last longer than one month and cause significant impairment or distress. Frequently, following a traumatic event an individual may not meet criteria for PTSD but may have Acute Stress Disorder (ASD) or Post-Traumatic Stress Symptoms (PTSS). ASD symptomatology matches that of PTSD but occurs within 30 days of a traumatic event (APA, 2000). People suffering from PTSS may have some characteristics of ASD or PTSD and may experience significant distress, yet do not meet full DSM-IV-TR criteria for either disorder.

While practitioners must carefully adhere to DSM-IV-TR criteria to diagnose PTSD, prevalence studies following mass trauma like the events of September 11 are rarely able to draw diagnostic conclusions. Using a clinical interview, a clinician can conduct a thorough assessment by gathering information on the duration and extent of the impairment, gauging the client’s prior history of trauma and psychiatric illness, and assessing for co-morbidity of other psychiatric illnesses. Researchers use brief questionnaires like the PTSD Checklist (PCL) (Weathers, Litz, Herman, Huska & Keane, 1993) to make statements about the prevalence of PTSD symptoms. Although such checklists are the most efficient way to uniformly collect data from large samples, they do not measure impairment of functioning or duration of symptoms, which are crucial for a DSM-IV-TR diagnosis. Research studies often do not conduct thorough assessments, and, when misrepresented or misinterpreted, may lead to inflated statistics about the true number of PTSD cases. Increasing the knowledge base concerning the data collection, analysis, and interpretation methods used in trauma research is necessary to provide a clearer picture of prevalence rates, responses to traumatic events, and the design of effective interventions for practitioners.

**Trauma, Terrorism, and PTSD Research**

Prior to September 11, the National Institute of Mental Health (2001) reported that 3.6% of adults in the United States (5.2 million people) had PTSD during a given year. While many of the studies of the psychological
impact of trauma due to terrorism in the United States were conducted on individuals exposed to the Oklahoma City Bombing (North et al., 1999), more recent studies of terrorism and PTSD in the United States focus on September 11. Several of these studies reported a surge in PTSD-related symptoms amongst persons living in New York City following the attacks (Bascarino, Galea, Ahern, Resnick, & Vlahov, 2002; Sattler, 2002; Schlenger et al., 2002; Schuster et al., 2001). Galea et al. (2002) found that 7.5% of a sample of adults living south of 110th Street in Manhattan showed symptoms consistent with PTSD. South of Canal Street, the prevalence rate was reportedly 20%. Schlenger et al. estimated that there could be more than 500,000 cases of PTSD as a result of the event in the New York metropolitan area alone and reported a rate of 11.2% of probable PTSD cases found in their study of New York City residents. Such results, however, must be considered carefully given that the methods used to interpret findings of PTSD symptoms vary from study to study.

The events of September 11 were distinct in nature due to both the large-scale destruction akin to a natural disaster and the component of intentional harm inflicted by one human towards another. Natural disasters have traumatic effects due to large losses of life and property (Cao, McFarlane, & Klimidis, 2003). However, it has been found that intentional harm inflicted by one human towards another has even longer-lasting effects in the development of PTSD (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999; Norris, Byrne, Eolia, & Krzysztof, 2001; Thabet, Abed, & Vostanis, 2002). According to the Code of Federal Regulations (as cited in the Federal Bureau of Investigations, 1998), terrorism is defined as “…the unlawful use of force and violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives.” Terrorism, as viewed from a mental health perspective, is particularly damaging and has resulted in a pronounced number of cases of PTSD (Bleich, Gelkopf, & Solomon, 2003; North et al., 1999; Schlenger et al., 2002). Additionally, a single-event terrorist attack such as September 11 may be as traumatic as repeated exposure. Bleich, Gelkopf, and Solomon conducted a study on a representative sample of the population in Israel, a country where frequent terrorist acts occur, and found that 9.4% of Israeli individuals met symptom criteria for PTSD (Bleich, Gelkopf, & Solomon). This is comparable to 7.4% (Galea et al., 2002) and 11.2% (Schlenger et al.) found in New York City following the September 11 attacks. These results are noteworthy considering that much of the sample gathered in Israel had experienced 19 months of repeated terrorist attacks prior to their study. However, the methodologies used for each of these studies were different, as were the sources of exposure considered, the subjects’ proximity to the events, and the sampling methods used.
Approaches to Research

The inconsistent application of questionnaires to conduct research on the prevalence of PTSD poses problems in comparing and validating results of research studies. Most studies utilize one of two major PTSD scales—the PCL or the Diagnostic Interview Schedule (DIS), which is based on the DSM-III-R (APA, 1987). Although comparisons between the two instruments are difficult to draw, the more distressing issue is the lack of consistency in interpreting results from the same measure. Three different methods noted in major studies of PTSD following the September 11 attacks illustrate this point. In the studies reviewed here, Schuster et al. (2001) opted to present PTSD symptoms according to levels of symptom severity; Schlenger et al. (2002) portrayed “probable PTSD” as a dichotomous variable, in which an individual met criteria through the tallying of symptoms; and Galea et al. (2002) grouped symptoms according to DSM-IV-TR criteria and determined whether the person met threshold numbers in each category. While these methods are useful as screening devices for potential PTSD cases, they can lead to inflated prevalence statistics.

Researchers who conduct large prevalence studies usually understand the inherent difficulties in diagnosing PTSD through scales and brief measures, rarely stating outright that they are measuring PTSD. Instead, they employ tentative language, carefully choosing their words to reflect the uncertainty of a clinical diagnosis. Below, the language used in each research study reviewed will be examined.

Levels of Symptom Severity

One of the largest studies conducted after September 11 was by Schuster et al. (2001) and has been cited extensively (Bleich, Gelkopf, & Solomon, 2003; North & Pfefferbaum, 2002; Schlenger et al., 2002). In this study, 560 adults participated in telephone interviews three to five days after September 11 that focused on their stress and coping responses. The researchers used the term “stress reactions” throughout their article. This careful use of terminology reflects the fact that PTSD cannot be diagnosed for at least one month after the event. Although assessing for stress reactions provides a measure of general distress, it does not discern which reactions are sufficient for a full DSM-IV-TR diagnosis of PTSD. The term “stress reactions” also seems to appropriately indicate that the use of cutoff scores for PTSD symptoms does not necessarily mean that the person meets a full DSM-IV-TR diagnosis of PTSD (North & Pfefferbaum).

Schuster et al. (2001) used the PTSD Checklist (PCL) to determine levels of symptom severity. The PCL is a 17-item checklist directly based on PTSD symptoms listed in the DSM-IV-TR. It was initially tested on combat veterans, and then adapted for civilians (PCL-C). It has been tested on vic-
tims of non-combat and non-assaultive traumas (Blanchard, Jones-Alexander, Buckley & Forneris, 1996). Based on participant responses to the PCL’s 5-point Likert scale, Schuster et al. reported that 44% of respondents had at least one substantial stress symptom (a rating of 4 or higher), 68% had one symptom “moderately” (3 on the Likert scale), and 90% had at least one symptom “a little bit.” Their claim that a high percentage of respondents demonstrate stress symptoms “a little bit’ may be misleading when based on a mark of two on a five-point scale. Likert scales offer an ordinal level of measurement without guidance as to the distinction between the choices. In addition, this method of classifying PTSD symptoms is based on the self-report of the individual of his/her apparent symptoms. The choices made are completely subjective, since one cannot know how each individual interprets his/her symptoms or what the distinction between a rating of 2 or a rating of 3, for example, means to each participant. In addition, as Schuster et al. note, though baseline measures exist for PTSD prevalence rates, none are available for stress symptoms. Having “a little bit” of insomnia, or increased physiological arousal could easily have been pre-existing and incorrectly attributed to September 11. Hence, it is not possible to objectively determine the effects of September 11 on PTSD or PTSS through this method.

The Tallying of Symptoms

Some researchers have tallied symptoms to derive a diagnosis of PTSD or “probable PTSD” (Schlenger et al., 2002; Simeon, Greenberg, Knutelska, Schmeidler, & Hollander, 2003). Schlenger et al. based this procedure on a report by Weathers, Litz, Herman, Huska, and Keane (1993) who state that a PCL cutoff score totaling 50 or greater has strong diagnostic utility for PTSD. This has encouraged the use of the PCL in PTSD research studies. However, Schlenger et al., in agreement with North and Pfefferbaum (2002), are careful to note that only clinical assessments can definitively diagnose PTSD. Schlenger et al. use the phrase “probable PTSD” to discuss their findings. Furthermore, it has been appropriately recommended that the PCL be used only as a screening device (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996). Although the PCL is efficient for data collection and has good diagnostic utility, it does not measure the duration and impairment criteria, which are crucial for a clinical diagnosis (North & Pfefferbaum). In addition, tallying alone fails to determine whether each individual meets the threshold requirements for each symptom cluster, according to DSM-IV-TR criteria.

DSM-IV TR Symptom Clusters

The DSM-IV-TR (APA, 2000) criteria for PTSD include three symptom clusters (B, C, and D) in addition to the requirements for exposure
(Criteria A), duration (Criteria E), and impairment (Criteria F). Criteria B symptoms are the intrusive re-experiencing of the event through flashbacks, nightmares, and physiological reactions to reminders. Criteria C symptoms are avoidance and numbing, including detachment from others, loss of interest, and avoiding reminders of the event. Criteria D symptoms indicate hyperarousal and include insomnia, irritability, and hypervigilance (APA). The DSM-IV-TR requires at least one B symptom, three C symptoms, and two D symptoms in order to qualify for a diagnosis of PTSD.

In an attempt to more closely imitate the requirements of a DSM-IV-TR diagnosis, some researchers interpreting data from brief inventories have adhered to requirements for the number of symptoms in each symptom cluster (Galea et al., 2002; Piotrkowski & Brannen, 2002). Galea et al. used items from a modified Diagnostic Interview Schedule for PTSD to determine “symptoms consistent with current PTSD” by noting the presence of symptoms meeting these threshold requirements. Although the symptom cluster method still fails to measure duration and impairment criteria required for definitive diagnosis, this method most closely approximates a DSM diagnosis. In addition, research reveals that the numbing and avoidance symptoms of the C category are the markers of PTSD (North et al., 1999). North et al. found that 94% of subjects who met Criterion C also met the criteria necessary for a full PTSD diagnosis. Researchers who cluster symptoms may predict those cases likely to qualify as full PTSD by noting the participants who report three or more C symptoms, offering a more accurate assessment of PTSD prevalence. A consequence, however, of more closely simulating a DSM diagnosis is that the symptom cluster method can disregard significant but sub-clinical distress that the other methods detect.

Discussion

There is no common practice for measuring PTSD and stress symptoms in research studies. The nature of large empirical studies precludes the use of thorough assessments by trained clinicians, the only way to conclusively diagnose PTSD. PTSD cannot be definitively identified through the use of brief questionnaires (North & Pfefferbaum, 2002). Hence, studies that use cutoff scores or categorize levels of symptom severity are susceptible to gross overestimation of the prevalence of PTSD. Even categorizing symptoms according to DSM-IV-TR criteria is insufficient, as checklists such as the PCL are subjective and often leave out the duration and impairment criteria, inaccurately reflecting the individual’s mental health.

An issue parallel to accurately assessing PTSD is detecting significant distress that may not reach a DSM-threshold level. Brett (1996) argues that the classification of disorders through the DSM-IV-TR leaves out many clinically relevant characteristics. Therefore, although categorizing levels of symp-
tom severity and tallying scores may not be sufficient for determining PTSD prevalence, they do reflect the presence of distress, whether sub-clinical or qualifying for DSM diagnosis. These studies offer information important for gauging mental health and need not be framed strictly in relation to PTSD.

Conclusion

Careful interpretation and application of published research on studies that include Post Traumatic Stress Disorder (PTSD), Acute Stress Disorder (ASD), and Post Traumatic Stress Symptoms (PTSS) following traumatic events is necessary due to the wide range in study methods currently employed. We suggest that consumers of such research take careful note of three points. First, investigate the use of terminology for PTSD. The authors of trauma research articles may use the terms PTSD, ASD, and PTSS, each of which have very different meanings. The correct use and interpretation of these terms is critical in making any further interpretations of such studies. Second, the use of measures cannot take the place of a clinician’s diagnosis. Conclusions drawn through the use of standardized measures must be considered merely a part of a complex set of responses to traumatic events. Third, the DSM-IV-TR, on which the most commonly used measures and clinical diagnoses are based, may fail to recognize persons who are, in fact, suffering severely but do not meet the designated criteria. Such classification systems may also exclude important information that may be addressed by more extensive and holistic means of studying individuals, such as a Person-In-Environment System assessment that includes their social role, environmental, mental, and physical problems (Williams, Karls, & Wandrei, 1989).

The role of research studies in informing helping professionals is crucial in an environment increasingly focused on evidence-based practice. Media publications have an ethical responsibility to accurately report and disseminate knowledge about trauma study findings to the public. In addition, advocates for and funders of mental health services must be aware of the potential range of post-trauma outcomes when seeking and offering funding. All consumers of research should strive to be informed and must tread carefully when extrapolating results from studies of traumatized populations.

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THE USE OF PLAY THERAPY WITH CHILD VICTIMS OF SEXUAL ABUSE

Jamie D. Aarons

Over three million children in the United States are reported to state child protection services as alleged victims of sexual, physical, and emotional abuse and neglect each year. Of these cases, approximately 903,000 are substantiated. Twelve percent of the substantiated cases involve child sexual abuse. This author provides an overview of the prevalence, risk factors, and symptomology of sexually abused children and critically examines the use of play therapy as an assessment and intervention tool.

Introduction to Child Sexual Abuse

Over three million children in the United States were reported to state child protection services as alleged victims of sexual, physical, and emotional abuse and neglect in 2003 (US Department of Health and Human Services, 2003). Of these cases, approximately 903,000 were substantiated. Twelve percent of the substantiated cases involved child sexual abuse (Kuehnle, 2003). Among males, the rate of sexual abuse is .4 per 1000; among females it is 1.7 per 1000 (US Department of HHS, 2003). While these abuse and neglect figures encompass children under age 18, over 50% of those children are below the age of eight. Childhood sexual abuse is clearly a pressing social problem.

Research suggests that national incidence figures may represent less than one-third of all occurring cases of maltreated children in America (Briere & Elliott, 2003; Finkelhor, 1994). This may be especially true for boys who are sexually abused, perhaps due to a stigma attached to their accounts. Incidents of child abuse during the preschool years are also likely to be underreported (Kuehnle, 2003). Further variability in national rates may exist because of the diversity of definitions that are employed by individual states. For instance, some states exclude child-on-child sexual abuse from their data. For the purposes of this paper, the definition of child sexual abuse will be that published by Cohen and Mannarino (1984), which defines child sexual abuse as “sexual exploitation involving physical contact between a child and another person. Exploitation implies an inequality of power between the child and the abuser on the basis of age, physical size, and/or the nature of the emotional relationship. Physical contact includes
anal, genital, oral, or breast contact” (p. 343).

Children are at an increased risk of sexual abuse when parents are unable to adequately supervise or nurture them, due to factors such as community or domestic violence, substance abuse, poverty, and single-parent status (Kuehnle, 2003). In a study by Straus, Gelles, and Steinmetz (as cited in Kuehnle), physical or sexual child abuse was found to occur simultaneously in 30 to 70% of two-parent families in which there was domestic violence. Other risk factors include early sexual maturation in girls and emotional and physical disabilities. Based on general population surveys, abuse by parents and step-parents constitutes between six and 16% of all cases, and abuse by any other relative comprises more than one-third of the cases. In clinical samples, parent figures comprise between one quarter and one third of the offenders, and all other relatives comprise approximately one half (Berliner & Elliott, 2002).

Symptomology of Child Sexual Abuse Victims

Sexually abused children may exhibit a wide range of potential symptoms, including low self-esteem, anxiety, depression, anger and aggression, posttraumatic stress, or dissociation. Much of the externalized emotional distress comes as a result of the children’s level of hyperarousal, emotional pain, and restimulation of abuse memories; the abuse represents a constant challenge to their coping mechanisms (Berliner & Elliott, 2002). Thus, any external activity that successfully reduces internal tension (e.g., through distraction, self-soothing, or anesthesia) is reinforced and sought out by the child. According to Berliner and Elliott, negative manifestations of these behaviors include self-mutilatory activities; increased or precocious sexual activity; bingeing and purging; and alcohol or substance abuse. Some minors who have been sexually victimized exhibit school-related difficulties, including low time-on-task, acting-out behaviors, and low academic achievement. In a study of adults who had been sexually abused as children, Saunders, Villeponteaux, Lipovsky, Kilpatrick, and Veronen (1992) found that these adults suffered a wide range of psychiatric disorders and problems, including depression, phobias, obsessive-compulsive disorder, panic disorder, post-traumatic stress disorder, sexual disorders, and both suicidal ideation and suicide attempts.

Once sexual abuse has occurred, the child’s functioning is likely to be more positive if the following conditions occur: the child is not closely related to the perpetrator; the child’s mother believes the report and is supportive; the family is stable and without violence; the sexual acts were not violent in nature; and the child endured the abuse for a shorter period of time (Kuehnle, 2003). The child will also have an increased likelihood of long-term positive outcomes if he or she utilizes an active/social coping strategy – as opposed to avoidant, internalized, or angry strategies – and does
not blame him- or herself for the abuse (Kuehnle). Based on the significant impairment that sexual abuse poses to the psychological and behavioral outcomes of children and adults, it is obvious that effective intervention strategies are necessary at an early age.

Reviews of the treatment outcome literature provide evidence that abuse-specific cognitive behavioral treatments (CBT) are effective for the posttraumatic stress reactions related to child sexual abuse (Berliner & Elliott, 2002). Commonly, this therapy includes psychoeducation, which involves the provision of information about the nature of the abuse and offenders, in addition to anxiety management. Children are taught how to identify their emotions and how to use various relaxation and coping strategies. Elements from exposure therapy are utilized, involving the gradual exposure to the abuse experience in order to de-condition automatic negative associations and to reduce maladaptive avoidance. This is sought through talking, drawing, or writing about the abuse. Finally, cognitive therapy is “used to challenge and replace cognitive distortions about the event or generalized negative attributions about self and others” (Berliner & Elliott, 2002, p. 67). Parents can be included in this treatment with some positive outcomes related to child behavior problems and improved parental support. Other potential approaches for this population, such as family therapy, behavioral interventions, and pharmacological treatments, have yet to be thoroughly empirically evaluated for effectiveness in treating sexually abused children.

Another therapy that has not undergone empirical testing for use with sexually abused children but that may prove effective is play therapy. One reason that play therapy may be a particularly useful approach for sexually abused children is that they have not yet developed the abstract reasoning abilities and verbal skills needed to adequately articulate their feelings, thoughts, and behaviors. “For children, toys are their words, and play is their conversation” (Hall, Kaduson, & Schaefer, 2002, p. 515). Play provides a symbolic language that makes communication possible. This paper will provide an overview of play therapy and critically examine its role as an assessment and intervention tool with the population of child sexual abuse victims.

Defining Play Therapy

Play therapy is a general term used to describe a variety of interventions that incorporate the use of play into the assessment and treatment of children and families. There are two basic forms of play therapy: directive and non-directive. Directive approaches are those in which the therapist selects the activity and moves the child’s play or discussion toward a specific topic or goal. This structured approach includes cognitive-behavioral play therapy, as described by Knell (1999). In nondirective, unstructured play therapy,
the therapist concentrates on establishing a relationship of unconditional acceptance of the child, within a safe environment, while the child is allowed to choose the play medium, set their own rules, and use the play objects and time as they wish (Guerney, 2001). Included in this category is the child-centered play therapy (CCPT) method developed by Axline (1969), based on the client-centered work of Carl Rogers, and non-directive puppet therapy (Carter, 1987).

**Past Research on Play Therapy**

In a comprehensive play therapy literature review by Phillips in 1985 (as cited in White & Allers, 1994), it was concluded that among 200 case studies, anecdotal articles, and empirical research reports that existed at the time, there were inconsistent definitions of play therapy, inadequate definitions of the qualifications and role of the play therapist, and inadequate or flawed statistical design. Based on the findings of this author’s research and current literature review, 18 years after Phillips’ analyses, the evidence related to play therapy appears nearly identical to that reviewed by Phillips, lacking well controlled-studies that could offer meaningful and informative statistics with which to empirically support the use of play therapy.

**Rationale for Play Therapy with Child Sexual Abuse Victims**

For the past 17 years play therapy has been regarded by numerous clinicians and researchers as a potentially effective intervention tool for use with child victims of sexual abuse. Regardless of the specific approach, most of the authors emphasize providing these children with a secure therapeutic setting in which the therapist shows support, acceptance, and perseverance. The authors also emphasize a setting in which the therapist acknowledges the thoughts and feelings expressed within the sessions (Cater, 1987; Kelly, 1995; Knell, 1999; McMahon, 1992; Singer, 1990).

Psychoanalytic play therapy, which incorporates both directive and non-directive approaches (Singer, 1990), aims to alter inner or outer functioning of the child by helping the sexually abused child understand his experiences and feelings. This occurs through the use of verbalization, interpretation, and clarification. A review of studies by Casey and Berman (as cited in Singer) “found good evidence that psychotherapy with children (compared to untreated controls) is at least as effective as with adults . . .” (p. 225). This supports the psychotherapeutic foundation on which child-centered play therapy is based. Consistent with the findings of Phillips, however, there is no indication that these studies had adequate sample sizes or that they utilized uniformed measurements. In a comparison study of parent therapy, play therapy, group therapy, and behavior modification for a cohort of children with a broad range of behavior problems, psychotherapeutic play therapy proved most effective for those children with internalizing
behaviors, such as depression, withdrawal, self-doubt, and fears (Singer). This could be promising evidence considering that these behaviors are consistent with those of many sexual abuse victims, as described earlier. Again, the term “psychotherapeutic play therapy” is used loosely, however, and it is impossible to surmise which aspects of the treatment were effective. The majority of support offered comes, instead, from individual case studies and anecdotes (Kelly, 1995; Singer).

Research related to both directive cognitive-behavioral play therapy and child-centered nondirective play therapy provides evidence to support the tenets on which they are based, but does not provide specific empirical evidence proving their effectiveness with sexually abused children. For example, Axline’s nondirective approach is based on the empirical and clinical evidence demonstrating support for Rogers’ client-centered methods. Likewise, in a study by Parpel and Maccoby (as cited in Guerney, 2001), a group of children whose mothers were taught to make supportive statements and to use nondirective approaches during play demonstrated more compliance than children whose mothers followed their own course (p. 14). This data offers support for the potential of child-centered play therapy but certainly does not qualify as empirical evidence to back this clinical approach.

Literature that devotes specific attention to the use of child-centered play therapy with sexually abused children is limited to case studies and anecdotal clinician and parent reports (Carter, 1987; Guerney, 2001; McMahon, 1992). By relaying examples from her own clinical practice, McMahon suggests a combination of nondirective and focused play techniques to be most effective with this population. She posits that the use of anatomically correct dolls is helpful both as an assessment and treatment tool, but provides no empirical evidence to back this claim. Suggested child-centered play therapy goals for the sexually abused child include the restoration of trust, the normalization of feelings, increasing feelings of control, expressing and coping with feelings of anger, fear, disgust and sadness, and enabling the eventual development of normal relationships of mutual sharing and care (McMahon).

Like child-centered play therapy, cognitive-behavioral play therapy is grounded in a body of research based on intervention strategies that have been proven effective with adults. Modeling, which is useful with adults (Bandura, as cited in Knell, 1999), is used to improve coping and as a means of psychoeducation with children; role-plays are used to practice problem solving skills and adaptive behaviors. According to Knell, “the fact that cognitive behavior therapies for adults have been empirically validated does not mean the same holds true for children” (p. 402). Her own evidence in support of cognitive-behavioral play therapy with sexually abused children is in the form of case examples.
Play Therapy as an Assessment Tool

Aside from the lack of empirical evidence to support the use of play therapy as an intervention tool, multiple authors recognize play as a vital means of assessing the sexually abused child (McMahon, 1992; Norton & Norton, 1997; White & Allers, 1994). Corresponding to the symptoms described previously, children who have been sexually abused may display developmental immaturity, opposition and aggression, withdrawal and passivity, self-destruction or self-deprecation, hypervigilance, sexuality, or dissociation during their play (Howard; Martin & Beezley; Terr, as cited in White & Allers, 1994). In comparison to a healthy child, the abused child may display a high level of intensity, atypical rigidity in play, or be overly dependent on the therapist for guidance in play. These play behaviors and themes have been shown to be valid and reliable means of identifying and assessing the sexual abuse victim. However, much of the research is based on small sample sizes and there is also a need for variables, such as hypervigilant and aggressive behaviors, to be defined thoroughly and consistently in future research.

Conclusion

Child sexual abuse is a disturbing problem within our nation – one that has serious behavioral and psychological ramifications for all involved. Play therapy, which may be directive, nondirective, or a combination of the two, is increasingly used for the clinical treatment of sexually abused children. Play therapy is the primary intervention model utilized by many social workers with children. Supporters of play therapy stand firm in their belief that this is an important clinical technique. Most of the research on play therapy and childhood abuse, however, has relied on non-statistical observations using single case or small-group samples. Just as Phillips (as cited in White & Allers, 1994) recommended 18 years ago, research deficits in the field must be addressed if therapists are to provide these children with effective care.

Now, and in the future, social workers will play a significant role in providing empirical research for the use of play therapy in the treatment of child sexual abuse victims. Statistical evidence is needed to show the effectiveness, or lack thereof, of play therapy with this population. Evidence is also clearly needed that compares the effectiveness of play therapy to other treatment modalities, including cognitive behavior therapy, family therapy, or nonspecific supportive therapy.

References


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This article examines the risks faced by helping professionals, such as clinical social workers, due to their tendency to be more attentive to clients than to their own needs. It is suggested that clinicians can improve job engagement and minimize burnout risk through increased self-awareness and self-care. Using an approach based on Giddens’ (1984) structuration theory, the authors provide specific suggestions for self-awareness and self-care, including the concept that workers should improve and exercise their self-advocacy skills as a form of self-care.

There is a long tradition within clinical social work and psychology of considering the importance of self in direct practice (Edwards & Bess, 1998; Guy, 2000; Jennings, Goh, Skovholt, Hanson, & Banerjee-Stevens, 2003; Kondrat, 1999; Skovholt & Jennings, 2004). The therapist or clinician plays a key role in therapeutic encounters, and it is thought that a healthy self is a clinician’s most important tool. In addition to considering the advantages of a strong self, this article examines the risks of depleting the self through an unbalanced focus on attending to others – unbalanced selflessness.

In the early 1980s, researchers began studying the unique stresses faced by human services workers stemming from the nature of their direct interactions with clients (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Posig & Kickul, 2003). This particular type of occupational stress became known as burnout and is most frequently thought of as a combination of emotional exhaustion, cynicism about the job, and a low sense of personal achievement. Burnout has a negative impact on the personal life and work performance of the affected worker, while the presumed antithesis of burnout, job engagement, has a positive impact on the worker’s personal life and work performance (Maslach; Maslach & Goldberg, 1998; Maslach, Schaufeli, & Leiter). This article considers some of the potential vulnerabilities of clinical social workers that may lead to a depleted self, key symptoms of this condition, and steps that can be taken to facilitate self-awareness and engage in self-care behaviors that can both strengthen and maintain the clinician’s self.
This article examines the social worker’s need for self-awareness and self-care, using the concept of person-in-environment, a framework that has been endorsed by the Council on Social Work Education and considered a hallmark of good social work practice (Council on Social Work Education, 2001; Kondrat, 2002; Rogge & Cox, 2001). In particular, Giddens’ (1984) structuration theory, an elaboration of the person-in-environment framework, will also be utilized. This framework develops the concept of bi-directional, recursive interactions between an individual and the individual’s environment and the ways in which this concept supports the notions of human agency and empowerment (Giddens; Kondrat, 2002). Another framework frequently used in social work, Bronfenbrenner’s multi-level, ecological systems model, which can be seen as an extension of the person-in-environment approach (Rogge & Cox, 2001), will also be incorporated. Bronfenbrenner’s model describes four levels of environment that can affect an individual or family – micro, meso, exo, and macro (Bronfenbrenner, 1979). However, this article will forego a complete analysis of each of Bronfenbrenner’s levels in the interest of brevity.

**Background on Social Workers and Self-care**

The tendency to limit or avoid self-awareness and self-care can take a serious toll on the practice and personal life of the clinical social worker. Helping professionals appear to be more adept at assessing and intervening with individuals and groups as opposed to assessing and helping themselves. Such avoidance could lead to less effective practice, professional impairment, boundary violations, and burnout. In addition, this avoidance could lead to personal relationship problems, depression, substance abuse, and even suicide in extreme cases (Brady, Healy, Norcross, & Guy, 1995; Gilroy, Carroll, & Murra, 2002; O’Connor, 2001; Sherman & Thelen, 1998; Sussman, 1995b).

Until recently, few studies focused on distress, burnout, and impairment specifically among social workers. These studies showed mixed results (Soderfeldt, Soderfeldt, & Warg, 1995). However, a 2003 study of social workers in North Carolina found that 11% of social workers studied were at serious risk of alcohol abuse, another 22% were at moderate risk of alcohol abuse, and that 53% of those at serious risk reported some kind of professional and personal impairment (Siebert, 2003). A recent study of social workers in the United Kingdom found that 74% of respondents suffered from borderline to pathological levels of anxiety (Lloyd, King, & Chenoweth, 2002). Although it is unfortunate that recent studies indicate a potential problem with distress, burnout, and impairment among some social workers, it is encouraging that these issues are receiving more attention among researchers. The implications of impairment and boundary violations extend beyond the individual helping professional, as the reputation of the
helper’s profession can also be tarnished by such acts (Sherman & Thelen, 1998).

While some clinicians suffer from distress, burnout, and impairment, there are other clinicians who have been found to thrive in their profession with therapeutic outcomes that are far superior to other colleagues (Brown, Dreis, & Nace, 1999; Okiishi, Lambert, Nielsen, & Ogles, 2003). There appears to be little, if any, research on the specific clinician attributes that lead to positive client outcomes, but there is an increasing body of research that looks at the common attributes among practitioners who are considered to be master therapists, as defined by their peers or by client outcome measures (Okiishi, Lambert, Nielsen, & Ogles; Skovholt & Jennings, 2004). To date, attention to the clinician’s self, through self-awareness and self-care, has been cited as a key characteristic of expert clinicians (Guy, 2000; Kondrat, 1999; Norcross, 2000; Schwebel & Coster, 1998; Skovholt & Ronnestad, 1992), and Skovholt and Jennings (2004) found that master therapists were as skilled at assessing themselves as they were at assessing their clients. Additional research is required to identify what degree of self-awareness and/or self-care are directly correlated with therapist wellness and client outcomes. In particular there is a need for longitudinal studies of therapist development (Skovholt & Jennings) which follow students from school though their professional careers.

**Self-Awareness**

Helping professionals are often driven by an intense curiosity about and interest in others (Kottler, 2003; Spurling & Dryden, 1989). As some authors have pointed out, however, it is ironic that the same levels of curiosity and interest are not always present when the practitioners consider themselves (Kottler; Skovholt, 2001; Sussman, 1995b). Kottler stated that social workers are encouraged to be reflective but tend not to seek out the same sort of help they provide for and encourage in others.

To some degree, social workers are in the business of “disillusionment” (Kottler, 2003, p. 23), helping clients to replace their illusions and misperceptions with a more realistic, helpful view of their lives. There are also potential benefits to clients if social workers can disillusion themselves as well. Through a more realistic lens, social workers can come to terms with a more balanced view of who they are, what motivates them, and how they behave in their profession, ultimately becoming more effective (Kottler). Personal therapy, supervision, consultation, and peer support are often-cited approaches to increase self-awareness and personal growth (Kottler, 1999; Kottler; Pieper, 1999; Skovholt & Jennings, 2004). Schools and training programs can also play a key role in encouraging students and trainees to become more self-aware (Schwebel & Coster, 1998; Sherman & Thelen, 1998; Sussman, 1995b).
It can be important to understand one’s motivations for entering the helping professions to ensure realistic aspirations. This understanding may also serve as a preventive measure against future burnout, impairment, and boundary violations (O’Connor, 2001). A number of authors have looked at the motivations of those in the helping professions, including social work (Berger, 1995; Gilbert, Hughes, & Dryden, 1989; Grosch & Olsen, 1995; Guy, 2000; Kottler, 2003; Norcross & Guy, 1989; O’Connor, 2001; Smith, 1995; Spurling & Dryden, 1989; Sussman, 1995a; Sussman, 1995b; Vincent, 1996). These authors have found that some of the same traits that can lead people to these professions and contribute to their effectiveness as helpers can also be potential vulnerabilities when it comes to taking care of themselves and their clients.

In many cases, helpers are driven by a “selfless caring for others” (Smith, 1995, p. 785). It is also possible that they are motivated by forces that are further from their awareness and more difficult to accept – a search for intimacy, power, admiration, and even a desire to address issues in others that are also their own (Gilbert Hughes, & Dryden, 1989; Pieper, 1999; Sussman, 1995a; Vincent, 1996). Skovholt and Ronnestad (1992) found that graduate students studying counseling and therapy believed they understood their motivations for entering the profession, while senior clinicians often stated they had not fully understood their motivations when they were beginning their career. While this was not a longitudinal study and this difference may be explained by the varying cohorts and teaching methods, it is possible that there is an evolution in clinicians’ concepts of their motivations.

It is important for social workers to understand their motivations. If they expect, even unconsciously, their clients to serve their own needs, they are likely to care less effectively for their clients and risk frustrating themselves, potentially leading to impairment or burnout (Brady, Healy, Norcross, & Guy, 1995; Kottler, 2003; Vincent, 1996). Through self-awareness, social workers can mitigate unrealistic expectations of their clients and their client relationships. Through such awareness social workers can recalibrate their expectations of themselves and their clients.

Another aspect of self-awareness is for social workers to recognize the impact of their personal histories on their choice of profession and how they practice. Many who work in the helping professions have played the roles of go-betweens, helpers, caregivers, or mediators in their families of origin (Kottler, 2003; Ronnestad & Skovholt, 2001; Sussman, 1995b; Vincent, 1996). The positive result of this experience may be that it helped them to develop particular skills and sensitivities toward helping others. However, that focus on the other could mean they have less experience and comfort when it comes to asking for and receiving help themselves. Recognizing
this can allow social workers to counteract such tendencies and seek out the help they need.

There are several steps that social workers can take in an effort to increase their level of self-awareness (Kondrat, 1999; Skovholt & Ronnestad, 1992):

- Notice their own biases.
- Get feedback from colleagues and clients.
- Utilize audio and video recording for self-monitoring.
- Secure good ongoing supervision.
- Engage in personal therapy.

**Self-Care at the Individual Level**

At the individual level, self-care is defined as the strategies that one uses to care for him- or herself, particularly those that build-up or replenish the self, lowering the risk of impairment, burnout, or simply less effective practice (Guy, 2000). Maslach (2003) suggests that the three dimensions of burnout are cynicism, exhaustion, as well as a sense of ineffectiveness and lack of accomplishment. While direct client work may lead to quicker burnout, social workers in every discipline need to be aware of and guard against burnout. In fact, Kottler (2003, p. 159) has suggested that “rustout” is a more accurate term than burnout “because it better represents the kind of slow, gradual process that eats away at a therapist’s spirit.” In many cases those around social workers may be the best sources of feedback about whether it is time to step up self-care efforts, given the difficulty of identifying the warning signs (Kottler).

In social work it is often hard to avoid disillusionment related to a sense of ineffectiveness and lack of accomplishment, one of Maslach’s (2003) three dimensions of burnout. The greater the imagined success and power, the greater the potential for disillusionment. Exhaustion, another of Maslach’s dimensions, is also a potential concern for those who work long hours. This is particularly true when there is a great need for services and scarce and diminishing resources with which to help clients. With high, potentially unrealistic expectations for what can be accomplished and inadequate time and resources to achieve constant success, social workers may find themselves becoming cynical, completing Maslach’s third dimension of burnout.

Building self-care into one’s way of life is recommended. Just as social workers automatically write progress notes to track client progress or advocate for client social service needs, they also need to build self-care into their schedules. Several possible strategies for individual self-care include (Kottler, 1999; Mahoney, 1997; Sussman, 1992):

- Maintain strong relationships with significant others.
Eat healthy balanced meals and get 7-8 hours of sleep a night.
• Get physical exercise at least three times a week.
• Try a few minutes of meditation in the morning or before seeing clients.
• Do not lose sight of hobbies such as movies, reading, arts, and museums.
• Take vacations away from routine schedules, home, and clients.
• Regularly capture thoughts and feelings in a reflective journal.
• Set limits and boundaries between work and personal life.
• Get supervision from peers or others.
• Embark on personal therapy to better understand motivations and possible sources of countertransference.

There are also strategies that could be used within the educational system (Schwebel & Coster, 1998; Sherman & Thelen, 1998; Sussman, 1992):

• Screen during the entrance process to ensure that students admitted to the program have a healthy, realistic understanding of their reasons for entering it.
• Include training on self-awareness and self-care within the curriculum, including family of origin work.
• Include training within the curriculum on recognizing and dealing with distress and impairment.
• Use a buddy system or small groups to help students become more self-aware.
• Ensure that supervisors can provide appropriate support.
• Continue or expand use of reflective journals and process recordings to ensure that students use these tools to improve their capacity for self-awareness.
• Encourage students to find an appropriate balance between study and outside interests.

Self-Care at the Person and Environment Levels

The degree of fit between an individual and his or her work environment, known as job-person fit, appears to be a major factor in burnout across a broad set of occupations (Maslach, 2003; Maslach, Schaufeli, & Leiter, 2001; Um & Harrison, 1998). Self-advocacy – an attempt to improve one’s professional and personal environment – can be seen as a form of self-care and an effective strategy in the quest to both improve job engagement and minimize burnout.

As stated previously, the dynamics of exchange between the environment and the individual fit well with Giddens’ (1984) model of person-in-environment. Social workers may exercise self-advocacy in both
the workplace and also within and on behalf of the profession of social work. In the workplace, social workers would be interacting with what Bronfenbrenner would term the individual’s mesosystem. In advocating for the profession, the worker’s profession would be considered to be part of the individual’s macrosystem.

If social workers find that they do not have the resources to do their jobs well, it may be time for increased self-advocacy in the workplace. Areas which can be addressed include workload/caseload, paperwork requirements, salary, office environment, amount and type of onsite supervision, alliance building, and the effective marketing of social work services.

On a broader level of the profession, using Giddens’ (1984) concept of bi-directional, recursive interactions between person and environment, social workers are impacted by the profession’s role in society but also have the potential to contribute to a redefinition of that role. Examples of self-advocacy used by social workers trying to impact the profession could include attempts to:

- Increase salary for all social workers.
- Improve the public perception of professional competence among social workers.
- Use and increase the power of the profession to practice at both micro and macro levels, practicing both case advocacy and cause advocacy on behalf of clients and others (Lens & Gibelman, 2000; Walz & Groze, 1991).

Strengthening alliances with other professions and practitioners would be of tremendous value to helping social workers and their clients. Particularly within the field of social work where the nature of the work can sometimes be isolating, social workers can work more effectively through a greater degree of collaboration with others. By leveraging these resources, social workers will not spend their energy forging a new path of advocacy and support for each additional client.

Advocating for self-interest may sound antithetical to social work, but when social workers help themselves, they help their clients directly. Selye (1974) writes about “altruistic egotism”, suggesting that altruism and egotism do not have to be seen as mutually exclusive. If a client sees that social workers are taking care of themselves, they may receive a positive modeling message of effective self-care. This becomes a useful model of self-advocacy that clients can internalize for their own lives.

**Conclusion**

Only when social workers incorporate an approach that includes self-awareness, self-care, and self-advocacy are they most likely to stay healthfully engaged in their chosen profession and of greatest service to their clients. If social workers begin to lose their self through unbalanced selflessness, they run the previously mentioned risks of impairment and burnout. Thus, social workers are faced with a need to rescue the self from pure selflessness so that they may build and maintain their sense of self for their own good and for the good of their clients.
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**PARADIGM OF RURAL HOMELESSNESS: A CASE STUDY OF CLINTON COUNTY, NEW YORK**

Jessica Spissinger

*Rural homelessness is a social problem that has drawn limited scholarly attention in the social work field. This case study of Clinton County, New York, examines the existing service structure to address homelessness while highlighting challenges universal to rural homelessness as a widespread phenomenon. This paper considers possible long-term solutions to rural homelessness, and argues for a structurally based approach to understanding homelessness, either in an urban or rural setting.*

**Understanding Homelessness**

Prior interventions to address homelessness have sprung from the belief that homelessness is a personal problem (Koegel, 1996). This paper leans toward understanding homelessness as the result of larger, structural problems, including: the lack of affordable housing; lack of a decent, living wage; restricted access to transportation; and lack of affordable childcare and health care. Under a structural framework, it is clear that beyond housing, a multitude of factors contribute to an individual’s state of homelessness (Jencks, 1994). As social workers, it is imperative to look critically at the macro level and understand how larger, economic conditions and policies have directly influenced the current paradigm of homelessness. Clinicians, generalists, administrators, as well as researchers must advocate to fight the growing trend of poverty in this country – in rural, as well as in urban settings.

**Homelessness in a Rural Setting**

With approximately 40,000 homeless people on a given night (New York City Department of Homeless Services, 2004), New York City has made a powerful mark on society’s perception of homelessness. An entire city government sector – New York City’s Department of Homeless Services – is dedicated to the homeless, and service providers from other cities have examined New York City’s services as a model for helping the homeless on their own streets (Campbell & McCarthy, 2000). Marked as an urban issue, homelessness is not often associated with the country or rural areas. In fact, rural homelessness is a problem that appears to be much smaller in size due
to smaller population densities (Aron & Fitchen, 1996). In urban regions, the street homeless constantly encroach upon public spaces, whereas homeless people who are utilizing shelters more readily blend into the mainstream. Likewise, in a rural setting, the problem of homelessness altogether escapes the public eye, due to the less concentrated proximity of small towns and distant rural settings.

Homelessness in a rural setting is defined by substandard housing, doubling up/overcrowding, squatting in abandoned buildings, and utilizing campgrounds as a year round domain (Fitchen, 1992). Because homeless populations in rural settings are more likely to live in sparse settings, outreach efforts are difficult. The issue of rural homelessness becomes a catch-22: since most of the rural homeless population are unaware of the services provided, there is not a large request for services. Due to this lack of request for services, many local departments of social services have not identified homelessness as a major problem (Aron & Fitchen, 1996). Thus, there are few services available due to the false conclusion that they are not needed.

Among scholars, rural homelessness is a subject that has not drawn widespread attention. Many research reports on homelessness, such as the National Survey of Homeless Assistance Providers and Clients (The Urban Institute, 1999) conclude that homelessness is predominantly an issue for urban areas to address. According to the report, 70% of the United States homeless population live in cities and 20% live in suburban areas. Because only 10% of the national homeless population live in rural areas, such areas are written off and the problem of homelessness is widely overlooked. Yet drawing the conclusion that homelessness is marginal in rural areas is flawed, as it does not factor in the ratio of homeless to non-homeless to realistically compare the proportion of people who are living in extreme poverty. In a study on rural homelessness in Iowa, the rate of homeless people in rural counties compared to urban areas was much higher in rural regions. New York City had an average of 5.09 homeless per 1000 people, compared to Appanoose County in Iowa where the number of homeless was 9.7 per 1000 people. Similar comparisons from other rural areas reveal an incidence of homelessness much greater than in urban areas (Lawrence, 1995).

Comparable to urban environments, rural poverty results from similar structural causes. Fitchen (1992), an avid researcher of rural homelessness in Upstate New York in the early 1990s, lists numerous factors that create a population in rural areas who are perpetually at risk of homelessness. These factors include dilapidated and overcrowded housing such as deteriorating trailers and converted farmhouses; the intergenerational cycle of poverty; limited access to public transportation; and lack of job opportunities, all of which are abundant in Clinton County, New York. The major difference between rural and urban poverty and homelessness is that in rural areas,
poverty and homelessness are spread out, making widespread appeals to the issue much more difficult to form. Rural homelessness varies tremendously depending on state, county, and locality. Despite the fact that New York State is considered a highly urbanized state, 44 of its 62 counties are classified as rural (Merwin Rural Services Institute, 2001). Fitchen based her research on a sampling of approximately eight rural counties in New York State. Honing in further on rural New York State, this paper will examine Clinton County, a mid-sized county classified as rural.

**Clinton County: An Economic Overview**

Clinton County is the most northeastern county in New York State, bordering Lake Champlain on the east and Quebec, Canada on the north. The Adirondack Mountain Region lies just south and west of the county border. The total population of Clinton County is 79,894 (New York State, 2003) divided among 29,423 households (National Low Income Housing Coalition, 2003). The Clinton County Housing Needs Report, compiled by the Clinton County Housing Committee in 2003, highlights the most pressing problems in Clinton County and outlines current methods utilized to address them. Considering a structural understanding of homelessness, three issues stand out in Clinton County: economic opportunity; public transportation; and affordable housing.

Clinton County is similar to many rural counties nationwide that suffer from slim economic opportunities. The majority of residents in Clinton County find work in the city of Plattsburgh, often at The State University of New York, Champlain Valley Physicians Hospital Medical Center, or Bombardier Transportation. While these institutions provide gainful employment for some, over 10,000 people in Clinton County live in households with an annual income below the poverty level (Clinton County Housing Committee, 2003). With the New York State minimum wage holding to $5.15 an hour, many full-time workers at this level are still unable to pay necessary expenses. Single women with children present the highest rate of poverty in Clinton County (Clinton County Housing Committee).

Access to reliable transportation is imperative for people who reside in rural areas to commute to and from work and run routine errands. Lack of access to transportation can be a major barrier for a person obtaining employment, thus resulting in poverty or homelessness. Approximately 10% of households in Clinton County and 20% of residents in the town of Plattsburgh do not have access to a vehicle (Clinton County Housing Committee, 2003). The only local transportation system, Clinton Area Rural Transit, offers limited bus routes into Plattsburgh.

Affordable housing, while available, is starting to diminish. Much of
the lower-rent housing which exists – mobile housing, low-rise apartments, and single-family homes – is substandard and often ill-suited to shut out the harsh winters. One of five residents in Clinton County lives in mobile homes (Clinton County Housing Committee, 2003). Many mobile home renters deal with numerous complications with their housing, often brought about by their landlords, causing the trailers to be in substandard condition. Some of the common complications include leaking septic systems, abandoned or dilapidated neighboring trailers, non-potable water supply, and hazardous electric wiring. These conditions are so prevalent, that approximately 25% of mobile home parks in Clinton County did not pass the Department of Health inspections during 2002 (Clinton County Housing Committee).

Homelessness in Clinton County

As with many rural areas, the precise number of homeless and duration of homelessness in Clinton County are difficult figures to determine. From January to June 2002, approximately 400 people utilized emergency housing services, including temporary shelters and supportive services such as food and transportation, throughout Clinton County (Clinton County Housing Committee, 2003). Of these, roughly one-third were families. An estimate of 800 people becoming homeless each year amounts to roughly .01% of Clinton County’s population. Though this may appear small, it is larger than the percentage in New York City, where the estimated average population of homeless is .005% of the total population.

The Clinton County Department of Social Services (DSS) has responded to emergency housing needs by providing shelters, intensive case management, and at times placing people in local motels or hotels through the local crisis center (Clinton County Housing Committee, 2003). There are also a few non-profit agencies that provide further resources for emergency housing. While emergency housing services are in place, the Clinton County Housing Committee estimates a 20-bed deficit for emergency shelter in the region, meaning the existing beds are continually at full capacity. This forces the DSS to utilize private motels to service the overflow. One major challenge to the Clinton County area is that it has received less state and federal dollars to support affordable housing than other similar counties throughout New York State (Clinton County Housing Committee). Again, this inadequate funding points to the catch-22 of rural housing: a lack of knowledge of existing services among homeless leads to less usage, and less usage leads to the legislative conclusion that the services are not needed.

When translating the number of homeless into the cost to provide emergency shelter, costs are approximately $400,000 per year. Supportive costs to keep children in school or day care, provide transportation, and obtain needed medical care and food quickly drives the costs past the half-million dollar mark. While this number may seem low compared to
urban areas that have multi-billion dollar budgets, the Clinton County DSS resources are strained to provide this assistance. As the DSS addresses additional needs of homeless families beyond immediate shelter, costs will clearly escalate.

**Solutions to Rural Homelessness**

During the 1980s and early 1990s, a nationwide surge of public awareness toward urban homelessness led to rapid construction of shelters to solve the problem. The contemporary perspective supported by researchers points to three levels to address homelessness: improve existing emergency shelter and prevention efforts for those on the verge of becoming homeless; provide transitional and permanent housing placements; and attack the underlying causes of homelessness through policy changes (Campbell & McCarthy, 2000; Fitchen 1991; Fitchen 1992; Koegel, 1996). An emphasis on continuum of care supportive services at all three levels is pointing to increased outcomes of successful transitions out of homelessness (Baron, 2003).

While rural homelessness does not compete in sheer numbers to urban homeless, it constitutes a problem with uniquely rural issues to address. These issues are not served by following an exclusively urban model. The three-level approach described above was developed for an urban model and ought to be changed to address rural differences. One over-arching modification to develop when considering a rurally focused service model is the definition of homelessness. Since the homeless populations in rural settings are more likely to live in a physical shelter such as substandard housing or campsites, the lack of visible street homeless in rural areas such as Clinton County diffuses any momentum that might exist to address the problem on a local, state, or national response. By changing the definition of homelessness in rural areas, two immediate changes would occur: a dramatic increase in homeless numbers and recognition by legislators and tax-payers that homelessness is a problem in their area. This would hopefully lead to motivation to respond to the problem.

As the rural response to homelessness is still in a period of development, modification from the urban service model is possible and necessary. Whereas New York City and other urban areas underwent large-scale construction of shelters to improve emergency shelter (Campbell & McCarthy, 2000), the rural response to homelessness could instead focus on preventative interventions. Structural improvements on existing housing classified as substandard and the creation of new housing stock to improve the lack of affordable housing in the area would address a crucial aspect of the problem. Such rehabilitation and construction could be financed under a National Housing Trust Fund, such as H.R. 1121 and S.1411, currently in committees in the House of Representatives and the Senate. Unlike
urban areas that are pressed for the space and affordability, building in rural areas is generally an affordable endeavor due to lower property value and abundant space to build. Creation of affordable housing and supportive housing is an economic stimulus, which might lead to the creation of jobs in the area. Supportive housing is a trend that is successful in both rural and homeless areas (Baron, 2003) and with federal, state, and local support, could be dramatically helpful in keeping people from becoming homeless. A continuum of care program has demonstrated success in urban areas, and would likely do well in rural areas, as it supplements preventative measures by supporting those who are at risk of becoming homeless.

Call for Action Among Social Workers

Social workers can play an important role in addressing the problems of rural homelessness through work as clinicians, advocates, researchers, and educators. Clinical social workers in rural areas who see the face of poverty directly can provide advocacy information to their clients and encourage them to make their voices heard. For rural homelessness to be addressed at the policy level, legislators must hear from concerned citizens. Social workers in positions of community activists, administrators, and policy advocates can begin organizing within local areas to bring more attention to the problem of rural homelessness. Further research in affordable housing and homelessness in rural areas is broadly needed and has been especially bypassed by social workers in particular. In addition, social work educators need to introduce more information on affordable housing and rural issues into the curriculum at schools of social work. The silence surrounding rural homelessness is surprising considering that stable housing is the foundation of personal independence. For social workers to truly start where the client is, affordable housing is an area that can no longer afford to be overlooked or be viewed from an exclusively urban perspective.

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REFLECTIONS OF RACIAL CONSCIOUSNESS IN SOCIAL WORK

Jamie Favaro

This article focuses on select reflections of a White social work student’s thoughts on racism within a historical, societal, and systems context. Topics discussed include prejudice, privilege, and power differentials within the White as helper, Black in need dichotomy. Research and personal outlook are interwoven to conclude that as agents of change, White social workers hold a unique responsibility in working towards an anti-racist agenda and confronting their own racist ways of knowing.

To-day the ferment of his striving toward self-realization is to the strife of the White world like a wheel within a wheel: beyond the Veil are smaller but like problems of ideals, of leaders and the led, of serfdom, of poverty of order and subordination, and, through all, the Veil of Race. Few know of these problems, few who know notice them; and yet there they are, awaiting student, artist, and seer, - a field for somebody sometime to discover.

–W. E. B. DuBois

The acknowledgement and unlearning of racism are especially salient to White individuals working within the social work profession. Due to an unequal power structure that categorizes Whites as helpers and people of color as clients, Whites must be pro-actively cognizant of the way in which societal and interpersonal contexts affect the multiracial practitioner/client relationship. Borrowing terminology from Belenky, Blythe, Goldberger, and Tarule (1986), this article focuses on a racist way of knowing to describe the distinct way in which Whites in the United States have cultivated their own reality and conclusions regarding the intersection of race, power, and privilege. The purpose of this article is to demonstrate that without a conscious understanding of one’s own racist ways of knowing, White social workers are primed to disservice their clients of color through various forms of racism.

To embark on this conversation about race, I would first like to acknowledge the simplification of the Black/White dichotomy corroborated by this paper when race is, instead, a complex social construct. The following article is by no means designed to function as a review of social
work literature or the state of racism in America. Rather, it is a heart-mind journey (Seldon, 2000) – reflections of unlearning racism, the questions and challenges it has posed in personal experiences and the professional practice of social work.

**A Question of Covert Repression**

While working in the South Bronx during my first year field placement, I confronted a daily turmoil involving, of all things, hair. In an agency where I was most often the only blonde, blue-eyed individual, I experienced heightened sensitivity to a culturally induced skewed beauty standard when male clients would express an allure towards my blond hair in front of their female companions. This experience, which occurred regularly with multiple clients, unleashed an inner dialogue and maelstrom within me. I became exceedingly alert to my own fears toward repressing clients and wondered: Is my hair color covertly repressive to a client of color? How does my Whiteness affect my practice? This internal argument was the catalyst for an intense and unremitting journey within my consciousness – a journey of reflection on racist identity and privilege.

Issues of race can be controversial and problematic to self-identity. To be labeled racist invokes defensive fears in all of us. As a White individual, I have come to acknowledge that I am aligned with the perceived class elite and the politically powerful which entitles me to a wealth of privileges regardless of my moral conviction or personal history (Steinhorn & Diggs-Brown, 2000). As McIntosh (1989) suggests, I was socialized to downplay my own racial issues and understand White people’s way of thinking as normative, neutral, and ideal. Despite a liberal education that focused on the damaging ideology of hierarchy and oppression, without self-reflection and a personal confrontation of my own racist schemas, I only superficially considered myself part of a racist structure.

When we think of White supremacy, visions of Klansmen and skinheads may pervade our definition; we rarely think of ourselves as the vehicle for oppression. Seldon (2000), however, reminds us that “Prejudice + Power + Privilege = Racism” (p. 26). Because most of my peers are White, and most of our collective clients are people of color, I have become particularly interested in how race and social work intermingle. In 2000, Whites composed close to 70% of Social Work students enrolled in Master’s level Social Work programs in the United States (Lennon, 2002). Thus the continuation of the White as helper, Black in need dichotomy is something I have had to critically examine to bring an anti-racist agenda into my practice.

McMahon and Allen-Mearnies (1992) define anti-racist social work as “helping people reflect on their situation so that they can understand the oppressive system they are in and working with them to change it” (p. 538). In contrast, I have chosen to tailor my own model of anti-racism
in a direction towards the self rather than the client. For me, anti-racism encompasses both pro-active critical examination and recognition of individual and institutional involvement in perpetuating racist structures. It also includes an analysis of the subtlety and complexities of racial dynamics in the historical, political, economic, social, and cultural realms of power structures. To be anti-racist is to move towards incorporating racial and social justice into all facets of personal and professional development.

**Examining Whites In the Victim Role**

In my opinion, the most interesting race-based conversation among social work students revolves around the fear of the walk from the subway station to their placements. I have been privy to thought processes in which students acknowledge and then minimize the racist undertones of their fears and proceed to externalize racism by suggesting their fears of criminality are statistically founded.

In fact, the criminalization of people of color highlights the legacy of slavery inherent within the criminal justice system. To illustrate this point, we can turn to drug sentencing statistics: “Blacks make up 12% of the United States’ population and constitute 13% of all monthly drug users… but represent 35% of those arrested for drug possession, 55% of those convicted of drug possession and 74% of those sentenced to prison for drug possession” (Butterfield, 1995, p.A8). Additionally, the media disproportionately focuses on crimes committed by Black men while the dangers people of color face are rarely highlighted (Glassner, 1999; Reiman, 2001).

In understanding how criminal injustice and skewed media portrayals exacerbate stereotypes about people of color, I am reminded that “a person is evaluated, either favorably or unfavorably, not because he does something, or even because he is something, but because others react to their perceptions of him as offensive or inoffensive” (Quinney, 1975, p. 67). To maintain a racist status quo, skewed perceptions supported by criminal injustice and media images fulfill and perpetuate the dominant culture’s need to place themselves in the inculpable position of victim. Therefore, students’ fears of walking through a neighborhood with the credence that one is in danger sanctions little need to critically examine negative schemas towards people of color and the poor. Focusing on the systematic, institutional structures responsible for the cause and maintenance of crime, poverty, and second class citizenship will make walking through an agency’s neighborhood take on an entirely different meaning.

**White Social Workers as Averse Racists**

By nature of the liberal principles presented in the Code of Ethics of the National Association of Social Workers (NASW, 1999), social workers
present themselves as socially progressive, and it is against this philosophy to internalize a racist identity or embrace a racist thought pattern. By externalizing one’s own racist lens, however, Whites fall into what Gaertner and Dovidio (2000) identify as aversive racism. Aversive racists are described as those who “sympathize with the victims of past injustice; support public policies that, in principle, promote racial equality and ameliorate the consequences of racism; identify more generally with a liberal political agenda; regard themselves as non-prejudiced and nondiscriminatory; but, almost unavoidably, possess negative feelings and beliefs about Blacks” (Gaertner & Dovidio, p. 289).

Furthermore, a study of White graduate students showed race-related guilt to be an evident manifestation when talking about Whiteness (Arminio, 2001). Arminio found that often, guilt was associated with efforts at indemnification; privilege was used to avoid recognizing racist patterns and as justification for not seeing oneself as part of the system. Research teaches us that by externalizing racist and negative thought patterns, fears are manifested in apprehension, discomfort, and uneasiness (Gaertner & Dovidio, 2000). Considering the impact of racism on the White mentality, White social workers hold a unique responsibility for self-reflection and critical thinking about one’s prejudices, privileges, and the implications of both. By the definition of our work, a great disservice is committed if we do not take a proactive stance towards combating externalized racism and confronting how covert fears present themselves in practice.

Venturing Beyond A One-Dimensional Reality

One of my most disturbing experiences as a social work student occurred during a first year required class, Human Behavior and the Social Environment in which the 1986 CBS documentary The Vanishing Black Family: Crisis in Black America (Wolff) was shown. The film showcased African-Americans living in Newark, NJ, depicting young men as irresponsible sex-crazed pimps and two generations of women as quintessential Welfare mothers.

A student interrupted this video and stated that she was offended with the content of the film. She labeled it “racist propaganda” and was unsure why the class was viewing it. This comment provoked other students to voice disappointment and anger toward the film’s failure to address the root causes of poverty. I remember the professor, outwardly flustered, attempting to conclude the discourse by stating it was taking away from the film’s message, and that we would understand its greater meaning if we continued to watch the entire movie.

The film’s agenda was to document the disappearance of the Black nuclear family. However, the content did not acknowledge the destruction of the Black family as an essential component of American slavery (Marable, 2000). Without historical connections or context, reality is one-dimensional.
For social work education to function in a one-dimensional manner, which presents race-based material void of the historical and political contexts, our ability to be critical thinkers is injured.

Despite one student asking if we could stop the movie to continue the discussion, the class sat agitated while the professor, obviously bothered, fast-forwarded through the two-hour film to make up the time we had lost talking. While the professor did set aside the last twenty minutes of the following class, one week later, to discuss the film, I felt like we were silenced and frustrated from the previous experience. The discussion lacked the original passion and productivity that was generated by the experience of watching the film. One week later, this discussion seemed deflated and decontextualized. I sense that many students yearn to discuss context and impact, but without a catalyst or encouraging environment, conversations dealing honestly and frankly with race are not permitted to exist.

I am saddened that my experience of social work education has minimally challenged my understanding of power and inequality. It has demonstrated a general lack of energy in its dialogue, unequivocally ignoring and therefore supporting a White supremacist status quo. If “a major objective in social work education is to impart knowledge that helps students engage in critical self-reflection about power and inequality” (Millstein, 1997, p. 491), then we must welcome the potential volatility of such discourse. White students unable to engage and gain proficiency in race-based dialogue within an academic environment will be less likely to initiate internal reflection or dialogue as professionals.

I sometimes listen to social work students’ call for more diverse faculty and student body citing the predominantly White student composition, yet I rarely hear a request for anti-racism class or field assignments. While acknowledging the importance of diversity in thought within any healthy community, I must also highlight that the presence of diversity in itself is not sufficient to imply a lack of racism. Academic institutions, such as the Smith College School of Social Work, have challenged themselves to create and implement an anti-racism field assignment, requiring students to recognize racial dynamics within their field practice (Basham, Donner, & Everett, 2001). While this is an intriguing window into the psyche of social work education’s response to the conception of an anti-racism field assignment, I challenge all institutions to continue to question how anti-racism assignments could fit into their curriculum, particularly through the full cooperation between faculty, students, and field instructors. If class or field assignments were designed to incorporate anti-racism in their agenda, what would they look like? How would the faculty and field advisors execute and evaluate them? How would the students receive and develop through them?
Call for Anti-Racism as a Critical Component of Social Work Education

Social work academia as an institution has an obligation to demand reflective, in-depth materials regarding anti-racism as a baseline for students pursuing social work. For cultural competence standards to truly be addressed, existing social work literature must be critiqued for its thoroughness and ability to address concerns in an unveiled, shameless manner. Critically examining not only issues of race, but those of class, ethnicity, religion, sex, gender, sexual orientation, disability, and societal definitions of deviance should be what sets social work apart from other professions.

While the Code of Ethics of the NASW (1999) provides multiple principles for the creation and maintenance of a culturally competent practice, the existing social work literature geared toward the promotion of social work’s specific responsibilities in unlearning racism, is at best, inconsistent. I have found texts, such as Allen-Mearnes & Garvin, 2000; Burgest, 1985; Vacc, DeVaney, & Brendel, 2003; Vacc, DeVaney, & Wittmer, 1995, that range from one paragraph on cultural competency to entire chapters on self-awareness. To dedicate a section or chapter to the issue of race perpetuates the illusion that discussion and examination should exist within a designated box or timeframe. McMahon and Allen-Meares (1992) believe, “The literature of a profession is the text of what that profession believes is important for knowledge and practice” (p. 537). It would be my hope that future social work literature dealing with issues of race be multifaceted, highly developed, thorough, and seamless in composition.

For social work to achieve self-respect, I feel it must aspire to be not only anti-racist but also pro-actively vigilant in the process of achieving racial and social justice. It is for this reason that academic curricula’s treatment of social justice must be examined for integration and thoroughness of anti-racist training and policies. Ultimately creating an anti-racist climate. Social work must acknowledge that accessing higher education is a privilege that prevents people of color from empowering their own underserved communities. To achieve social justice, social work should confront the institutional structures that contribute to the disproportionate racial composition of its graduates.

Reflections on Racial Consciousness

Like McIntosh (1989), I struggle with my own position within the system of dominance and oppression from which I benefit. It was in social work practice that I first had to confront my own intellectualization of prejudice and meet head-on my own racist ways of knowing. I spent most of my first year of my Master’s program attempting to pick up the pieces of a shattered White knowledge base. My sensitization to the complexity of these issues
has made them salient in life to the point that I am sometimes alienated by my own awareness. Through the equally invigorating and exhausting time I have spent unlearning a history authored by Whites, I have increasingly felt more detached from my social work peers. I have come to understand that silence creates a vacuum, and the absence of antiracist awareness personally, politically, and academically signals the presence of covert racism.

Reflecting on this progress, I acknowledge a previous clandestine discomfort with my own Whiteness, which undoubtedly influenced my competency in working with clients of color. Through the process of thinking, writing, and editing this article, I have been forced to confront my own fears of defensive intellectualization as well as attempt to enmesh a continually transforming view of my own cultural competence and understanding of racist ways of knowing. During my deepest and most painful thought processes around racism, I often roll around the phrase “ignorance is bliss”. I sometimes think this because I am feeling fatigued, sad, and dejected. I am able to think this because, as a White individual and even as a White social worker, I can survive and thrive unaware as Whites have done for generations. However, I feel a profound responsibility to enter into the pain and discomfort of identifying and acknowledging my racist ways of knowing and to welcome and truthfully confront problems that arise interpersonally, politically, and in practice. My personal journey towards an anti-racist ideology has led me to feel more powerful as an individual, and as a social worker, than I ever have before.

W.E.B. DuBois believed that racism should not just be a burden on the backs of nonWhites but had to be thoroughly acknowledged by progressive Whites as well. It would not be until this White awareness, that antiracist politics and attention to the needs of the oppressed could be addressed (1924). Social work, as a profession, has dedicated itself to the mission of social change and is therefore obligated to be a leader in anti-racist policies, academia, training, and practice.

Endnotes

1 I have chosen to focus on the Black/White duality due to a legacy of slavery and White superiority that has economically exploited and politically underdeveloped Black America. For the purpose of this paper, the term African-American is used to distinguish the descendants of the North American slave trade from that of Black which is used as an umbrella term to include African-Americans as well as those who wish to identify as recent generation Blacks, Caribbean-Americans, Haitian-Americans, and so on. The term “people of color” is used to identify those who are not Caucasian or of West European decent.
Research highlights the pervasive nature of a distorted beauty standard that favors Eurocentric ideals and supports what Malcolm X in 1963 referred to as “brainwashed”, “slavemaster worship” (Hill, 2002; X, 1999, p. 166).

Statistics show that 64% of the prison population is people of color and 32% of Black men could expect to serve in federal prison at some time in their life (Bureau of Justice Statistics, 2001).

I suggest that social work, as a profession, exists under what Helms (1990) terms pseudo-independence. In the Helm’s model of White racial identity development, pseudo-independence exists as a stage which devotes much of its time to helping the other and inadvertently supporting a belief system which perpetuates Whites as superior instead of transforming the dominant paradigm. In this stage, Whites are used as the normal model, while the focus of interaction revolves around assisting Blacks in transforming their lives to look like that of Whites (Helms).

References
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